Westmorland Healthcare Limited

Westmorland Court Nursing and Residential Home

Inspection report

High Knott Road
Arnside
Carnforth
Lancashire
LA5 0AW

Tel: 01524761291

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced focused inspection at Westmorland Court on 7 November 2016. This was to assess the progress being made by the service to meet two warning notices to improve had been issued after an unannounced comprehensive inspection of this service on 4 and 6 July 2016.

The warning notices were in relation to a continuation of breaches of two regulations where requirement notices had been issued at an inspection in September 2015. This was in respect of Regulation 17 (Good Governance) as the quality monitoring systems were still not being fully effective in identifying risks. It was also in respect of Regulation 12 (Safe care and treatment) because the registered provider had not protected people against the risks associated with the safe management of medication.

We also found at the inspection in September 2015 incidents that had occurred within the home that might affect people's safety had not been appropriately referred to the local authority safeguarding team or notified to CQC. We found that the registered provider had also not always acted in accordance with the requirements of the Mental Capacity Act 2005 (MCA). In addition, care plan assessments had not always reflected a person-centred approach to managing people's care needs.

Following the comprehensive inspection in September 2015 and July 2016 the registered provider wrote to us and sent us an action plan saying how and when they intended to make the improvements needed to meet the regulations.

At the inspection in July 2016, we found that action had been taken to comply with the breaches of regulations with the exception of Regulation 12 (Safe care and treatment) because the registered provider had not protected people against the risks associated with the safe management of medication. Also in respect of Regulation 17 (Good Governance) as the quality monitoring systems were still not being fully effective in identifying risks

At the focused inspection on 7 November 2016 we found that some further actions had been taken to make the improvements stated in the action plan regarding medicines management and governance. However, the breaches of the two regulations had not been met in full. Although some breaches of the requirements of the regulations have been addressed, some remain. The service rating overall remains Requires Improvement.

The service did not have a registered manager in post at this inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. At the time of the inspection in July 2016, there was a new manager in post but had not yet completed the process to register as a manager with CQC. They had left the post before our inspection on 7 November 2016 without completing registration.

A new manager has now been recruited and had been working in the home for a month when we inspected. We could see from audits and action plans the new manager had done that they were reviewing all that had been done so far to comply with the regulations and what still needed to be completed and embedded with staff. They demonstrated a clear understanding of the areas that must be addressed straight away and we could see that improvement work was underway. We saw that the lack of consistent and effective management during the time since the inspection in July 2016 had had a significant effect upon the service's ability to implement and monitor improvements and to embed new practices and awareness with staff.

Westmorland Court Nursing and Residential Care Home (Westmorland Court) provides personal and nursing care for up to 48 people. Set in National Trust owned land the home is a short walk from the centre of the village of Arnside. There is parking available for visitors and a garden area for people living there to use. At the time of the inspection in November 2016 there 31 people living in the home. Twenty of the people were receiving nursing care and 11 were residential receiving personal care.

We found that that some improvements had been put in place since our previous inspection concerning quality assurance and monitoring processes. The policies and procedures for staff to follow had all been reviewed and updated and the new manager was monitoring staff practices. Since taking up the post the manager had being conducting 'base line' checks that were to form the basis of a full programme of audits and a monthly manager's audit. The new manager was clear that a baseline was needed to monitor and measure development. The monitoring systems and quality management structures the new manager was implementing were only just starting and would need to continue to be used and evaluated to evidence consistency.

The new manager had done group and individual supervisions with staff to help to get to know them. The manager had also carried out observations of practice with them including moving and handling practices and hand hygiene. As a result they had identified that some staff had training needs that had to be addressed and this had been organised.

The new manager had been carrying out detailed medication checks themselves in the short time they had been in post. They had found that some procedures had not been followed by nursing staff and had held a nurse's meeting to take staff through the correct procedures so they were all made aware of the shortfalls and of their professional responsibilities.

However, we found that medicines were still not handled safely. We saw that there had been improvements in some aspects of record keeping but these were insufficient to fully demonstrate that people consistently received their medication safely We found that some of the concerns were still on going from the previous inspection. The records about the amount of stock of people's medication in the home were still not consistently accurate and did not always show that medication was accounted for or had been given as prescribed. The records about the administration of medication were also not consistently accurate.

We found that supporting information or 'protocols' were still not made clear to guide staff to administer medicines which were prescribed to be given "when required" or as a "variable dose". Clear guidance is needed to help ensure people are given these medicines safely and consistently for such things as anxiety, constipation and sleeping. A small number of people were prescribed medicines to be used to prevent pain and other unpleasant symptoms that may occur during the end of life care. Care plans to guide nurses as to when these drugs should be commenced in order to help alleviate distress were still not yet in place.

