Weyspring Limited

Weyspring Park

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Weyspring Park is registered to provide nursing care and residential care for up to 34 people with a range of care needs, including frailty of old age, people living with dementia, and mental health conditions. At the time of our inspection, 32 people were living at the service.

People's experience of using this service and what we found
People told us that they could talk to staff and that they felt safe living in the service. One person told us they had moved to Weyspring Park for convalescence and liked it so much they asked to stay. Relatives told us they felt people were safe and well looked after. We found people were not always supported to have maximum choice when moving around the service. Blanket measures designed to keep people safe were restrictive to some people.

Risks to people were not always identified and managed. Care plans lacked information about people's dementia and how this impacted on their behaviour and communication.

People were not always receiving safe care. As required medicine (PRN) protocols and care plans failed to provide guidance to staff on when it was appropriate to administer a particular medicine or associated risks. We identified occasions when people had been administered PRN medicines without due consideration of this being the least restrictive or necessary option for the person.

Staff did not always receive effective training or support. Staff had not received training on people's specific health conditions to support safe and consistent care. Some staff told us they had not had recent support or training. Some staff felt supported by managers however others disagreed.

Existing leadership and governance measures were not effective in identifying service shortfalls and failed to assess, monitor and mitigate risks relating to health, safety and welfare for people.

There were indications of a closed culture at Weyspring Park. A closed culture is a poor culture in health and social care that increases the risk of harm. This includes abuse and human rights breaches and may be deliberate or unintentional. During the inspection we made the provider aware of our concerns.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

Rating at last inspection
The last rating for this service was Good (published 20 December 2018)

Why we inspected
We undertook an initial targeted inspection to follow up on a specific concern we had received about the service. The inspection was prompted in part due to concerns received about safeguarding, staffing and infection prevention and control (IPC). A decision was made for us to inspect and examine those risks. We inspected and found there was a concern with restrictions for people, staff training and support and the culture of the service so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective and well-led. This necessitated the team returning to the service to undertake a second day of inspection. We identified concerns with medicines and therefore returned with a pharmacy inspector to examine those risks to people.

The provider needs to make improvements. Please see the action we have told the provider to take at the end of this report. The provider has taken some action following our feedback during the inspection process and provided assurances of their improvement plan.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Weyspring Park on our website at www.cqc.org.uk.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively

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

We have identified breaches in relation to safeguarding, safe care and treatment, staffing and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

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

Follow up
We sought some immediate assurances following the first site visit due to the level of concern we had about the standards of quality and safety. We will request an action plan from the provider to understand what they will do to continue to improve the standards. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not always effective	**Requires Improvement**
Is the service well-led? The service was not well led	**Inadequate**

Weyspring Park

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors, a pharmacist inspector and an Expert by Experience who made calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The pharmacist inspector joined us for the third visit due to concerns we had regarding medicine management.

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

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

Notice of inspection
This inspection was unannounced on the first day and a short period of notice was given before the team returned for the second day of inspection. The third visit was unannounced.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the last inspection. This included information received from whistle-blowers. A whistle-blower is a person, usually an employee or ex-employee, who exposes information or activity about an organisation that is deemed unsafe, for example. We used all of this information to plan our inspection.

