Leisure Care Homes Limited

Westcotes Residential Care Home

Inspection report

70 South Parade
Skegness
Lincolnshire
PE25 3HP

Tel: 01754610616

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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?	Inadequate

Summary of findings

Overall summary

About the service: Westcotes Residential Care Home is a residential care home that was providing personal and nursing care to 14 people aged 65 and over at the time of the inspection.

People's experience of using this service:
• Staff were caring and there were enough staff to meet people's needs and staff had received the training and support needed to enable them to provide safe care. Staff knew how to protect people from abuse. However, recruitment processes did not ensure the required checks had been received in the home before staff started to work.
• Medicines were not always safely managed and good practice guidance was not always followed.
• Risks to people were not fully identified and care was not always planned to keep people safe.
• Care plans contained generic information and did not support staff to provide person centred care. Care plans had not been completed for people on respite care.
• The maintenance of the home had not ensured that high standards were maintained and some infection control issues were identified.
• Systems to monitor and improve the quality of care provided was ineffective and did not identify concerns. In addition, incidents were not properly investigated and effective action was not taken to ensure similar issues did not reoccur.
• People's views of the care they received were gathered and complaints were investigated in line with the provider's policies.
• People were offered a choice of food and action was taken to help people maintain a healthy weight.
• People received compassionate care at the end of their lives.
• People's rights under the mental capacity act were respected and people were supported to make decisions about their lives.

We identified two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 relating to safe care and treatment and good governance. Details of action we have asked the provider to take can be found at the end of this report.

Rating at last inspection: At the last inspection the service was rated as Requires Improvement (report published 23 January 2018). At this inspection we found the provider and manager had failed to make all the necessary improvements.

Why we inspected:
This was a planned inspection based on the previous rating.

Follow up:
We have asked the provider to send us an action plan telling us what steps they are to take to make the improvements needed. We will continue to monitor information and intelligence we receive about the service to ensure good quality is provided to people. We will return to re-inspect in line with our

inspection timescales for Requires Improvement services. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC 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? The service was not always safe Details are in our Safe findings below	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Westcotes Residential Care Home

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was completed on 14 February 2019. The inspection was completed by a single inspector.

Service and service type:
Westcotes Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Westcotes Residential Care Home can accommodate 17 people in building.

There was no registered manager for the home.

Notice of inspection:
The inspection was unannounced.

What we did:
• Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, and local authorities.
• Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.
• We reviewed other information that we held about the service such as notifications. These are events that

happen in the service that the registered provider is required to tell us about.
• We spoke with the manager and a care worker.
• We spoke with two people living at the home.
• We looked at a range of documents and written records including four people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Using medicines safely

• At the last inspection the provider had failed to ensure the safe management of medicines. Systems to ensure people received their medicines in a safe consistent manner were not always adequate. Some medicines were not used in line with the prescription.

• At this inspection we found that the provider had not made the necessary improvements and found other concerns around the safe management of medicines.

• Protocols were not in place to support staff to administer safely and consistently medicines prescribed to be taken as required such as pain medicine. We saw when staff offered people 'as required' pain medicines they did not check with people where the pain was or how severe it was. This meant they could not monitor the effectiveness of the medicines.

• Records around medicines were not kept in line with best practice. Hand written Medicine Administration Records (MAR) were not checked or double signed to check if they were correct. Medicines had also been signed for on the wrong date. An example of this was one person whose medicines had been signed as administered the day after the inspection.

• Information on the number of medicines received into the home to enable audits of medicines was not always recorded and when it was recorded it was not always accurate. For example, we saw one person's record noted that they had 23 tablets available to them. However, they had been administered 26 tablets. We saw another medicine had been administered multiple times a day and two staff had signed to confirm the administration and that the count was correct. However, when we checked this count of medicines was incorrect.

• MAR charts did not always match the information that was recorded on the medicine packet. For example, one person was prescribed paracetamol to be taken as required according to the packaging but was written on the MAR to be administered at set times each day.

• We observed staff administering medicines, we saw that the member of staff did not always follow good practice guidelines. For example, staff signed that the medicine had been taken before offering it to people. This meant there was a risk that the person may not take the medicine and the administration record would be incorrect. In addition, we saw that staff touched the medicines with their hands which increased the risk of cross contamination and also put staff at risk as some medicines can be absorbed through the skin.

• We saw that good practice guidelines had not been followed when people had been admitted into the home. We saw one person was admitted for respite following a fall and a fracture. A medicine which was in the bag of medicines but was not listed on their discharge note and which did not have instructions for use was added to their MAR chart and administered regularly for pain relief. There was no discussion with healthcare professionals to confirm if the person should be taking this medicine.