We need to be confident that the registered provider can demonstrate consistent and improved practice

over time. The registered provider has voluntarily suspended admissions to the home for a period of time, agreed with CQC, while the work still needed to fully meet the warning notices is completed. We will review our regulatory response and our ratings for safe and well led at the next inspection when the continuing breaches of regulations must be met.

We found the service, despite the improvements made, was still in breach of Regulation 12 Safe care and treatments (Management of medicines) and Regulation 17 Good governance. Where we have found continued breaches of the regulations we will ensure that action is taken.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link on our website at www.cqc.org.uk'

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People were still not always protected against the risks associated with the use and management of medicines.

While some improvements had been made the regulation has not been fully met and we have not revised the rating for this key question.

Is the service well-led?

Requires Improvement

The service was not well led.

Improvements to the quality monitoring systems had been made but there were still areas where the registered provider was not monitoring service provision effectively and so not meeting all of the requirements of the regulations.

While improvements had been made, the regulation has not been fully met and we have not revised the rating for this key question.

Westmorland Court Nursing and Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in July 2016 had been made. We inspected the service against two of the five questions we always ask about services: is the service safe and is the service well led. This is because the service was not meeting legal requirements in relation to those questions.

This focused inspection took place on 7 November 2016 and was unannounced. The inspection team consisted of an adult social care inspector and a pharmacist inspector. Before our inspection we reviewed the information we held about the home, this included the provider's action plans. We spoke with the local authority commissioning and quality management teams, the clinical commissioning group (CCG) the home's regional manager and looked at the notifications made to CQC and safeguarding referrals that had been made. The home was already involved in the local authority quality improvement process and had been visited by them to monitor improvements against an action plan.

During the inspection, we spoke with people who lived there in communal areas and in private in their bedrooms. We looked in detail at the medication records for 18 people and tracked their care. This included looking at records and care plans relating to people's nursing and personal care needs and assessed risks in detail. We observed medicines being handled and discussed medicines handling with staff. We looked at records that related to the management of the service and regarding how quality was being monitored within the home.

Requires Improvement

Is the service safe?

Our findings

At our previous inspections in September 2015 and July 2016, we had some concerns about the way medicines were being managed throughout the home. After our July 2016 inspection we issued a warning notice telling the provider that improvements must be made by the end of August 2016.

During this inspection a pharmacist inspector visited the home specifically to check that improvements had been made and that people were not at risk of harm due to poor medicines management and to ensure that the regulations were being met. We found medicines were still not handled safely and there was a continuing breach of Regulation 12(1).

We looked at medication and records about medication for 18 people out of the 31 people living in the home on the day of our visit. We found concerns regarding some aspects of safe medication. We found that some of the concerns were on going from the previous inspection and there was a continuing failure to handle medicines safely at all times.

We saw that some improvements had been put in place and were being sustained since our previous inspection. The medication policies and procedures for staff to follow had all been reviewed and updated and the new manager was monitoring staff practices. We saw improvement in how waste medicines were being stored correctly for disposal and we could see that new medication was being checked and booked in accurately. Clinical room and refrigerator temperatures were being checked twice daily to help make sure medicines were stored at the correct temperatures. This helped to keep them in good condition for administration. There were no eye drops being used that were out of date

We saw that there was a reduction in the number of signature omissions on the record for oral medication. Improvements had been made to administer medicines in accordance with the manufacturers' directions regarding if required to be taken with food. However we saw for one person that nurses had failed to recognise that a newly prescribed antibiotic needed to be given on an empty stomach. The records showed that it had been given at meal times. This placed them at risk of the infection not being properly treated.

Some medication such as antibiotics and paracetamol must have specific time intervals between doses. The time that these medicines were given was still not recorded so it was not possible for the nurses giving the next dose to know if they were administering it with an appropriate or safe time interval between doses. This was also noted at the previous inspection.

We saw that there had been improvements in some aspects of record keeping but these were insufficient to fully demonstrate that people had received their medication safely. The records about the application of prescribed creams lacked consistency with numerous signature omissions. This meant that those records could not be relied on to show that creams had been applied as prescribed. Information to guide staff as to where a cream should be applied was not always complete, so creams may not be applied correctly.

The records about the amount of stock of people's medication in the home were not consistently accurate

and did not always show that medication was accounted for or had been given as prescribed. The records about the administration of medication were also not consistently accurate; some medication had been signed for but not given.