During the inspection
Site visits began on 22 March 2021 and concluded on 05 May 2021. On 8 April 2021 we commenced our inspection at 7.00 am in order to observe staff and speak with night staff. We spoke with four people who used the service about their experience of the care provided, and observed people interacting with staff and taking part in activities. Due to the nature of people's complex needs, we were not able to speak to more people directly and therefore spent time observing. We spoke with fourteen members of staff including the registered manager, deputy manager, registered nurse, seven health care assistants, activities coordinator, a member of the housekeeping staff, administrator and the maintenance person. We also spoke with a visiting health professional. The pharmacist reviewed eight medicine administration records and four medicines related care plans. They also reviewed the policies in place for medicines management at the service. They spoke to four members of the staff which included registered nurses and managers about medicine practices in the service.
We reviewed a range of records. This included ten people's care records. We looked at ten staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek urgent assurances from the provider to validate evidence found. We contacted West Sussex County Council Safeguarding with concerns about some restrictive practices. We contacted West Sussex Fire and Rescue Service about the provider's fire evacuation plan to ensure the measures in place were adequate. We spoke with the nominated individual for the service to seek assurances on how they support the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We requested feedback about the service from relatives of people who live at Weyspring Park and health and social care professionals who work with the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the potential risk of inappropriate restraint. One person's emotional and psychological well-being care plan identified they may become "physically aggressive towards staff". Their care plan contained advice that three staff may be required to support the person with two undertaking a therapeutic hold. There was no reference or specific direction for staff to describe what a therapeutic hold was or how to support the person safely when they displayed signs of behaviours which may challenge. The registered manager accepted that the language used in care plans sounded restrictive and said that they had now removed this. They also provided verbal assurance that staff were not using therapeutic holds. Staff had not received training to safely support people with behaviours that may challenge. The lack of guidance and training meant people were exposed to the potential risk of inappropriate use of restraint. Following the inspection staff have been provided with challenging behaviour training.

● People's freedom to move around the service was restricted by the use of coded keypad doors. This meant people typically spent up to 12 hours during the day in a secure communal lounge-diner. People needed to ask staff to open doors for them if they wanted to leave the communal lounge. All meals and activities took place in this room. Staff told us this was to ensure people's safety.

● For example, on 22 March and 8 April, we observed 25 people in the lounge-diner. People were seen periodically trying to use the door handles or asking to go for a walk. On each occasion people were supported by staff to sit down. People's care plans and risk assessments failed to consider other less restrictive practices to keep people safe

● Our observations between staff and people in the lounge-diner showed a lack of positive engagement. Staff spent their time sitting or standing alone observing people. People were not engaged in meaningful activities or occupation. A television was switched on in one part of the room, and a few people were watching it, but staff selected the channels. Staff did not check if people were watching the program before they selected a different channel. Staff interactions were reactive, task focused and prompted by the need for people to receive personal care or by people's behaviour.

● For example, we observed across our inspections a person stand up and look out of the window. On each occasion staff approached the person and guided them back to their seat informing them they needed to sit down. The person's care plan said they would look out of the window when they were having difficulty understanding what was happening around them and required reassurance. People's ability to make choices and decisions about how they spent their time was restricted by their physical environment and by the staff who supported them.

● People were not always protected from the risk of inappropriate treatment. A behaviour record for one person detailed two occasions when the person experienced behaviours that challenged whilst staff were attempting to provide personal care. Staff had not noted specific triggers to these behaviours and had recorded, despite all encouragement person was getting more agitated. The consequence recorded for the

person on these two occasions was for them to be given "as required" PRN medicine prescribed for agitation. There was no evidence to demonstrate that staff had considered whether this was a necessary, proportionate response in relation to the risk of harm to the person or others. The provider had not monitored or reviewed the use of some medicines and as a result could not be assured that people were protected from improper treatment.

● Staff had received safeguarding training. This training was designed to aid staff understanding of the signs of abuse including discriminatory abuse, and why it was important staff acted if they recognised any concerns. We received mixed responses from staff about reporting concerns regarding people's safety. Some staff told us they would report any concerns they had to the registered manager or nurses; others said they were fearful of not being listened to or of reprisals by the provider.

● Prior to the inspection CQC had received information of concern about inappropriate practices of staff, lack of respect and person-centred care, and bullying within the staff team. Our observations showed that the culture at the service showed indictors of it being closed. A closed culture is a poor culture in health and social care that increases the risk of harm. This may include abuse and human rights breaches and may be deliberate or unintentional.

● We made the registered manager, nominated individual and a director of the company aware of our concerns and observations. The provider was required to take immediate action to address these concerns.

