Barchester Healthcare Homes Limited

Westgate House

Inspection Report

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Date of inspection visit: 19 May 2014
Date of publication: 09/12/2014

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Summary of findings

Overall summary

We carried out this inspection under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by the CQC which looks at the overall quality of the service.

This was an unannounced inspection. At our previous inspection of Westgate House in November and December 2013 we found the provider was not meeting the requirements of the law in relation to the care and welfare of people, dealing with complaints and record keeping. Following that inspection the provider sent us an action plan to tell us the improvements they were going to make. During this inspection we looked to see if these improvements had been made.

Westgate House is a nursing home for up to 80 older people. At the time of our inspection 78 people were living at the service.

People were generally positive about the care provided at Westgate House. However, we found that people's safety was compromised in some areas. This was in relation to the usage of slings and bed rails. We saw positive interactions between staff and people using the service, but staff were busy during the lunchtime period and were not always able to respond to people when they needed assistance during this period.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make a decision. For example, on one floor of the building we were told that staff did not do mental capacity assessments for specific decisions despite some people needing their capacity to be formally considered.

We found people's health care needs were assessed, however we saw a number of risk assessments which had been completed incorrectly.

Staff were recruited safely and given appropriate training.

The service had a complaints procedure and we saw records to indicate that complaints were being dealt with in line with the procedure. Relatives we spoke with knew how to make a complaint and were confident that their feedback was acted on.

Staff at Westgate House carried out regular audits. Where any improvement or action was needed this was dealt with. However, the monthly auditing of care records did not identify the issues we found.

The service sought the feedback of relatives and people living at the service. Residents' meetings were held at least every three months and further actions arising from these meetings were recorded and dealt with appropriately.

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Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

The service was not safe. The people using the service were being put at risk because some unsafe practices were being carried out and some risk assessments were completed incorrectly.

We saw that staff were not always following the requirements of the Mental Capacity Act (MCA) 2005 as they were not always conducting capacity assessments for people in relation to specific decisions. However, staff were meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff were recruited safely and knew how to recognise and respond to abuse correctly. Staff also knew how to safely respond to accidents or incidents.

Are services effective?

The service was effective. Most people we spoke with were happy with the care they received and relatives felt staff involved them in the planning of care.

Staff we spoke with told us they felt they received enough training and supervision to do their job effectively. Relatives told us they knew about their relative's care plan and that they were invited to be involved in the review of the care plans.

Are services caring?

The home was caring. Staff members we spoke with explained people's behaviours and demonstrated that they understood what people wanted. People we saw were dressed in clean clothes and looked physically well cared for.

Relatives told us that privacy and dignity of people was always maintained and staff gave us examples of how they did this. Relatives told us there was regular and effective communication between themselves and staff at Westgate House.

We saw positive interactions between staff and people living at Westgate House throughout the day, but not during the lunchtime period as staff seemed busy completing tasks.

Are services responsive to people's needs?

The service was responsive. The home had a suitable complaints procedure. We saw records to indicate that complaints were being dealt with in line with the procedure and relatives confirmed that they knew how to make a complaint and were confident that their feedback was being acted on.

Summary of findings

People we spoke with told us staff listened to them and responded to their wishes.

Staff gave examples of how they communicated with people and what particular behaviours meant.

Care planning documentation did not always give information to staff about people's life histories, their likes or dislikes or preferences with regard to activities or food.

Are services well-led?

The service was not consistently well led. Audits were carried out regularly, but these had not identified the issues we found with care records.

The service sought the feedback of relatives and people living at the service. Residents' meetings were held at least every three months and further actions arising from these meetings were recorded and dealt with appropriately. Relatives felt their feedback was being acted on.

Summary of findings

What people who use the service and those that matter to them say

We were unable to speak to some people who used the service as we were unable to understand their methods of communication. We therefore carried out general observations and spent a period of time carrying out a Short Observational Framework of Inspection (SOFI), which is a specific way of observing care to help us understand the experiences of people. We saw positive interactions between staff and people using the service throughout the day, however staff were rushed during the lunchtime period and they did not respond to requests from people using the service. We sought the views of five family members and 10 people who used the service. Feedback was generally positive about the care being given and family members felt they had been kept informed about the changing needs or any updates regarding their relatives.

