Care Quality Commission

Isle of Wight Council

Westminster House

Inspection report

Westminster Lane
Newport
Isle of Wight
PO30 5DP
Tel: 01983 526310

Date of inspection visit: 02 & 08 December 2015
Date of publication: 27/01/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Westminster House is a care home run by the local authority, which provides short term respite to people with learning disabilities. The home can accommodate a maximum of 10 people and on the days we visited the home, there were four and five people staying respectively. There were a total of 41 people registered to use the respite service, some of whom used it on a weekly basis and others less frequently. The inspection was unannounced and was carried out on the 02 and 08 December 2015.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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 2008 and associated Regulations about how the service is run.

People were at risk of receiving unsafe or inappropriate care because care records were not always up to date and did not contain sufficient information to inform staff as to people's individual needs.

Summary of findings

Risks relating to people's care and welfare were not always managed effectively and risk assessments were not up to date.

There was not an effective system in place to manage short term absences, such as staff sickness. Staff were not always supported to develop through supervisions and appraisals.

The registered manager did not always notify CQC, without delay, of incidents of abuse of allegations of abuse affecting people using the service.

Staff sought verbal consent from people before providing care. Staff were knowledgeable about the people they supported and when appropriate followed legislation designed to protect people's rights and ensure decisions taken on behalf of people were made in their best interests. However, there were no records in people's care plans to new enable staff to understand the ability of the person to make specific decisions for themselves. We have made a recommendation in respect of this.

We found the home was meeting the requirements of the Deprivation of Liberty Safeguards.

There were systems in place to monitor quality and safety of the service provided. However, some audits were completed on an informal basis and were not recorded. We have made a recommendation in respect of this.

People were supported by staff who had received the appropriate training to enable them to meet their individual needs. There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training.

Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain their family relationships. People's families were involved in discussions about their care planning, which reflected their assessed needs.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people in a patient and friendly manner.

Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. They were patient when speaking with people. Staff were able to understand people and respond to what was being said.

There was an opportunity for families, health professionals and regular visitors to become involved in developing the service and they were encouraged to provide feedback on the service provided. They were also supported to raise complaints should they wish to.

Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the full version of the report.

Summary of findings

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 always safe.

The registered manager had not always assessed individual risks to people or ensured they were relevant and up to date.

There were not always enough staff to meet people's needs. Recruiting practices ensured that all appropriate checks had been completed.

People's families felt their relatives were safe and staff were aware of their responsibilities to safeguard people.

Medicines were managed appropriately.

Is the service effective?

Requires improvement 

The service was not always effective.

Staff received an appropriate induction and ongoing training. However, staff were not supported effectively, supervisions were sporadic and appraisals and not been completed since 2009

The registered manager and care staff understood their responsibilities to support people who were unable to make certain decisions relation for themselves. However, the care records did not always reflect this approach or contain sufficient information to assist staff understand a person's ability to make these decisions.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Is the service caring?

Good 

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and links with the local community.

Is the service responsive?

Requires improvement 

The service was not always responsive

Care plans were detailed but did not always reflect how best to support people's individual needs.

People told us the staff were responsive to their needs.

Summary of findings

The provider sought feedback from people or their families and had arrangements in place to deal with complaints.

Is the service well-led?

Requires improvement

The service was not always well-led.

The provider and registered manager did not always notify CQC of allegations of abuse without reasonable delay.

There were systems in place to monitor the quality and safety of the service provided, however, some audits were completed on an informal basis and not recorded.

The implementation of change was not effective due to tensions between the registered manager and staff who were resistant to change

People, their representatives and staff had the opportunity to become involved in developing the service.

Westminster House

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 checked 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.

The inspection was unannounced and was carried out on 02 and 08 December 2015. The inspection was carried out by an inspector.

Before this inspection, we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to send to us by law.

We met with five people using the service and spoke with the families of four people. We observed care and support being delivered in communal areas of the home. We spoke with six members of the care staff, the administrator who also carries out some care duties, the cook, the registered manager and the group manager for the provider.