The provider's processes and working practices did not ensure an adequate level of scrutiny and oversight that was needed to ensure people were protected from the risk of harm, abuse and improper treatment. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we referred our concerns to commissioners and two incidents were being considered through safeguarding processes. We sought urgent assurances from the provider of the actions they were taking to ensure people's immediate safety and well-being. They informed us they would monitor and review the use of all medicines. They provided assurances there would be clear information about least restrictive options that must be deployed prior to consideration of administering medicine PRN.

● Due to the COVID-19 pandemic and government guidelines, families had been restricted from visiting the service on a regular basis. The service had facilitated alternative forms of contact with families. Relatives told us they had trust in the provider's processes to act upon any concerns in their absence and ensure their loved ones were protected from abuse. One relative told us, "they manage [persons]safety well their needs are complex and difficult, and this is the safest [person] has been.

● One person told us they felt safe living at Weyspring Park and had no concerns about the way they were supported. They told us it had been their choice to live at Weyspring Park and they had not regretted this decision.

Assessing risk, safety monitoring and management and learning lessons when things go wrong

● Staff had not been trained to support people with behaviours which may challenge and risk management plans failed to provide guidance to ensure the safety of people and staff. This placed people and staff at risk of experiencing avoidable harm. Since inspection, 22 staff have completed training on managing behaviours that challenge. Care plans lacked guidance and information to staff on how to support people who may display behaviours which challenge. We reviewed the psychological and emotional wellbeing care plans of five people whose care plans described their behaviours as' unpredictable' and posed a high risk of causing harm to others. Care plans lacked information and support strategies to guide staff on how to support and manage people's behaviour safely, or how to reduce the chances of this happening in the future.

● Risks to people were not always identified and managed appropriately. For example, guidance produced by the Alzheimer's Society advised that people living with dementia can find it difficult to communicate,

which may result in the display of challenging behaviour. Staff should know how to recognise the signs for this and be proactive in their response. Care plans lacked information about people's dementia and how this impacted on their behaviour and communication. Monitoring for specific triggers was not in place and there was a failure to ensure staff were provided with appropriate training and guidance. Specific triggers are unique to each person and can include restlessness and repetitive behaviours, the failure to monitor these increased the risks of people living with dementia not receiving appropriate support in a consistent and safe way.

● Where risks were known, records were not always detailed to support safe care. For example, a person was prescribed 'as and when required' (PRN) emergency medicine for a severe allergic reaction to bee stings. The risk posed by bee stings was not documented within the person's care plan and there was a failure to ensure staff were trained to know the signs and symptoms of anaphylactic shock and the action they were required to take. Anaphylactic shock is the name given to a severe allergic reaction. There was a reliance on trained nurses administering the medicine from a prefilled syringe known as an EpiPen. Consideration had not been given to administering the medicine when the person was away from the service such as when out on a walk with care staff as they had not been trained to administer the EpiPen. The lack of information, training and guidance for staff meant the person was at risk of experiencing significant and avoidable harm.

● People's epilepsy was not always managed safely. Care plans did not contain clear guidance for staff to safely support people's epilepsy or seizure activity and lacked guidance on action to take in the event of a seizure or a cluster of seizures. Guidance was not provided to describe what a person's seizure looked like, warning signs or triggers before seizure activity or when to seek additional support, including calling the emergency services. This meant that people could not be assured of being protected from risks associated with their health and well-being.

● The provider had not always learnt from themes or incidents that had occurred. There was a lack of robust analysis of incident and accident records to identify themes and drive service improvement. For example, there was a failure to audit falls or to use this information to mitigate further risks to people.

● People were at risk of repeated injuries because incidents were not reviewed, and this did not enable preventative measures to be taken. We reviewed incidents and accident records and daily notes of ten people. There were reoccurring themes that were not addressed or explored. For example, one person had sustained several recent falls. There was a general acceptance that following a referral to the falls team in 2019 nothing more could be done to prevent this person falling. Therefore, the increase in recent falls had not been explored to consider other possible causes such as underlying health conditions, medicines or environmental factors.