People could not always have the medicines they were prescribed because medicines were not obtained on time and they had run out. We saw that five out of 18 people had run out of their medicines such as antidepressants, analgesics and medication prescribed to help with breathing problems for between two and eight days. This placed people's health at risk of harm. The lack of a consistently robust system to order medicines was an on going concern from the previous inspection.

We saw that there was no information to guide staff to administer medicines which were prescribed medicines to be given "when required" or as a "variable dose". Clear guidance is needed to help ensure people are given these medicines safely and consistently for anxiety, constipation and sleeping. A small number of people were prescribed medicines to be used to prevent pain and other unpleasant symptoms that may occur during the end of life care. Care plans to guide nurses as to when these drugs should be commenced in order to help alleviate distress were not in place. The service now had equipment required to deliver end of life medication

Some people had a thickener prescribed to help ensure that they could have drinks and other fluids without choking. There was no information with the medication administration records detailing how each person's drink should be thickened. This placed people at risk of not getting appropriately thickened drinks. We found that care staff that made thickened drinks for people did not have full details of how people needed their fluids thickened.

The new manager had been carrying out detailed medication checks themselves in the short time they had been in post. They had found that the correct procedures were not being consistently followed by nursing staff. The new manager had held a meeting for all the nursing staff to take staff through the correct procedures so they were all made aware of their shortfalls and of their professional responsibilities.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspections in September 2015 and July 2016 we had concerns about the governance, quality monitoring and audit systems in the home. The systems in use were not being effective in monitoring the quality and effectiveness of the service and in identifying where improvements were needed.

During this inspection we checked to see if that improvements had been made in the effectiveness of the quality monitoring and audit systems and the overall management governance in the home. This was to help ensure that the regulations were being met. We found that some of the concerns were on going from the previous inspection and there was a continuing failure to make sure that there was effective governance and auditing systems to be able to properly meet the warning notice and there was a continuing breach of Regulation 17 (1).

At this inspection we found that some improvements had been made to the use of quality monitoring systems and audits were taking place and being effective in several aspects of the service. However it was evident that these had not been fully effective in the monitoring of medication management.

Medication audits were being done by the new manager. These had highlighted some discrepancies but the improvements made were insufficient to demonstrate that medication was being safely and consistently managed.

The first audit the new manager carried out on taking up their post showed only 40% compliance, the next full medication audit a week later showed a 60% level of compliance. This monitoring has provided an indication of progress although there was clearly still a considerable amount yet to be achieved.

We were told that the registered nurses carried out the care plan reviews. However we noted that the reviews done by nurses had not addressed all potential risks or evaluated if all a person's current care needs had been considered. For example, around pain monitoring, diabetes, the management of tube feeds, the use of medication to thin the blood [anticoagulants] and end of life medication and wishes. Care plans were not always up to date to reflect changes in conditions and care management. However, a check on Deprivation of Liberty Safeguards (DoLS) in place did highlight the need to change a person's care plan to make sure it reflected the conditions of the approval.

Since taking up the post the manager had been conducting 'base line' checks that were to form the basis of a full programme of audits and a monthly manager's audit. The new manager was clear that a baseline was essential to effectively monitor and measure development. The monitoring systems and quality management structures the new manager was implementing were only just starting and would need to continue to be used and evaluated.

A weekly performance indicator report was about to be started and the manager's daily report system had already started. The aim of this was to improve communication at all shift changes and to make sure the manager was informed quickly of any incidents, accidents and changes in people's conditions.

We found that work had been done to update the policies and procedures that staff should be following. These were held both in hard copy and electronically. We saw that new policies had been added to promote best practice including around the deprivation of liberty safeguards and on emergency admissions. We saw that an audit of nutritional assessments was underway and that there were now monthly weight trackers to alert to any fluctuations.

We saw that the new manager had started to implement a programme of quality monitoring and audits. They had undertaken an infection control audit and the manager had been doing weekly walk rounds. An action plan had been developed as a result. The action points raised following the audit had been completed including with the night staff cleaning hoists, commodes and wheelchairs and mattress audits were also now part of this process.

Monitoring of trends was beginning to take place for example, the rates of infections such as urinary tract infections and chest infections. This had just started but was intended to highlight risk factors so action could be taken to reduce risks. Also just started was a weekly clinical audit of rooms and sluices and the home environment.

The new manager had done group and individual supervisions with staff to help to get to know them. The new manager had also carried out observations of practice with them including moving and handling practices and hand hygiene. As a result they had identified that some staff had training needs that had to be addressed and this had been organised.