Care Quality Commission

Westgate House Limited

Westgate House

Inspection report

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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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection took place on 20 & 24 August 2015. Westgate House provides support and nursing care for up to 46 people with dementia and mental health needs. At the time of the inspection there were 40 people living at the home.

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.

The systems and process in place for the safe administration of medicines need to improve. Administration guidance from the pharmacist was not always followed and the process of covertly administrating medication needed to be tightened.

Summary of findings

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

Staff generally approached people in a carefully considered way, however there were some occasions when this was not the case and where some staff did not explain what was happening to people and did not seek their consent to provide care.

Record keeping in relation to assessment, care planning, risk assessments and day to day care was in need of improvement to ensure people received personalised care and risks were identified to keep people safe.

Mental capacity assessments and Deprivation of Liberty Safeguards (DoLS) applications had been completed for people in relation to the administration of covert medicine, however were not in place for other aspects of care for those people who lacked capacity to consent to their care.

People felt safe in the home. Staff understood the need to protect people from harm and abuse and knew what action they should take if they had any concerns. Staffing levels were sufficient and ensured that people received the support they required at the times they needed. The recruitment practice protected people from being cared for by staff that were unsuitable to work at the home.

People were supported to maintain good health and had access to a range of health professionals who visited the home on a regular basis.

People participated in a range of activities both in the home and in the community and received the support they needed to help them do this. People were able to choose where they spent their time and what they did. There was a range of activities available and entertainment was brought in to the home.

People benefitted from being cared for by staff that had good relationships with the people who lived at the home. Complaints were appropriately investigated and action was taken to make improvements to the service when this was found to be necessary.

The registered manager and the home owner had good working links with other professionals and providers to learn from good practice and discuss new initiatives which improved the quality of care for people living at the home.

The manager and home owners were visible and accessible to staff and people who used the service.

People benefitted from being cared for by staff that had good relationships with the people who lived at the home. Complaints were appropriately investigated and action was taken to make improvements to the service when this was found to be necessary.

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.

People were not always protected from the risks associated with the administration of medicines because staff did not always follow the procedures that were designed to protect people.

Risk assessments were in place but not always updated in a timely manner to reflect the changing needs of people to ensure they received the support they required and access to other health care professionals.

People felt safe in the home and staff were clear on their roles and responsibilities to safeguard them.

Safe recruitment practices were in place and staffing levels ensured that people's care and support needs met on a daily basis.

Is the service effective?

Requires improvement 

The service was not always effective.

People were not always actively involved in decisions about their care and support needs. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) but decision specific assessments were not completed.

People received personalised care and support but this was not reflected in the care plans for people so there was a risk of new staff not knowing how to support people in a way in which they preferred.

Staff received training to ensure they had the skills and knowledge to support people appropriately and in the way that they preferred.

People's physical and mental health needs were kept under regular review and people had access to health care professionals.

Is the service caring?

Requires improvement 

The service was not always caring.

People were encouraged to make decisions about how their care was provided, but people's privacy and dignity were not always protected and promoted.

People experienced mostly positive interactions with the staff but there were also times when people were not always comforted when they were distressed.

Staff promoted people's independence to ensure people were as involved as much as possible in the daily running of the home.

Summary of findings

Is the service responsive?

Requires improvement 

This service was not always responsive.

Staff demonstrated an in depth understanding of people's care and support needs and their likes and interests; however there were inconsistencies in the way in which this was recorded and detailed in the care planning documentation.

Staff were not always responsive to people's needs and we observed that when people were distressed that some staff did not try to comfort them and ease their distress.

People were supported to engage in activities that reflected their interests and supported their physical and mental well-being.

People using the service and their relatives knew how to raise a concern or make a complaint. There was a transparent complaints system in place and complaints were responded to appropriately.

Is the service well-led?

Requires improvement 

This service was not always well-led.

The management structure and organisation of tasks was disorganised and required streamlining.

There were systems in place to monitor the quality and safety of the service and any issues identified were completed in a timely manner.

A registered manager was in post and they were active and visible in the home. They worked alongside staff and offered regular support and guidance. They monitored the quality and culture of the service and responded swiftly to any concerns or areas for improvement.

People living in the home, their relatives and staff were confident in the management of the home. They were supported and encouraged to provide feedback about the service and it was used to drive continuous improvement.

Westgate 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 20 & 24 August 2015 and was undertaken by three inspectors.

Before the inspection we contacted health and social care commissioners who place and monitor the care of people living in the home. We also reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with nine people who used the service, 10 members of staff including care staff and members of the management team and five family members. We also spoke with a visiting professional and the GP.

We spent some time observing interactions between people using the service and staff to help us understand the experience of people who lived in the home.