The provider had failed to assess, manage risks relating to people's health and welfare or learn lessons when things went wrong. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We made the registered manager aware of our concerns and they took action to improve the level of guidance and information available to staff to ensure risks would be managed safely.

● The provider undertook checks on equipment and the environment. This included maintenance of hoists, water temperature controls, portable electrical device testing (PAT) and fire safety checks. During our inspection on the 22 March the fire alarm was activated by staff smoking in a designated smoking area outside the building. Following this incident immediate measures were taken to move the designated smoking area away from the external smoke detector which had activated the alarm.

● Staff reacted to the fire alarm in a calm manner and followed protocols and risk management plans. We observed that two fire doors did not close automatically because they were either held open or the automatic closures failed. We made the provider aware of this and they took immediate action to address these failings. We contacted West Sussex Fire and Rescue Service because we observed the internal corridor

doors that were locked did not release when the fire alarm was activated, and we wanted to be sure people could evacuate areas of the building safely. West Sussex Fire and Rescue Service undertook an immediate review of the provider's fire risk policy and evacuation plans and deemed these processes to be safe.

Using medicines safely

● PRN (medicine to be administered as needed) protocols did not always provide guidance on the criteria for staff to give PRN medicines, monitor reactions or risks. For example, the PRN protocol for a person living with a health condition outlined the need to give 10-20mls of rescue medicine. The medicine came in 10ml tubes and there was a lack of instruction to clarify if one or two tubes should be administered and when the first dose of rescue medicine should be administered. The PRN protocol did not provide any guidance as to when the first dose should be administered. We made the registered manager aware of our concerns and observations regarding PRN protocols. Following our feedback, the registered manager took action to address our concerns.

● A review of people's medication administration records (MAR) showed 13 people were prescribed a PRN medicine used to treat anxiety disorders and problems with sleeping. one persons, MAR and PRN protocols recorded this was prescribed for agitation and when they could not respond to reassurance from staff. PRN protocols and care plans failed to provide guidance to staff on when it was appropriate to administer this medicine or any associated risks. Side effects could include drowsiness which might lead to an increased risk of falls. According to the British National Formulary (BNF)this medicine is usually prescribed as a short term treatment and from records reviewed it is not evident that this had been regularly reviewed. There was a failure to guide staff to consider alternative and preventative strategies prior to administering this medicine. There was no information as to what the reassurance techniques could be used by staff to reduce anxiety and agitation in the person's care plan or PRN protocol. A review of people's daily notes evidenced that alternative strategies were not being considered prior to PRN medicines being given.

● For example, one person's MAR recorded PRN for this medicine had been administered 11 times in one month. On five occasions the medicine was administered without any corresponding entry for the reason it was given or the outcome for the person. This was not in accordance with National Institute for Clinical Excellence, (NICE) good practice guidance. Another person's MAR recorded this medicine was administered on their return from a hospital appointment. There was no record to say why it was given. The person's daily notes did not record any change in their behaviour or signs of agitation and there was a failure to record that the medicine had been given. There was a lack of information on when people should receive medicines PRN or an outcome recorded when one particular medicine was administered'.

● A review of people's medicine care plans identified 10 people who received their medicine covertly. This is when the person lacks capacity to make this decision for themselves and "medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink," (NICE guidelines). Where this is being considered this should be following a Best Interest meeting with health professionals, relatives and the management of the service and the decision reviewed regularly in line with the Mental Capacity Act 2005. Records reviewed were unable to evidence that relatives had been consulted in this process, did not contain specific guidance about how to administer medicines in a disguised format and as a result did not evidence that covert medicines had been considered in the best interest of the person or in line with legislation and guidance. Since inspection, the service has provided assurance agreements to administer covert medicines were now in place

● Medicine care plans did not always have accurate and adequate information. For one person there was no information in their diabetes care plan about the prescribed medicines. This meant there was an increased risk staff may not be able to support people's medical and health needs effectively. We sought assurances from the registered manager who completed a review of medicine care plans to ensure information was accurate.