We looked at care plans and associated records for seven people using the service, staff duty records, seven staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in December 2013 when no issues were identified.

Requires improvement

Is the service safe?

Our findings

The families of people using the service told us they did not have any concerns regarding their relatives' safety. One family member said, "We can go to bed at night and relax knowing she is safe and well looked after". Another family member told us, "I am sure [their relative] is totally safe there, they are so excited when they are going for their stay, I don't have any concerns at all". We observed the people who were unable to tell us verbally about their experiences and saw they were relaxed and engaged fully with the staff who were supporting them.

Although people told us they felt safe, we found that risks to people were not always documented and managed effectively. For example, following a serious safeguarding incident between to people using the service in 2014, there were no risk assessments in relation to either of the two people and the potential risk they posed to each other or other people using the service. One person's care plan identified that they were "terrified of dogs" however, there were no risk assessments to in place to assist staff in understanding the action they should take to support this person when out in the community.

Where risk assessments were in place to support people these were generic, did not reflect people's individual needs and did not provide staff with the information necessary to keep people safe. For example there was a generic risk assessment in each person's care plan which related to travelling in the minibus. The risk assessment for one person did not reflect the fact that they remained in their wheelchair during the journey. One person's risk assessments had not been updated since October 2013, although their health care needs had changed during that period. All of the care records we look at contained a risk assessment in respect of people's bedrooms which stated 'staff to be aware of the temperature in each room ensuring it meets my preferences'. The registered manager and staff told us they did not record the temperature in each room, they were not aware of people's preference with regard to room temperature and the home did not have the facility to change the temperature in each room. Another generic risk assessment stated people using the service were not allowed in the kitchen area. However, the manager told us that people do access to kitchen to make cakes and help prepare food. All of the generic risk assessments had not been updated since 2013.

We raised this with the registered manager and the representative of the provider who agreed this was an area for concern and had commenced an action plan to ensure risk assessments were in line with best practice guidance.

The failure by the provider to ensure they peoples' risks were identified and reasonable action taken to reduce those risks is a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not always able to deploy sufficient numbers of suitably qualified and experienced staff to meet people's care needs because they did not have a robust system in place to manage short term absences for example when a member of staff was off sick. Care staff told us there were occasions when, as a result of staff sickness, staffing levels fell to a level, which impacted on their ability to support people safely. Two members of staff gave examples of when staff shortages had meant that there were only two members of staff available to meet people's needs, including one person who required two people to support them with mobilising and personal care. They told us there were occasions when they were required to leave people unattended for long periods of time. They gave an example of when the only two members of staff working were supporting a person to use a hoist in their bedroom and had to leave the door open so they could hear if there was a problem with the other people left on their own in the lounge. They told us "it is not safe".

We reviewed the duty rota for the dates between 02 November 2015 and 08 November 2015 and found that on six of the 14 day shifts when there was only a duty manager and one member of care staff working. In addition, the staff were also require to support addition people who attended the home on a day service basis. We raised this with the registered manager who accepted there were problems finding cover when staff went sick at short notice. They told us cover was usually provided by staff working overtime, the provider's bank staff or agency. They said as a last resort they would cancel peoples respite and reallocate the hours. They added that staff were already covering extra duties and the bank staff system was ineffective as people were never available.

The minutes of the staff meeting dated 24 November 2015, which was attended by the registered manager and the

Requires improvement

Is the service safe?

group manager on behalf of the provider, staff raised concerns that they felt the practice of the care in the centre was being impacted by a lack of staff and felt that they are not operating within safe working levels.