During our inspection we used the 'Short Observational Framework Inspection (SOFI); SOFI is a specific way of observing care to help understand the experience of people who could not talk with us.

We reviewed the care records and of six people who used the service and five staff recruitment files. We also reviewed records relating to the management and quality assurance of the service.

Requires improvement

Is the service safe?

Our findings

People could not be assured that their medicines were always managed and administered in a safe way. The instructions on some Medicine Administration Records (MAR) did not always reflect the safe administration of medicines and this had not been taken forward or clarified with the local GP. This related primarily to the instructions to follow when covertly administering medicines. Where medicines were being covertly administered Mental Capacity Assessments (MCA) had been completed and best interest's decisions had been made with the involvement of GPs and district nurses. However the documentation related to two people that were having their medicines crushed and administered in jam needed to be updated to clarify why administration in this way was necessary.

People had not always received their medicine in accordance with the advice given by the pharmacist. Records evidenced that the pharmacist had given advice for three people's medicines to be dissolved in water; however, the nursing staff were crushing adding these medicines to jam. This practice had not been discussed with or agreed by the pharmacist and there was a risk that the medicines could be less effective as they had not been dissolved in water as indicated by the pharmacist.

Records related to the administration of medicines were unreliable. We observed that a number of occasions in the last week where medicines such as tablets, creams and eye drops had not been recorded as having been given. In some instances the medicines were not in the person's blister pack and this indicated that they had been administered however it was not possible to confirm this.

This is in breach of Regulation 12 (g) (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people felt safe living in the home. One person told us that they had been concerned as other people living in the home had come into their bedroom; however when they spoke to the manager about this a lock was put on their bedroom door and this has helped them to feel safer. Another person told us "I feel safe here; I keep an eye out for everyone."

The provider had procedures for ensuring that any concerns about people's safety were appropriately reported. Staff demonstrated an understanding of the type of abuse that could occur and the signs they would look for. They were clear what they would do if they thought someone was at risk of abuse including who they would report any safeguarding concerns to. Staff said they had not needed to report any concerns but would not hesitate to do so if they saw or heard anything that put people at risk. Staff had received training on protecting people from abuse. They were aware of the whistle-blowing procedure for the service and said that they were confident enough to use it if they needed to.

People were enabled to take risks and staff ensured that they understood what measures needed to be taken to help them remain safe. A range of risks were assessed to minimise the likelihood of people receiving unsafe care but assessments were not always updated to meet the changing needs of people using the service. The provider had identified an area of the building where there was an increased risk because there was not always staff in this area; they were looking into the use of CCTV to monitor this area. Family members and the provider were concerned that someone using the service could fall in this area and staff would not be aware straight away.

Individual plans of care were reviewed on a regular basis to ensure that risk assessments and care plans were updated regularly or as changes occurred; however we found that although all people had a falls risk assessment some of these were incomplete which could result in an increased risk of harm because it was not always identified people were at risk. When accidents did occur the manager and staff took appropriate action to ensure that people received safe treatment. Training records confirmed that all staff were trained in emergency first aid. Accidents and incidents were regularly reviewed to identify any incident trends and control measures were put in place to minimise the risks.

There was sufficient nursing and care staff available to provide people's care and support. One relative said "There are always lots of staff about and they make time to talk to all the people that live here." There were qualified nurses on every shift and a clinical advisor was available for support and advice. Throughout the inspection we saw there was enough care and nursing staff to meet people's needs.

People were safeguarded against the risk of being cared for by staff that were unsuitable to work in a care home. The staff recruitment procedures explored gaps in employment

Requires improvement

Is the service safe?

histories, obtaining written references and vetting through the government body Disclosure and Barring Service (DBS). Staff we spoke with confirmed that checks were carried out on them before they commenced their employment.

Requires improvement

Is the service effective?

Our findings

The registered manager and the provider were working with the staff team to reinforce the importance of actively involving people in day to day decisions about their care. We observed that staff generally approached people in a carefully considered way, explained what was happening and ensured that the person was happy with the care that they were about to receive. However we also observed occasions where this did not happen and where some staff did not explain what was happening to people and did not seek their consent to provide care. On one occasion we saw staff move a sleeping resident into a hoist and move them to a different part of the home and on another occasion a staff member administered eye drops to a person who was eating their meal, despite the person asking them to wait until they had finished their meal. When this was fed back to the provider they said that they would take this forward as a learning opportunity for all staff.

Staff and the manager had received training and were aware of their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and the Deprivation of Liberty Safeguards (DoLS) code of practice. However there were inconsistencies in how these were being applied in practice. Mental capacity assessments and DoLS applications had been completed for people in relation to the administration of covert medicine, however were not in place for other aspects of care for those people who lacked capacity to consent to their care.