● Medicines were not always stored safely. The staff did not carry out regular stock checks for medicines that

need additional storage and administrative controls as per the providers policy. We identified medicines recorded to be disposed of in a cupboard which was not designated for waste medicines which left them open to potential misappropriation . We were not assured the processes in place to dispose waste medicines were robust.

There was a failure to ensure the proper and safe administration of medicines by registered nurses. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We made the registered manager aware of our concerns with regard to safe management of medicines. The registered manager took immediate action to review processes for administering PRN and covert medicines and the storage and safe disposal of medicines. They also sought further information from medical professionals involved in the persons care.

● We reviewed the management of medicines and observed medicines being administered to people. Medicines were administered by registered nurses. Correct procedures for the administration of medicines were in place and were being followed. Prescribed topical creams had body charts to show where the cream should be applied, and all MARs had been completed correctly.

Staffing and recruitment.
● The provider did not use a staffing dependency tool to assess the staffing requirement. The registered manager informed us that carers were instead allocated to a floor and would typically support seven to eight people at night. Incident reports did not provide any evidence of increased incidents at night or of a failure to meet people's care needs in a timely way. During the inspection call bells were answered in a timely way and our observations showed there were enough staff to meet people's personal care needs. Following our inspection, the provider implemented a tool to assess staffing levels at night and increased these to include an additional carer.
● Our observations did not provide assurances that people were provided with personalised meaningful stimulation and occupation. This was particularly prominent during the current global pandemic of COVID-19 and government guidance to stay at home. There was an activity co-ordinator who provided an activity programme for part of the week and people were seen to be enjoying this engagement and participation; one activity was provided by a community musician. However, there were long periods of time when people were not offered meaningful stimulation or occupation and the provider had failed to consider this.
● Concerns were raised to CQC about the recruitment checks of agency staff who were living at the service. The service is remotely located. It is surrounded by woodland and is not served by public transport. Two permanent staff were living on site along with agency staff. Staff accommodation was accessed through the care home. Agency staff typically worked for several weeks at a time to ensure continuity of staffing.
● Agency staff were supplied by two agencies. Employments checks were undertaken by the agency and the service had profiles of each worker which included checks with the disclosure and barring service (DBS) to ensure their suitability to work with people, right to work checks and training record. Following our inspection, the provider implemented increased checks on agency staff living on site which included undertaking their own DBS checks. This provided additional assurances as to the suitability of any staff living on site.
● There were safe systems and processes for the recruitment of staff employed. The service followed safe recruitment processes to ensure people were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references. Checks were made with professional bodies such as the Nursing and Midwifery Council to check the fitness to practice status and registration of nurses.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Housekeeping staff were undertaking cleaning of the service; however, cleaning schedules had not been amended to reflect an enhanced level of cleaning during the national pandemic of COVID-19 and outbreaks of the virus within the service. COVID-19 disinfecting schedules were not in place and there was no schedule to evidence enhanced sanitation of frequently touched high risk areas. Staff told us that they were cleaning frequently touched areas regularly. We fed this back to the registered manager who provided assurances this was addressed

● We were somewhat assured that the provider was meeting shielding and social distancing rules. The layout of the building had not been considered to support cohorting in smaller groups. People gathered in the communal lounge and dining area and were unable to socially distance from each other.

● We were somewhat assured that the provider was using personal protective equipment (PPE) effectively and safely. We observed some staff entering the service in uniform. The provider's infection and control policy and procedure states staff must ensure their uniform is only worn when working at the service and uniform must not be worn outside work.

● We were assured that the provider was preventing visitors from catching and spreading infections.

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

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

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

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

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

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

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.

