Westgate House Limited

Westgate House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Westgate House is a care home that is registered to provide accommodation and personal care for up to 44 older people including people living with dementia. At the time of inspection 31 people were using the service.

People's experience of using this service and what we found
Safeguarding procedures were not consistently followed. Unexplained injuries were not always investigated, and physical interventions were not always appropriately recorded.

People were put at risk. Records were not consistently completed to evidence people's needs were met. Not all known risks to people had been assessed or mitigated.

Medicine management required improvement. People did not always receive their medicines as prescribed.

Preventing and controlling infection required further improvement. We found the service appeared cleaner, however best practice and government guidance on preventing the spread of COVID-19 had not always been followed.

Staff did not always receive up to date training to enable them to learn the skills required to support individual people.

Provider oversight of the service was ineffective. Concerns found on inspection had not been identified therefore, no actions had been implemented to reduce the risks.

People were not asked to feedback on the service and staff told us they did not feel involved in the running or improving of the service.

People, staff and relatives knew how to complain. The registered manager understood their responsibilities under the duty of candour.

People were supported by staff who had been safely recruited. We found sufficient numbers of staff on duty during the inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 18 September 2021) and there were three breaches of regulation. At this inspection we found improvements had not been made and the provider was still in breach of regulations.

This service has been in Special Measures since 6 September 2021. During this inspection the provider had not demonstrated that improvements have been made. The service is therefore still rated as inadequate overall and remains in Special Measures.

Why we inspected
We received concerns in relation to records, safeguarding, staff training, risks and oversight. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We also undertook this inspection to check whether the Warning Notice we previously served in relation to Regulations 12 (Safe care and treatment), 13 (Safeguarding service users from abuse and improper treatment) and 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Westgate House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risks to people, safeguarding, records, staff training and oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Westgate House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Westgate House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this

report.

During the inspection
We spoke with three people who used the service and two relatives about their experience of the care provided. We spoke with eight members of staff including the provider, registered manager, nurses and care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 21 people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Part of this inspection was to check if the provider had met the requirements of the warning notice we previously served.

Systems and processes to safeguard people from the risk of abuse
At our last two inspections the provider had failed to ensure systems and processes were sufficient to ensure people were safeguarded from abuse and improper treatment. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not made improvements and was still in breach of regulation.

- People were at increased risk from inappropriate restraint. Records were not completed in line with the providers policies. For example, records did not always contain the type of physical intervention used, which staff were involved or how long the physical intervention took. There was no evidence of debriefs being completed after to review if the intervention was necessary, the least restrictive option and what lessons could be learnt. This put people at risk of inappropriate treatment.
- People's care plans did not always contain sufficient information regarding what restraint techniques could be used with a person. Management told us; staff often held people's hands down to stop them harming staff. One staff member told us, "We hold [person's] arms and hands every time [during personal care] otherwise we would get hit." We found this information had not been recorded and management confirmed this information was not consistently recorded.
- People were at increased risk of abuse. When people received an unexplained injury, investigations to establish what may have caused these injuries had not always been completed.
- The providers safeguarding policies and procedures were not consistently followed. Not all unexplained injuries, medicine errors or potential incidents of harm had been reported to the local authority safeguarding team for further investigation.

The provider had failed to ensure systems and processes were in place and followed to ensure people were protected from abuse and improper treatment. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure risks to people's health and safety had been assessed

and done all that is practical to mitigate those risks. The provider had failed to ensure the proper and safe management of medicines. These were a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not made improvements and was still in breach of regulation.

● Risks to people had not always been consistently assessed or mitigating factors been implemented. One person required regular checks to reduce the risk to themselves and others. However, records did not evidence this was being completed and one member of staff said, "Many times staff forget to write or check [person] every half hour, they [staff] often forget. One day I came in at 1pm and no-one had written anything, they [staff] had forgotten." This put people at risk of harm.
● Staff did not always have the information required to support people safely. For example, two people with health conditions did not have all the necessary information recorded in care plans or risk assessments. This meant people were at increased risks associated with their health conditions.
● Strategies recorded to mitigate known risks were not consistently followed. For example, we found gaps in the recording of blood sugar monitoring. This put people at risk from their known health conditions.
● People were at increased risks of skin pressure damage. Some records for people who required support with repositioning tasks were outside of the prescribed timeframes and others had no repositioning tasks recorded.
● People were at risk from not receiving support with continence care. For example, we found records of support with continence checks and continence tasks, had not been completed within the specified timeframes for people. One person's records evidenced a gap of 12 hours between support with continence care, and the person suffered from skin damage.
● Medicine administration was not always completed correctly. For example, we found seven people had not received their medicines as prescribed on one occasion and one person had not received their medicines on another occasion due to staff error. This put people at risk of not receiving their medicines as prescribed.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. The provider had failed to ensure the proper and safe management of medicines. These were a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Not all staff had the required training to complete their roles and support people safely. There was no evidence of staff receiving seizure or communication training. Records evidenced five staff were out of date with mental capacity training and eight staff were out of date with dementia training. Not all care staff had received training in falls or mental health. The provider had not ensured staff had the relevant skills and training to keep people safe.