Staff understood and were knowledgeable about people's individual dietary needs and preferences and supported people to eat a balanced diet. People who were at risk of not eating or drinking enough had been identified and staff offered appropriate support and records showed that their weight was monitored. People were referred to the Speech and Language Therapy Team if they had difficulties with swallowing food and if required referrals were made to the NHS Dietician. Records showed that people were also helped to manage weight gain and were activity supported to lose weight where this was indicated and agreed.

There were some inconsistencies in the care planning documentation related to this aspect of peoples care. Some care plans contained detailed instructions about people's dietary needs and these included information about managing diabetes and swallowing difficulties. However the support offered to people who experienced swallowing difficulties and were at risk of choking was not always sufficiently detailed. Health care professionals who had recently visited the home reported that some people who required thickened fluids had not received them and they were concerned about the risk this presented to these people. At the time of our inspection we observed that thickened fluids were given where needed however noted that the records and care planning documentation did not provide sufficient detail to confirm that this was a consistent aspect of the care provided to these individuals.

New staff received a thorough induction which included classroom based learning and shadowing experienced members of the staff team. The induction was always carried out by the clinical advisor and was comprehensive and included key topics on dementia, nutrition and person centred care. The induction was focussed on the whole team approach to support people to achieve the best outcomes for them. One staff member told us "I had a really good induction and it is always delivered and monitored by the same person so it is consistent for all staff."

Training was delivered by a mixture of face to face and e-learning modules and the providers mandatory training was refreshed annually. Staff were provided with the opportunity to obtain a recognised care qualification through the Qualifications and Credit Framework (QCF). Manual handling training was out of date for some staff, although the provider had commissioned a trainer to deliver 'train the trainer' workshops to enable manual handling training to be delivered by the homes own staff. Staff said "Training is thorough, we go through the workbooks with the trainer and once we have completed the work books they get marked by the trainer."

People's needs were met by staff that received supervision and received an annual appraisal. We saw that supervision meetings were available to all staff employed at the home, including permanent and 'bank' members of staff. The meetings were held in groups and were a combination of training, information sharing and group supervision; new recruits received one to one supervision in their role and all staff were able to have one to one supervision upon their request.

People's healthcare needs were carefully monitored and detailed care planning ensured care could be delivered effectively; Information on records relating health professionals visits and health procedures were available in

Requires improvement

Is the service effective?

peoples care plans. Care Records showed that people had access to opticians, GP's and Chiropodists on a regular basis. Care files contained detailed information on visits to health professionals and outcomes of these visits including any follow up appointments.

Requires improvement

Is the service caring?

Our findings

People were happy with the care and support they received. They told us they liked the staff and said they were 'friendly'. One person said "The staff are nice and they get me everything I ask for."

The manager and the provider were working to embed a culture where people received care that was always provided with kindness, compassion and respect. Although we saw many examples to show that this was happening we also observed times when this was not the case. We saw two staff supporting a person in a hoist but they did not engage in conversation or explain what they were going to do, but spoke over the person's head to each other. We also observed opportunities where staff could have spent time with people but where they chose to stand and 'observe' instead of using the time to actively involve people in conversations.

Staff consistently took care to protect people's dignity; they made sure bedroom and toilet doors were kept closed when they attended to people's personal care needs and assisted people to their bedroom whenever they needed support that was inappropriate in a communal area.

People had been involved in personalising their own bedrooms so that they had items around them that they treasured and had meaning to them, one person said "I love my bedroom, I chose the colours."

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in a staff communication book which was a confidential document or discussed at staff handovers which were conducted in private.

There was information on advocacy services which was available for people and their relatives to view. No-one currently living at the home used an independent advocate but staff were knowledgeable about how to refer people to advocacy services and what advocacy services could offer people.

Visitors, such as relatives and people's friends, were encouraged and made welcome. The manager told us that people's families could visit when they want and they could speak with them in the lounge area or their bedrooms. One relative said "We are always made to feel welcome and can ask any of the staff or managers any questions we want."

Requires improvement

Is the service responsive?

Our findings

People's care needs were assessed before they came to live in the home and care was taken to ensure that information was gathered about their past history, where they lived when they were younger, and what interested them. This enabled care staff to personalise the care they provided to each individual, particularly for those people who were less able to say how they preferred to receive the care they needed. Although staff demonstrated an in depth understanding of people's care and support needs and their likes and interests, there were inconsistencies in the way in which this was recorded and detailed in the care planning documentation.

Some care plans had been reviewed on a regular basis and provided clear and detailed guidance to help ensure consistency of care; however in other care plans the detail was not personal to the individual and had not been updated to reflected changes in their condition or in their care and support needs. The differences in the adequacy and quality of the care plan in place appeared to relate to the training and skill base of the staff involved in developing them and the provider will take this forward as part of staffs on-going training plans.