At the last inspection this key question was rated as Good At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff did not receive the training they required to support people's specific and complex needs.
- Staff had not received training on specific health conditions of people they were working with. Some people were living with dementia and may experience behaviours that challenge. We observed staff working with people in communal areas. One person who was walking with purpose was persistently managed back to their seat, however staff did not recognise that the person may be trying to communicate or express how they were feeling. Good practice guidance suggests people walk with purpose for a variety of reasons and may have a need for something, for example a need for occupation, exercise, seeking reassurance or may be in pain. During our observations staff did not try to establish why they might be walking and as a result may not have identified a need the person was expressing. This demonstrated how staff lacked knowledge and skills to support people living with dementia effectively.
- Staff told us that they had not received specific training on the health conditions of people they supported. Records confirmed that staff had not had recent training and there was no evidence that staff had training in dementia or behaviours that challenge. Some staff told us they had worked in other care settings and had training with a previous employer. Staff told us they had discussions with their manager about training, however, none had been scheduled.
- Some staff told us they had not had supervision with their line manager recently. Staff had not had opportunities to keep their knowledge and professional practice updated in line with best practice. One staff member referred to the lack of support and training, "There's no supervision, appraisal or training. I've attended one day training in the last year."
- The provider's Statement of Purpose reads, "Staff are trained on the importance of positive engagement and person-centred and value-based approaches to care. They are trained to assess behaviour, methods and techniques to reduce potential violence and breakaway techniques." The registered manager was not able to evidence that staff had completed this training and as a result people may not always have received effective support with behaviours that may challenge.
- The registered manager acknowledged that training and supervision was in need of improvement and informed us of their plan to address this failing.

The provider had failed to ensure staff received appropriate support, training, supervision and appraisal. This was a breach of regulation18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were not always assessed in line with current guidance, as some of the language used was not always person centred. Person centred language is about always respecting the dignity, worth, unique qualities and strengths of every individual this was not always apparent in care plans. The registered manager took action to review this immediately.
● Weyspring Park supports people who may not be able to tell staff about their needs and choices and therefore the information gathered in initial assessments and care plans was essential to ensure staff had enough information to provide effective support. A health care professional told us," They have been confident when placements are offered that they can meet the individual's needs, they undertake in-depth assessments which are very individual focussed".
● Prior to admission people had been assessed and information on their health conditions and important contacts were recorded. Care plans contained details about the person's occupation, hobbies and interests and information about family relationships. This ensured that essential information was available to staff which supported them to provide care in a holistic manner in line with the person's choices. One person's protected characteristics as defined in The Equality Act 2010 were detailed within their communication care plan, and this noted to use large block letters to help the person understand what was being communicated. This demonstrated staff had recognised the specific support this person may need when making care and support decisions.
● Relatives told us they had been kept informed of any changes to their family member's needs. One relative said, "They will phone with any issue that may come up …I think they do keep me involved".

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough. We observed people being offered a variety of snacks and drinks.
● Staff told us that people received a variety of meals and there was always a choice of two main meals. People were offered choices from a structured menu. Staff told us that they spoke with people to gather ideas to bring new foods to the menu. People were also offered drinks and snacks in accordance with their individual requirements. For example, one person was offered a drink that had been thickened in line with the guidelines provided by a Speech and Language Therapist (SaLT). Another person who was assessed as requiring a modified diet and was supported with a pureed meal prepared in a way that identified the various food items on the plate. This ensured the meal looked appetizing and mitigated the person's risk of choking.
● People we talked to told us they enjoyed the food, one person remarked on how they enjoyed their cooked breakfast.

Staff working with other agencies to provide consistent, effective, timely care
● Records reviewed identified that staff worked closely with health professionals. One health professional told us, "I have always found the clinicians very competent, knowledgeable and effective with communication". They went on to say," They are open to change - clearly demonstrated in their adaptations during [Covid-19] - but also previously in management of patients with complex needs. They have been able to care for patients who have been unmanageable in previous settings, including inpatient wards".
Supporting people to live healthier lives, access healthcare services and support
● The COVID-19 pandemic has affected how people access healthcare services. It was evident from records that staff had maintained communication with healthcare professionals throughout the pandemic and these professionals continued with appointments with people in person and through video links.