Westgate House

Detailed findings

Background to this inspection

We inspected the home on 19 May 2014. We spoke with five relatives, 10 people who use the service and 12 members of staff which included the registered manager. We looked at areas of the building, including the kitchen, bathrooms and communal areas. Throughout the inspection we observed how staff supported and interacted with people. We also spent time looking at records, which included 11 people's care records, and records relating to the management of the home.

The inspection was conducted by two inspectors and a specialist in dementia care.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed the information we held about the home and spoke with the local safeguarding team.

Are services safe?

Our findings

At our previous inspection we saw there were some problems with record keeping. For example, we saw monitoring records which had been completed before the recorded time and some monitoring records contained inconsistent information. We asked the provider to send us an action plan outlining how they would make improvements. When we inspected the home again in May 2014 we generally found improvements had been made to the quality of the records that were kept.

Most of the daily monitoring records we saw had been completed on time and most of the risk assessments we saw had been reviewed within the last six months. This was an improvement from our previous inspection.

We looked at care records for 11 people who used the service. We saw a number of risk assessments which had been completed incorrectly. For example, one risk assessment for bed rails stated that bed rails were not in use, but we were told by staff that this person did have bed rails in place and this form had been completed incorrectly. We saw another person's moving and handling risk assessment stated that they were unable to stand, but we observed the person being mobilised by their relative. We also saw that care planning records did not provide up to date information about each person's care needs and how these should be met in the home. For example, we looked at the Malnutrition Universal Screening Tool (MUST) for one person. The MUST helps identify whether a person is underweight or at risk of malnutrition as well as those that are overweight. We saw that this person was at risk of malnutrition, however, there was no record of how staff were dealing with this. We spoke with staff and they confirmed that the person's meals were not being fortified and their diet was not adjusted in light of the MUST score. They confirmed no other actions had been taken in light of the risk identified. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the planning of care did not ensure the welfare and safety of people using the service.

We saw some unsafe practices being carried out. The service used hoists which are mechanical devises used to lift and transfer people who had difficulty mobilising. The hoist is used with a sling, a piece of fabric designed to take the weight of a person which is attached to the hoist. We were told that slings were being shared among residents on one floor and were therefore not of the correct measurements for their requirements thereby presenting a health and safety risk. We were also told and saw from laundry records that disposable slings were being laundered against manufacturer's guidance, which made them unsafe for use.

We saw bed rails risk assessments did not specify the required height of bed rails and staff were not aware of these requirements on the day. Some of the bed rails we saw were at an incorrect height for people to use and therefore could not ensure people's safety when they were in bed. This was also a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the delivery of care did not ensure the safety of people using the service.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We found that Westgate House was meeting the requirements of the DoLS. Staff received appropriate DoLS training and were able to tell us the appropriate process to follow if required. None of the people living at Westgate House had DoLS authorisations in place at the time of our inspection, but we were told by the manager that two applications were pending. We did not observe any potential restrictions or deprivations of liberty during our visit.

We spoke to the registered manager and 11 other staff members about how they obtained consent from people using the service on a daily basis. All staff explained that each person had different means of communicating their wishes which they had learned to recognise. We were given some detailed examples of the routines of some people as well as their general likes and dislikes. However, we saw that staff were not following some of the requirements of the Mental Capacity Act (MCA) 2005. Some staff we spoke with were not aware of their roles and responsibilities in relation to capacity and best interest decisions. We saw an example of a "do not resuscitate" form being filled in and signed by the person's representative without any reference made as to whether the person had capacity to be involved in the process. Therefore it was not possible to determine if this person agreed with the decision made on their behalf not to resuscitate them in the event of a medical emergency. We were told by staff on this floor that the person did have capacity, but they had not completed a capacity assessment to determine this. Staff could not explain why this person had not signed this form. Staff also

Are services safe?

stated that they did not do mental capacity assessments in any circumstances for any of the residents on that floor. Staff were not able to explain why this was the case. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider did not have suitable arrangements in place for obtaining, and acting in accordance with the consent of people using the service.

We spoke with 12 members of staff who told us that they had received safeguarding adults training and records confirmed this. Staff correctly explained how they would respond if they suspected abuse and most also said they would follow the homes whistleblowing procedure if they felt their concerns had not been taken seriously. We saw records of safeguarding alerts and saw that these had been dealt with appropriately. We also spoke with a member of the safeguarding team at the local authority. They confirmed they did not have any concerns about the staff handling of safeguarding issues.