The failure by the provider to ensure they deployed sufficient staff to meet people's needs is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a safe and effective recruitment process in place to help ensure that staff who were recruited were suitable to work with the people they supported. All of the appropriate checks, including Disclosure and Barring Service (DBS) checks were completed on all of the staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

Staff had received safeguarding training and knew what they would do if concerns were raised or observed in line with their policy. Staff members were able to describe types of situations which would cause them concern and the action they would take. They told us they were confident that anything they reported would be followed up. Staff had also completed, or were in the process of completing, vocational qualifications in care, which contained a section relating to safeguarding. Where safeguarding concerns were identified, they worked with the local authority and where requested, investigated the matter internally and reported their findings to the appropriate authority.

The provider had an up to date medicine policy, which provided detailed guidance for staff. there was an effective medicine management system in place built around the short term nature of people's stays at the home. Only the deputy managers, who had received the appropriate training and had their competency assessed were able to administer medicines to people staying at the home. People's medicine administration records (MAR) had been completed correctly and were audited at the completion of each period of respite. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. A family member told us staff looked after their relative's medicines "which is really well organised".

Accidents and incidents were recorded and contained sufficient detail to allow staff to identify patterns and put in place remedial actions. The registered manager monitored and reviewed all accident and incident records to ensure that appropriate management plans were in place.

There were arrangements in place to deal with foreseeable emergencies. There was also a fire safety plan for the home. Staff were aware of the plan and were able to tell us the action they would take to protect people if the fire alarm went off.

Requires improvement

Is the service effective?

Our findings

The families of people using the service told us they felt the service was effective and that staff understood their relatives' needs and had the skills to meet them. One family member said "Westminster House is absolutely fantastic; the staff are wonderful and really understand how to look after [my relative]. The facilities are wonderful, in fact when we first looked at the home we would move in there ourselves". Another person's relative told us "They know exactly how to look after [my relative]. He loves it there; I have no concerns".

There were arrangements in place to ensure staff received an effective induction into their role. Each member of staff had undertaken an induction programme based on the principles of the care certificate which is a set of standards that health and social care workers adhere to in their daily working life. Each new member of staff spent time shadowing more experienced staff, working alongside them until they were competent and confident to work independently. The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as, fire safety, infection control, manual handling and safeguarding vulnerable adults. Staff had access to other training focused on the specific needs of people using the service, such as, Makaton communication, autism awareness, epilepsy awareness and the new care act. Staff were also supported to achieve a vocational qualification in care.

Staff members had access to supervision and an annual appraisal. However, for some staff these were sporadic, with some staff not having received a supervision since 2012. None of the staff had received an annual appraisal since 2009. Supervisions and appraisals provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. Staff said they felt supported, and the registered manager had an open door policy and they could raise any concerns straight away.

The failure by the provider to ensure appropriate support in respect of supervisions and appraisals is a breach of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. We observed that staff asked people for their consent when they were supporting them.

Although the registered manager and staff had received MCA training and were applying the core principles in practice the records did not always reflect this approach. For example we saw that the care records for one person stated that they were 'fully able to make choices for myself'. However, a different entry identified that staff were providing care in in response to directions from a relative. The registered manager told us the person had capacity to make decisions for themselves. The care records for some of the people using the service contained information which identified that they were living with a cognitive impairment and lacked capacity to make certain decisions. However, there was no information or assessments in the care records to assist staff in understanding, and supporting the person's ability to make specific decisions for themselves. For example, the action staff could take to support the person to make a decision, such as giving them more time to understand the information being provided or using pictures or other communication methods to enhance understanding.

We recommend that the provider seek advice and guidance on adopting the latest best practice guidance in respect of supporting people living with a cognitive impairment and mental capacity assessments.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to

Requires improvement

Is the service effective?

deprive a person of their liberty were being met. Whilst no-one using the home was currently subject to a DoLS, we found that the manager understood when an application should be made and how to submit one

People were supported to have enough to eat and drink. Family members were complimentary about the food and told us their relatives' were supported to eat the food they liked. The cook was aware of people's likes and dislikes, allergies, preferences and special dietary requirements. Meals were appropriately spaced and flexible to meet people's needs. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. Staff were aware of people's needs and offered support when appropriate. Staff encouraged people to drink throughout the day.