Adapting service, design, decoration to meet people's needs
● Weyspring Park is a large country house that had been adapted, but not always in line with good practice guidance. The Social Care Institute for Excellence (SCIE) identifies important factors in a "dementia-friendly

environment" and this recommends consideration of creating a relaxing environment, awareness of noises, a range of activities, access to the garden and a safe quiet place for people to be alone. We observed people spent most of their time in the large lounge/diner area. People relied on staff to open the internal doors if they chose to leave the lounge. We fed back our observations about the use of coded doors as a restrictive blanket measure with the provider and the registered manager.
● People's rooms were personalised and there was some colour coded signage and pictures to support people to orientate around the building and locate various rooms.

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 when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Some people were subject to DoLS that specifically identified that they would be vulnerable should they access the community unsupported, therefore entry and exit to the service was controlled. This ensured that people did not leave the building unsupported. However, our observations showed that people were subject to blanket measures through the use of key coded doors that had not been fully assessed. This meant consideration had not always been given to the least restrictive option for others who live in the service
The provider's processes and working practices did not ensure an adequate level of scrutiny and oversight that was needed to ensure people were protected from the risk of harm, abuse and improper treatment. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person told us, they loved living there, but their one "niggle" was having to ask staff to help them to open doors. Following inspection, the provider informed us they had offered this person the key code and they had declined.
● Records demonstrated that staff had completed mental capacity assessments with people and where required had completed referrals to the local authority for DoLS authorisation.
● Relatives told us how they had been involved in making decisions on behalf of their loved one if they lacked capacity. One relative recalled speaking with a social worker and being involved in the DoLS process. This was also evident within the person's care records.

Inadequate

Is the service well-led?

Our findings

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

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

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

● A review of information about Weyspring Park showed in the past two years this service's capacity has grown from 18 to 34 people. People appear to have more specialist needs with increased complexity and behaviours that challenge. However, this inspection has highlighted the providers systems and processes have not kept pace with the changes.

● Systems and processes to protect people from the risk of abuse and harm failed to operate effectively. The service did not reflect a culture that empowered people to achieve good outcomes and be equal partners in their care. People were dependent on staff for their personal care needs and we observed routines to be institutionalised and task focused. Care was not person-centred or tailored to meet their needs. Consideration had not been given to adapt or provide an environment which reflected their needs and preferences.

● This inspection was prompted in part due to concerns we had received regarding the culture of the service. Some staff had told us that they felt they could not raise concerns with their manager. Referring to raising concerns, one staff member said, "They're [the manager] not open, find it difficult so don't say anything now". This was a view shared by several of the staff we spoke with. Other staff told us that they could raise concerns with the manager. This meant some of the team did not feel included and empowered to speak openly in the workplace. Since inspection, the provider has informed us of action they have taken to improve the experience for staff.

●The provider did not have effective systems that assessed or monitored the day to day culture of the service, and this meant they had not identified the warning signs of a closed culture noted during the inspection. CQC's work on closed cultures included risk factors apparent at Weyspring Park, which meant people who were highly dependent on staff not being able to speak up for themselves, a lack of external oversight (this being of particular concern during the COVID-19 pandemic) and staff not being encouraged or supported to raise concerns.

● Staff told us they had previously raised concerns regarding the staffing levels at night due to the increased pressures of supporting people at night and the increased risk of falls this presented with one person. Records we reviewed had identified this person experienced regular falls and a number of these were at night. Some staff felt the registered manager had not listened to or acted on concerns raised. The provider did not analyse incidents of falls and as a result failed to identify concerns for people. The registered manager informed us they had since implemented additional staff support at night to mitigate the risk of falls whilst they were in the process of reviewing staffing levels. Since inspection, the provider has informed