There were arrangements in place to deal with foreseeable emergencies. Staff we spoke with told us they had received first aid training and were able to describe the procedure they would follow in dealing with an emergency. There was a policy in place for dealing with accidents and incidents and we were told that a nurse was always on duty in case of an emergency. Accident and incident records that we saw indicated that correct procedures were being followed.

We looked at two staff files and saw they contained the necessary information and documentation which was required to recruit people safely. Files contained photographic identification, references including one from previous employers, criminal record checks and application forms. We were told by all staff we spoke to and saw from records that newly appointed staff received an induction when they commenced employment at Westgate House. This included a period of shadowing more experienced staff. Staff we spoke with confirmed they had received a robust induction and subsequent training. They told us the induction had made them feel confident about their ability to carry out their role competently. We saw from records that staff were completing mandatory training and this was monitored by the manager.

Are services effective?

(for example, treatment is effective)

Our findings

We spoke with 10 people who used the service. Most people we spoke with were happy with the care they received and felt their choices for treatment and support were fulfilled. Comments included “staff do listen”, “I have freedom” and “staff do things the way I want”.

We also spoke with five relatives of people who used the service. People told us they knew about their relative’s care plan and they were invited to be involved in the review of the care plans. One person told us “they always keep me informed and up to date.” People were generally happy with the quality of care being provided. One person said they “can’t fault the way they treat [my relative]” and they had “only found them caring.” Another person told us they felt “informed and up to date” whilst another relative said they felt confident they were being kept up to date with their relative’s care. We saw evidence in care planning documentation that people and their relatives were involved in the assessment and planning of their care.

Most staff we spoke with had good knowledge of people’s individual needs and preferences. We were given detailed examples of people’s likes and dislikes in matters ranging from how they liked their food or drink and how they preferred to spend their free time. However, care planning records did not contain details about people’s preferences and choices in relation to their care. For example we saw there was very little recorded detail about people’s likes and dislikes in relation to food and documents detailing people’s life histories lacked detail. This meant there was little written information for newer members of staff to refer to.

Staff we spoke with told us they felt they received enough training to do their job effectively. People using the service and relatives gave positive feedback about staff. We were told “staff always put themselves out”, “staff are good” and “they know what they’re doing” and “[my relative] is well looked after.” Mandatory training in areas such as infection control, moving and handling, medication administration and safeguarding were up to date and we saw records to indicate this.

Staff and management told us, and we saw from records that supervision took place on a regular basis. Supervision enables staff to receive support and guidance about their work and discuss on-going training needs. We saw minutes of supervision records. These indicated that supervision sessions were conducted in groups. We saw supervision records contained details of further learning and action plans.

Staff and management told us staff meetings were held regularly and minutes were made available for all those who were unable to attend. We saw minutes of four staff meetings. Records showed these provided a forum for staff to speak openly and discuss issues they were having.

Are services caring?

Our findings

We spoke with 10 people who used the service. People we spoke with told us that staff were kind and caring. We also spoke with five relatives and they confirmed that staff were caring in their interactions with their relatives and knew them well. Comments included "staff are good, they care" and "staff are nice and caring".

Due to communication difficulties there were some people we were not able to speak to. We therefore carried out observations using the Short Observational Framework for Inspection (SOFI) and observed interactions between staff and people using the service during the lunchtime period. We did not see positive staff interactions during the lunchtime period. Staff we observed were too busy providing people with their lunches and did not have time to interact with people. We heard one person complaining about the lunch but we did not see anyone responding to or acknowledging their comments. However, we did see other positive interactions between staff and people living at Westgate House at other times of the day. We saw staff speaking kindly and respectfully with people and responding to their requests. For example, we saw some people being approached and asked how they were and whether they would like a drink.

There was a team of staff who had worked at the home for a number of years and knew the people they supported well. The manager told us that they used some bank staff, but they were always supported by more experienced staff and were inducted into the organisation in the same way as permanent staff. Staff members we spoke with explained people's behaviours and demonstrated that they understood how people communicated and what people wanted.

Relatives told us that privacy and dignity of people was always maintained. Comments included: "they are very respectful of [my relative's] privacy and dignity. They always follow [my relative's] wishes", "they respect what [my relative] wants." We were also given positive comments by people using the service. One person said "I have freedom, I can come and go as I please."