People were supported to maintain good health and had access to appropriate healthcare services. A family member told us the staff "always tell us what [my relative] has been doing, how they are; they ring us if [they] is not well". The registered manager told us that is a person was unwell, where appropriate; they would liaise with their family to arrange for them to see either their own GP or attend the Beacon Centre, which is a walk in doctor's surgery.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. Staff had all been at the home for a long time and knew the people using the service very well. Family members told us they did not have any concerns over the level of care provided or how it was delivered. One family member said, "The staff are lovely and caring [my relative] is very happy and settled in well". Another family member told us "Honestly, the staff are so nice and caring. They are excellent and do wonderful things with [my relative]. They always go the extra mile".

People were cared for with dignity and respect. Staff spoke to people with kindness and warmth and were observed laughing and joking with them. Staff responded promptly to people who required assistance. A member of staff identified that a person appeared unhappy with the programme they were watching on the television. They checked with the person whether they wanted to watch the programme or whether they want to watch something else. They spent time with the person talking about the different programmes and music videos the person liked.

Staff understood the importance of respecting people's choice, and privacy. They spoke to us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what the preferred to eat and whether they took part in activities. Choices were offered in line with their care plan and preferred communication style. Where people declined to take part in an activity or wanted an alternative their choice was respected. We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited before entering. People were offered a choice of which bedroom they would prefer when they arrived for their stay.

However, people were not offered a choice with regard to the gender of the staff supporting them with personal care. We raised this with the registered manager who told us "We have a policy that male staff won't provide personal care to women".

People and where appropriate their families were involved in discussions about developing their care plans. One family member told us "We were all involved in [my relative's] care plan. We sat down with the manager and a couple of other staff and went through everything. What [my relative] liked or didn't like. [My relative] was there as well so we all chipped in".

People were supported to maintain friendships and to maintain links with the local community. Family members told us their relatives were encouraged to attend local groups and clubs while staying at the home. One family member said "We wanted [my relative] to be motivated and they ensure they have plenty of things for them to do they encourage them to be independent when they are out with them". Another family member told us "Staff arranged for [my relative] to continue to attend their regular day centre while they were they, so they could keep their routine and be with their friends".

Requires improvement

Is the service responsive?

Our findings

The families of people using the service told us they felt the service was responsive to their relative's needs. One family member said, "The staff are very good. They see how [my relative] is and then do everything they can to make their stay the best it can be". They added their relative was "always motivated when they go there so we know [my relative] is happy".

Although staff were aware of people's needs and how to meet them, the care records were not kept up to date to ensure they reflect peoples current needs. The care plan for one person which had not been updated since July 2013 stated they had cataracts in both eyes. The registered manager told us the person had had a successful cataract operation in the summer 2015 and both cataracts had been removed. There was no information in the care plan in respect of the operation, post-operative support and how this has changed their care needs. Care plans for another person, which had not been updated since 2013, identified the person was vulnerable and should not be alone in the company of men, apart from another specific person using the service. A serious safeguarding incident had occurred between these two people in April 2014, however neither persons care plans had been updated to reflect the incident and its impact on their care needs. All of the care plans we reviewed had sections which had not been updated or reviewed since 2013. We raised this with the registered manager who told us he was disappointed because he had allocated care plan to staff to update but they haven't done it. Staff were able to demonstrate an understanding of people's needs, how they had changed and how to support them. Handover meetings were held at the start of every shift, which provided the opportunity for staff to be made aware of any changes to the needs of the people they were supporting. One member of the newer members of staff said, "When I first came here I looked at the care plans. Then when I got to know the people I thought that is not how they are in their care plans".

We looked at the minutes of the staff meeting dated 15 September 2015 and at item 13 'Staff were reminded that service user care plans must be completed as identified some time ago, some are incomplete and/or require reviewing and updating. This needs to be actioned now'.