• Some people in the home were self-administering their medicines. However, there was no record of any check of how often or when they were taking the medicine or if they needed any support to self-administer.

This meant there was a risk some people would not have been able to correctly manage their medicine.
• There was no policy in place for homely remedies such as indigestion relief or pain medicines. Some people were taking these medicines. There had been no discussion with professionals to check if they were safe to take with other medicines people were taking. In addition, there was no record of how often a person was using these medicines.

Assessing risk, safety monitoring and management
• People told us that they felt safe at the home and that staff supported them. One person told us, "There is always someone to take you up on the stairlift."
• Risks to people had not always been adequately assessed. For example, one person living at the home had been admitted for respite following a number of falls in their own home. Their falls risk assessment had not been fully completed and therefore there was no acknowledgement of their falls risk and no care plan in place to keep them safe. This person had fallen while being at the home and had torn the skin on their hand which had required dressing by the community nurses. The fall had not been fully documented and a care plan had not been written following the incident to keep the person safe in the future.
• Risks of developing skin damage due to pressure was not always correctly monitored and care plans contained inconsistencies. For example, one person's assessment showed that they were at a high risk, however their care plan recorded that the person was at low risk of developing skin damage due to pressure. Some of the care plans around how to reduce the risk of skin damage were generic and not written around the needs of the individual. They noted that the healthcare professionals could recommend equipment but did not list if any equipment was in use.
• Environmental risks to people were not always identified. For example, we saw a handle was broken on a chest of drawers and a half inch long piece of sharp metal was exposed. Radiators upstairs were not covered which meant that there was a risk of people burning themselves on then. These environmental issues increased the risk of people being harmed in the home. In addition, we saw that the cupboard used to store cleaning chemicals was unlocked. While not in an area of the home people living at the home used there were no locked doors to prevent them accessing this area.

This was a continuing breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.
You can see what action we told the provider to take at the back of the full version of the report.

Staffing and recruitment
• People told us they were happy with the level of staff to support them. One person told us, "If you want anyone there is always someone around to help."
• There were enough staff available to meet people's care needs. A member of staff told us, "We have time to care for people but at times people will have to wait if we are caring for someone else."
• The manager had completed checks on people to ensure that they were safe to work with people living at the home. This included applying for a Disclosure and Barring Service (DBS) check. However, the manager explained that they allowed people to start working at the home before their DBS was fully completed. The manager did not any risk assessments in place to assure themselves that people were safe from staff with incomplete DBS checks. The manager told us that this was their policy. However, the provider did not have written evidence of this and how they managed the risk.

Preventing and controlling infection
• People told us they were happy with the cleanliness of the home. One person told us, "The home is clean, staff clean downstairs during the night." Another person said, "They keep it nice and clean."
• Staff we spoke with had received training in infection control. They explained how they would wash their hands and use protective equipment such as gloves and aprons to reduce the risk of spreading infections.

• However, we saw that there were some areas where good infection control processes had not been followed. For example, light cords had not been protected to ensure they could be effectively cleaned. There were cobwebs in some rooms and lime scale on some of the taps which could harbour infection. In addition, there was an excess of bird faeces on the fire escape.
• The manager explained that there was a schedule for deep cleaning bedrooms. However they were unable to provide any evidence of which rooms were due for a deep clean.

Learning lessons when things go wrong
• Accidents were recorded in the accident book and in people's care files. However, incident forms were not passed to the manager to identify if any actions were needed and for final sign off. This showed that learning from incidents was not identified or shared with staff to improve the safety of care for people.
• Body maps to record when people were injured were not always completed or dated making it harder to track incidents and the outcomes for people.

Systems and processes to safeguard people from the risk of abuse
• Staff had received safeguarding training as part of the mandatory training programme. They told us that they would observe people's behaviour for any signs that they felt uncomfortable. Staff were confident about raising concerns with the manager or if they felt it was appropriate with external agencies.
• Details of the provider's safeguarding policy and procedures were advertised on the office wall. Safeguarding alerts had been made to the local authority. The manager had ongoing discussions with the local authority safeguarding authority to ensure the policy and procedures were followed correctly.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People did not always receive an adequate assessment before they moved into the home. Records showed that people who needed respite care did into have their needs assessed. As the assessment was also used as the care plan this meant risks to people were not identified and care was not always put in place to meet their specific needs. No assessment meant no care plans.