Most of the time we observed that staff responded quickly if people needed any support; checking people whether they were comfortable and asking them if they wanted any assistance. However staff were not always responsive to people's needs and we observed that when people were distressed that some staff did not try to comfort them and ease their distress. The provider had recognised the need to improve the responsiveness of some staff members and had integrated observational practice and lessons learnt into their training programs to help improve this aspect of their practice. The risk of people becoming withdrawn and lonely within the home was minimised by encouraging them to join in with the activities that were regularly organised. People living in the home spent time in the garden doing activities, playing board games and being involved in motivational groups. Care staff made efforts to engage people's interest in what was happening in the wider world and local community.

People participated in a range of activities in the home. There was an activities calendar displaying what activities were available which included a service conducted by a local vicar, musical entertainers and motivational group exercises. The home was holding its summer fete on the weekend of our inspection and we saw photographs after the event of people participating and joining in on the day.

When people were admitted to the home they and their representatives were provided with the information they needed about what do if they had a complaint. There were appropriate policies and procedures in place for complaints to be dealt with. There were arrangements in place to record complaints that had been raised and what had been done about resolving the issues of concern. Those acting on behalf of people unable to complain or raise concerns on their own behalf were provided with written information about how and who to complain to.

Requires improvement

Is the service well-led?

Our findings

Along with the manager the provider takes an active role in the running of the home and together they have systems and processes in place to monitor the quality and safety of the service. Quality audits and reviews were undertaken and the findings were used to help focus improvement action in the home. However the organisational structures and record keeping processes which support this activity could be improved and streamlined. Information and records were stored in various different places, some in paper formats and some electronically; this impacted on the ability to gather up to date records and lead to a disorganised feel to this aspect of home management.

Record keeping in relation to assessment, care planning and day to day care was also in need of improvement. A computer programme was used for writing and reviewing care plans. We looked at a sample of the electronic documents and these did not always accurately reflect the level of care received by people. This was acknowledged by the provider and training on the care planning system that they used had been increased to enable them to develop more personalised care plans in the near future.

There is a clear vision for the service which was to 'support people to live in a homely environment and for people to receive graduated levels of care as required from assisted living to total care'. It was clear from our observations and talking to people that those people who were able to be independent in some areas of their lives were encouraged to keep these skills and some people were supported on a rehabilitation program with the intention of returning home once they had regained some independent living skills.

Staff understood the roles they played in supporting the vision of the service and the provider had embedded 'a no blame just train' culture to encourage openness and practice development. We observed examples of carefully considered care and found that the provider was taking proactive action to drive on-going improvement in those areas where we identified inconsistencies in practice outcomes.

People told us the manager and staff were approachable and that they could speak with them at any time. One relative said "The manager and the home owner are friendly and approachable and they are always about if we need to speak with them." We saw that people were relaxed around the manager and staff were at ease in interactions they had with them.

Communication between people, families and staff was encouraged in an open way. Relatives' feedback indicated that the staff worked well with people and there was good open communication with staff and management and they were informed of people's progress. The manager told us they had an open management style and wanted to involve people, relatives and staff in the day to day running of the home as much as possible. Staff said the management team was very approachable and really supportive. The provider developed a quarterly newsletter for families updating them on the findings of the annual survey, improvement projects and upcoming activities.

People using the service and their relatives were able to feedback on the quality of the service they received. The provider used an independent person to gain feedback from relatives and people living at the home. Feedback from people and relatives was generally positive.

Family members of people who live or used to live at the home had formed a group called 'Friends of Westgate', this group met on a regular basis with the provider and people who lived at the home to talk about fundraising opportunities, improvement projects, new initiatives and any feedback they wanted to give to the provider. The group had recently raised enough money to contribute towards a cinema screen so people could watch films on a bigger screen and to use the time as a social event.

The provider was a member of a number of organisations that shared information on good practice and innovative ways of providing care for people. The provider was also involved with information sharing sessions with other local providers to share knowledge and discuss ways of improving care for people living in residential homes. They used these opportunities to also reflect on the practice in the home and to help focus their improvement plans.

The management team were proactive in wanting to improve the lives and well-being of people who lived at the home, they had recently trialled a system to replace call bells in some peoples bedrooms because they were unable to use them with an acoustic monitoring system. They have

Requires improvement

Is the service well-led?

used some ideas from the dementia design centre at Stirling University and are in the process of making a long corridor look like a street which helps people living with dementia feel more orientated.

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 People who use services were not always protected from the risks associated with the administration of medicines because staff did not always follow the procedures that were designed to protect people. Regulation 12 (1) (g).