The failure by the provider to ensure that records were accurate and contemporaneous is a breach of regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about people's right to choice. They were aware of the types of activities people liked to do. People had access to activities that were important to them. A family member told us the staff made sure there were "plenty of thing for [my relative] to do". They added their relative "likes to help around the house at home, so they encourage her to do that while she is there". Another family member said staff were "always chatting to the people who were staying or doing some activities".

People, their relatives and friends were encouraged to provide feedback and were supported to raise complaints, if they were dissatisfied with the service provided at the home. The family members we spoke with told us they knew how to complain but had never needed to. One family member said, "I don't have any complaints but I am 120 percent certain the [the registered manager] would sort it out if I did. He is so dedicated". Another family member told us "I have never needed to complain but have raised a couple of issues since [my relative] has been going there and they always listen and put it right. If I did want to complain I would speak to [the registered manager] and then if I wasn't happy I would go to [the provider]". We looked at the complaints file and saw that no complaints had been received during the past year. The registered manager explained the action he would take if a complaint was received.

The registered manager told us that because of the short term nature of people's stay the sought feedback were they can after each stay. One family member told us, "We are always being asked for feedback. Whenever I phone or go in they ask was [my relative's] stay okay and what could we have done better". The registered manager told us that if issues were identified he would take action to put them right.

Requires improvement

Is the service well-led?

Our findings

The families of people using the service told us they felt the service was well-led and they would recommend the home to their friends and family. One family member said, "The home is definitely, well led, the new manager is excellent. He is the right man in the right job". Another family member told us "The manager is very approachable, it is like you are talking to one of your family when you are talking to him; he is lovely. I would definitely recommend the home to anyone".

Although, the registered the manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration, there were three occasions when an incident had been referred to the local authority but not to CQC. For example, an allegation of third party abuse towards a person using the service.

The failure by the provider to ensure that CQC was notified without delay of any abuse or allegation of abuse in relation to a service user is a breach of regulation 18(1)(2)(e) of Care Quality Commission (Registration) Regulations 2009.

The provider's vision and values were set out in the service user's guide providing short term respite support to people with learning disabilities. However, there was a tension between the new registered manager who was trying to bring in new ideas and improve the service delivery and some staff who had been working at the home for a long time. The registered manager told us they had tried to introduce a new style of care plan into the home but it had met with resistance from some of the staff and they reverted back to the old one. One member of staff said "I know the care plans are out of date. When I first came here I had a fit and [the registered manager] asked me to do the typed care plans but then he told me to stop and go back to the original one".

Regular staff meetings provided an opportunity for the management team to engage with staff and provided an opportunity for staff to provide feedback and become involved in developing the culture of the service. For example the staff meeting held on 24 November 2015 was focused on concerns raised by staff over staffing levels within the home. During the meeting staff were offered the opportunity to make suggestions for the way forward. There was an opportunity for people and their relatives to comment on the culture of the service and become involved in developing the service through regular feedback opportunities at the end of each period of respite.

There were some systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment, for example checks of the water temperature and fire alarms systems and processes. However, other audits were done on an informal basis by the registered manager, which were not recorded, such as a review of medicines administration, cleanliness and infection control. During our inspection we observed that the home was clean, staff were following infection control guidelines and medicines were being managed effectively.

We recommend that the provider seek advice and guidance on adopting the latest best practice guidance in respect of monitoring and recording the quality and safety of the service provided.

The service had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary. The staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected.

The provider had suitable arrangements in place to support the registered manager, through the Group Manager for Learning Disabilities Homes. They regularly spoke with the registered manager as part of their quality assurance process. The registered manager was also able to raise concerns and discuss issues with the registered managers of the other services owned by the provider.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider failed to ensure that peoples' risks were identified and reasonable action taken to reduce those risks.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider failed to ensure that records of people using the service were accurate and contemporaneous**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider failed to ensure they deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider to ensure that staff received appropriate professional development and support in respect of supervisions and appraisals.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

The provider failed to ensure that CQC was notified without delay of any abuse or allegation of abuse in relation to people using the service.