The provider had failed to ensure staff received appropriate training to enable them to carry out the duties they are employed to perform. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were protected against the employment of unsuitable staff. Records confirmed that Disclosure and Barring Service (DBS) checks were completed and references obtained. These are checks to make sure that potential employees are suitable to be working in care.
● During the inspection we observed suitable numbers of staff on shift. We found no concerns with staffing levels.

Preventing and controlling infection

● We were not fully assured that the provider was preventing visitors from catching and spreading infections. The provider had not followed government policy on COVID-19 screening processes for visitors.

● We were not fully assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The provider was not consistently following government policy on taking people's temperatures twice daily.

● We were not fully assured that the provider was using PPE effectively and safely. Some staff were observed not wearing their face masks correctly.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. High touch cleaning had not been recorded as completed fully. However, staff told us these areas were cleaned twice daily.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.
This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Part of this inspection was to check if the provider had met the requirements of the warning notice we previously served.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last two inspections the provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of Regulation 17 (1) (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not made improvements and was still in breach of regulation.

● Systems and processes were not effective in identifying when care tasks had not been completed as required. We found gaps in the records of people's food and fluid intake, continence checks and oral care. One person was found to be at risk of impaction due to the lack of records. This put people at risk of harm from dehydration, malnutrition, impaction, constipation and dental issues.
● Systems and processes were not effective in identifying when risks had not been assessed or mitigated. We found risk assessments did not always contain up to date information and some did not have mitigating strategies implemented. This put people at risk of harm from known risks.
● Systems and processes did not identify when health needs were not recorded appropriately. We found gaps in the recording of people's blood sugar monitoring. This put people at risk from their health conditions.
● Systems and processes did not identify when records were not completed for skin integrity risks. We found multiple gaps in the recording of repositioning tasks. This put people at increased risks from skin pressure damage. One person had an pressure ulcer.
● Systems and processes were ineffective in ensuring documentation regarding physical interventions were in place and were ineffective in ensuring procedures were followed regarding physical interventions. We found incomplete records of physical interventions had been signed off by management. This put people at risk of inappropriate restraint.
● Systems and processes were not in place to ensure injuries to people were recorded appropriately and causes for the injuries were identified or investigated. We found records evidencing unexplained injuries had

occurred for five people and investigations had not been completed to identify the potential cause or identify any risks that would require mitigating.
● Systems and processes did not identify when incorrect or missing information had been recorded within people's care plans. We found incorrect information regarding pressure mattresses and use of thickener for fluids. We found missing information regarding health concerns such as seizures and what interventions had been agreed to use. This put people at risk of not receiving the correct support as staff did not have all the necessary information.
● The provider had not always learnt from feedback given and improved the quality of care. The provider received information from previous inspections regarding improvements needed. These concerns had not been addressed on this inspection.

The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of Regulation 17 (1) (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their responsibility under the duty of candour. Records of phone conversations held with family members were in place when an incident or accident occurred. However, we found no formal duty of candour letters sent after incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider did not send out surveys or gain feedback from people using the service.
● Staff told us they were not always involved in changes or improvements to the service. However, they attended staff meetings to discuss and issues. One staff member told us, "They [managers] tell us if changes are being made, but I don't get asked what I think."
● Some relatives were involved in a group called 'Friends of Westgate." This group arranged events to raise money were able to make decisions on how donations were spent.

Working in partnership with others
● The provider worked closely with the GP and district nursing team.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received appropriate training to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. The provider had failed to ensure the proper and safe management of medicines.

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes were in place and followed to ensure people were protected from abuse and improper treatment.

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

Notice of Decision