Staff support: induction, training, skills and experience
• Staff told us that they had a structured induction to the home when they started working there. This included shadowing more experienced staff to get to know people and their needs. In addition, new staff were required to complete the Care Certificate if they had not already done so. The Care Certificate is a national set of standards which covers the skills needed to provide safe care.
• Staff also told us how they completed regular training to ensure their skills remained up to date. In addition, the manager explained how they supported staff to gain nationally recognised qualifications in care.
• Staff received ongoing support from the manager by having individual meetings with the manager once every three months. This supported them to raise any concerns they had about the care provided in the home and any areas of training they felt they needed. Staff also received annual appraisals to support them with their career development.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us they were happy with the food provided to them. One person told us, "There is always plenty to eat." Another person said, "The food is alright, sometimes I eat and sometimes I don't." People were offered a choice of food at mealtimes and if they did not want anything on the menu the cook was able to make another meal of their choice.
• Care plans recorded when people were struggling to maintain a healthy weight. For example, we saw that one person's care plan noted,' Poor appetite, at times will prefer biscuits for meals and will refuse food. Offer favourite foods when in this frame of mind. Fresubin available.' Fresubin is a calorie rich supplement prescribed to support people to maintain weight. Records showed that this approach was successful and the person was gaining weight.
• Where needed people had been referred to healthcare professionals for advice and support about their nutritional needs.
• Where people needed special diets such as diabetic this was recorded in their care plan and appropriate food was offered to people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

• People told us that they were supported to access healthcare when needed.
• People's care records showed that GP's community nurses and other healthcare professionals had been involved in people's care when needed. For example, we saw people had been supported to attend hospital appointments when needed. Staff had ensured they followed any advice from healthcare professionals.

Adapting service, design, decoration to meet people's needs
• The home was not maintained to an appropriate level. Some maintenance had taken place in the home for example, a new floor had been fitted in the kitchen. However, other areas of the home were in need of attention. For example, we saw in some places that carpets were not fastened securely and were a trip hazard. The manager tried to open a window in one person's room and was unable to due to the type of lock fitted on the window.
• There had been a lack of attention to details when improvements had been made. For example, where light fittings/ smoke detectors had been moved the areas had not been painted and made good. When double glazing had been installed the tape to protect the windows in transport had not been removed and had yellowed on the window frames.
• The furniture in the home was in need of attention and did not support people's dignity, in some of the bedrooms it was mismatched and broken. For example, drawers did not always have handles.
• The home did not have a shower; therefore, everyone was required to have a bath or a strip wash. We raised this with the manager. They explained that they made this clear to people when they came to look around the home.
• We discussed the ongoing maintenance of the home with the manager. They explained that they had been given no budget for maintenance and that there was no maintenance plan for the home. This meant that the manager could not effectively manage the risks in the home.

Ensuring consent to care and treatment in line with law and guidance
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 made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Records showed that the manager had assessed people's ability to make decisions. Where people may not be able to consent to living at the home, the manager has submitted applications for them to be assessed for a DoLS. There was only one DoLS authorised and there were no conditions attached to the DoLS.
• Staff had received training in the mental capacity act and understood people's rights to make decisions for themselves wherever possible.
• When needed decisions had been made in people's best interest and the decision-making process had included family members and healthcare professionals. For example, we saw assessments had been completed into people's ability to consent to bedrails being used to keep people safe in bed.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People told us that they were well looked after in the home and that staff were compassionate and respectful. One person told us, "Staff are kind and gentle, they talk to you."
• Staff greeted people by name and asked about their day. We heard staff complementing people on their outfits and hairstyles.
• A person living at the home had recently died, we saw that details of their funeral service had been displayed in the home so that their friends at the home knew what was happening and were offered the opportunity to attend if they wanted to.

Supporting people to express their views and be involved in making decisions about their care
• People told us they were able to make choices in their lives. For example, they were able to choose when to get up and go to bed, and where they chose to spend the day either in the communal lounges or in their bedroom.
• Staff told us how they offered people choices when providing care. For example, by offering them visual choices of clothes. Where people struggled to make a choice from verbal options staff had access to a picture book to support people to make informed choices.
• Care plans recorded people preferences when people were unable to express them. For example, care plans recorded their food likes and dislikes and their night-time preferences.