us the staffing review has assessed the staffing level to be adequate.
● The provider did not have quality monitoring systems in place to monitor staff practice that would have identified the need for training in specific health conditions. The provider had failed to ensure staff had effective training to support people with complex needs including dementia and behaviours that challenged. People were highly dependent on staff knowledge and skills. During the inspection staff were observed working in a task-focused manner that did not promote positive engagement with people. Subsequent to the inspection 22 out of 38 staff have received training in challenging behaviour and dementia.
● Several staff told us they had not received supervision for several months, and staff records reviewed evidenced the lack of supervision structure. As a result, staff did not receive feedback from managers in a supportive and motivating manner or formal opportunities to develop their practice.
● The provider did not demonstrate effective systems to evidence continuous learning. The provider's statement of purpose states, "Weyspring Park strives to achieve best practice and quality assurance through its governance systems. For example, there will be regular audits of staff training and development and auditing of nursing practice". Feedback from staff had identified gaps in training there was no audit of training needs in place.
● The provider did not have adequate auditing processes in place to ensure they were continually monitoring the risks to the health, safety and welfare of people. The registered manager had informed us that during the pandemic they had had regular contact calls with the nominated individual, however, they had failed to identify concerns regarding safe care and treatment of people identified at inspection. For example, the lack of detailed guidance for staff supporting people with PRN (as required) medicines. The registered manager and provider did not have systems in place to provide assurances medicines were always given in accordance with the prescriber's instructions or identify the lack of guidance available to staff. Staff members carried out medicine audits. However, the audits were not robust and had failed to identify the concerns relating to medicine management we found during our inspection.
● The registered manager did not operate a system for monitoring and analysing accidents or incidents. They had not carried out an analysis of falls and therefore could not provide assurances that all possible actions had been considered to mitigate the risks to people.
● The provider did not have effective systems in place to monitor records relating to the care and treatment of people. Some essential care records were illegible; others had used language that was not person-centred, and some included the possible use of unauthorised restrictive practices.

We sought immediate assurances from the registered manager to ensure how these issues were addressed.

The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This placed people at risk of harm. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we spoke with the provider. They informed us of the immediate actions they were going to take to address the concerns and failings in the operational oversight of the service and quality assurance processes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were not always considered or engaged in using the service. Involvement and participation were limited.
● Some people using the service participated in residents' meetings. Records reviewed detailed how these

were focused on activities people were interested in. The registered manager had effective communication with relatives, however, it was not evident how feedback was used to develop the service or how the views of people was being considered within the service.

● Some staff were not actively engaged in developing the service or involved with developing new ways of working. The registered manager had told us about the communication challenges they had experienced, which had increased during the pandemic and had impacted on the frequency of staff meetings. They had recently implemented a messaging app in order to offer staff engagement opportunities.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their responsibility to be open and honest with people and act on the duty of candour.

One person told us they could tell the staff if they felt anything was wrong and that they would be listened to; the staff were "lovely, really great". Relatives provided feedback on their experiences of how concerns were managed, and one relative told us," If I had a complaint, I would phone up the manager … he is quite good at discussing any situation". Another relative said," I would phone up and complain to the manager if I had any concerns, but I have none at all".

Working in partnership with others

● The COVID-19 pandemic had impacted on the amount of direct contact stake holders and commissioners had with registered services over the last year. Feedback from professionals was positive and evidenced that the registered manager shared information appropriately. A health professional told us," They are very good at communicating, with myself as well as relatives". Records relating to people's care confirmed regular involvement and contact with professionals.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess, manage risks relating to people's health and welfare or learn lessons when things went wrong. There was a failure to ensure the proper and safe administration of PRN medicines by registered nurses.

The enforcement action we took:

positive conditions on providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's processes and working practices did not ensure an adequate level of scrutiny and oversight that was needed to ensure people were protected from the risk of harm, abuse and improper treatment.

The enforcement action we took:

positive conditions on providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This placed people at risk of harm.

The enforcement action we took:

positive conditions on providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

The enforcement action we took:

positive conditions on providers registration

The provider had failed to ensure staff received appropriate support, training, supervision and appraisal.