Respecting and promoting people's privacy, dignity and independence
• Staff had received training in supporting people's dignity while receiving care. For example, a member of staff told us they would always close the curtains, ensure the door was closed while providing care and use a towel to keep the person covered up as much as possible. They explained how they encourage people to do as much as possible for themselves and always ask if they are able to do something independently before providing the care. They told us they always allow people time for a soak in the bath.
• People's care records were stored securely so that only people who needed access to them were able to look at them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People told us they had been involved in planning their care as much as they wanted but had preferred to leave it to family members. One person told us, "My daughter sorted it all out." However, we saw that most care plans had not been signed by the person living at the home or their relatives to show that they agreed with the care provided.
• Care plans were not always person centred and we saw that people's care plans often repeated the same information. At times they lacked the information needed to support people's needs.
• People on respite care had not had care plans completed. Therefore, there was a lack of support and guidance on how staff should provide care for these people. Where people's aim was to return to their own home there was no record of this goal in their care plan. This meant that care was not structured to meet people's desired outcomes.
• Some people living at the home had diabetes and were supported to be involved in monitoring their condition and self-medicating.
• The service did not fully understand people's information and communication needs. We did not see sufficient evidence of how the Accessible Information Standard had been applied through identifying, recording and highlighting people's individual information and communication needs in their care plans.
• There was a lack of activities in the home. When we asked people about how they filled their time they told us, "I spent time reading and watching telly," and "I watch TV. I like to go upstairs and lay on my back." The manager told us that there was no separate activities member of staff, but that staff were required to completed activities with people when they had completed their care tasks. The manager also explained that they had a weekly visit from and external company to do movement exercises for people.

Improving care quality in response to complaints or concerns
• The provider had a complaints policy in place and this was discussed with people when they moved into the home. It was recorded in their care plan if people had understood the complaints procedure and knew how to make a complaint.
• People living at the home told us that they were happy with the care provided and that they had no complaints.
• Records showed that there had been one complaint received since our last inspection. It had been investigated and responded to in line with the provider's complaints policy,

End of life care and support
• Staff worked proactively with other health and social care professionals to ensure people had a dignified death. For example, they worked with Marie Curie nurses. Where possible end of life anticipatory medicines were in place to help people have a pain free death.
• Where people were happy to discuss their wishes for the end of their life, this information was recorded in

their care plans. This included their preferred place of death and if they would want resuscitated. People's families were supported to spend as much time as they wanted with the person as they neared the end of their life.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• At the last inspection we found that the provider was not meeting the regulations in relation to ensuring the management of the home was effective.

• At this inspection we found that the provider had not made the improvements necessary to meet the regulations. The provider had not ensured that the quality assurance systems were reliably managed to enable them to identify and resolve any shortfalls in the service provided for people. We found that medicines were not properly managed and risks to people had not been correctly identified. People had not always received an assessment before moving into the home and people on respite care did not have care plans in place. There was no maintenance plan for the home and so we had no assurance that action was being taken to rectify the concerns we identified.

• There was no registered manager for the home. The previous manager had deregistered 15 May 2018. The new manager had been in post since May 2018. However, due to incorrectly completed application forms they had failed to complete their registration at the time of the inspection.

• The manager and provider had not always ensured that learning in the home was identified. For example, the manager did not review all the incidents in the home to identify causes, to share learning and reduce the risk of similar incidents occurring. Furthermore, when issues were identified the action taken by the manager had not ensured that staff worked to reduce similar incidents. For example, records showed that the manager had raised concerns with the staff about not completing care plans for people on respite care. However, we also found concerns with care plans for people on respite. The manager had not increased their monitoring of these care plans to check that the issues had been resolved.

• The provider had employed an external agency to develop policies and procedures. However, the manager was unable to provide policies and procedures which supported them to provide safe care. For example, they were unable to provide us with a copy of the cleaning schedule to review and while they told us they were recruiting staff in line with their policy they were unable to provide us with a copy of the policy.

• We found that the provider had not always provided information to us needed by law. For example, there was no up to date statement of purpose.

This was a continuing breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

You can see what action we told the provider to take at the back of the full version of the report.

Continuous learning and improving care

• The manager explained how they would have an annual appraisal with the provider's nominated individual. A nominated individual is a director, manager or secretary of the organisation who is in a position which carries responsibility for supervising the management of the carrying on of the regulated activity. In the appraisal the nominated individual would set out the provider's aims for the home for the coming year.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• We saw that the website for the home did not accurately reflect the environment. For example, we saw that the website noted that the home had a private garden. This was not true. The outside area available to people consisted of a patio at the front of the home which was not secure.
• Surveys had been completed to gather the views of people living at the home. We saw that the outcome of the last survey had identified concerns around the environment and that people needed more activities. People living at the home were also kept up to date with regular meetings where they could raise concerns.
• Staff were kept up to date with changes in the home with regular staff meetings on a monthly basis. Staff told us that they had confidence in the manager and that they found them approachable and were confident that they would take action on any concerns raised.

Working in partnership with others
• The registered manager had developed partnership working with external agencies such as local doctors, specialist healthcare services and local authority commissioners. This enabled people to access the right support when they needed it.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) The provider did not ensure that medicines were safely managed and that risks to people were identified and action was taken to mitigate risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) The provider did not ensure that systems to assess, monitor and improve the quality and safety of the service were effective.