Staff we spoke with were aware of the need to protect people's dignity whilst helping them with personal care. We were given examples of how staff protected people's privacy and dignity. One staff member said "I try to make them feel comfortable. I make sure that only the part being washed is exposed. I also explain what I'm going to do and make sure they are ok with it first." Another female carer told us they always made sure that male users of the service were comfortable being given personal care by them.

Staff members told us they always knocked on people's doors before entering and this was confirmed by family members we spoke with and observed by us during our inspection. People we saw throughout the day were dressed in clean clothes and looked physically well cared for. This showed that staff took time to assist people with personal care. One relative said their family member "always looks clean and presentable."

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

In our previous inspection we found little evidence that people's interests were supported and that the activities coordinator was supporting people with their care. In our most recent inspection two out of 10 people we spoke with living at Westgate House complained about activities provision, but most people did not have any complaints. Most people felt they could participate in activities when they were of interest, but otherwise felt they had the freedom to follow their own interests. One person said "I can do what interests me".

The home employed a full time activities coordinator who worked with an assistant to organise and implement the activities programme within the home. The types of activities on offer included going into the garden, going to the park, playing board games, watching movies or going to local shops. However, most staff we spoke with felt there was not enough time available to them to encourage people's interests outside the set activities organised by the coordinator.

At our previous inspection we found not all complaints that had been relayed to the CQC had been investigated by the provider. During this inspection we found the home was no longer in breach of this regulation. We saw the home's complaints policy and procedure. The policy outlined clear stages of the complaints procedure with a timescale of when people could expect their complaint to be addressed. We were shown a copy of the complaints log and daily complaints forms. These showed what action was taken on a daily basis to respond to people's complaints.

Relatives we spoke with told us they had not had reason to complain but would know how to complain if necessary. They said they were confident any complaint would be dealt with appropriately. One person said "they've always responded to my feedback so I'm sure they'd respond to my complaint, if I had one."

Most people we spoke with told us staff listened to them and responded to their wishes. One person said "they will ask what I want and do it". Some of the people who lived at Westgate House had communication difficulties. Staff gave examples of how they communicated with people and what particular behaviours meant. Relatives told us they had opportunities to be involved in the development and review of care plans if they wished. Relatives we spoke with told us they felt communication with the home was good and they felt "informed" regarding care planning and any changes in health needs.

We asked the registered manager how they gathered the views of people who lived at the home. We were told that Residents' meetings were held regularly, at least every three months. We saw the minutes of the last meeting which took place in March 2014 and we saw that numerous subjects were discussed with people and their feedback was recorded. Further actions were also listed and we were told that some of these had been implemented whilst others were in the process of being implemented.

Are services well-led?

Our findings

Care records were not monitored appropriately to ensure they were accurate and up to date. We were told that care records were audited on a monthly basis but auditing systems did not identify issues in care planning documentation.

A member of the management team told us, and we saw from the documentation, that staff at Westgate House carried out other audits on a regular basis. The audits carried out were associated with nutrition, pressure ulcer management and accidents and incidences. Where any improvement or action was identified in these audits we saw they were dealt with.

Most of the staff we spoke with confirmed that they felt confident in expressing their views both in team meetings and in private. They told us that they felt the registered manager cared about their general welfare as well as their work performance. Comments included “she cares about us” and “I can speak to her if I have a problem”.

Accidents and incidents were recorded appropriately. We saw these were analysed on a monthly basis and follow up actions were taken. We looked at some of the accident and incident records for 2013- 2014. We saw follow up actions that had been taken were recorded. We saw an incident had been recorded in one of the care files we viewed. We also saw this had been reported as an accident through the accident and incident reporting procedure and their risk assessment had been updated to reflect further actions. Westgate House also had a satisfactory complaints procedure in place.

At the time of the inspection the manager told us that there were some vacancies at the home, but they were using bank staff to cover these vacancies in the interim period. We were told by the manager and saw from records that bank staff used were inducted into the organisation in the same manner as permanent staff and were always scheduled to work with more experienced staff members.

The registered manager told us all new members of staff including bank staff completed a six week induction that followed the Skills for Care Common Induction Standards (CIS). The CIS is a national tool used to enable care workers to demonstrate high quality care in a health and social care setting. During this period they would shadow more experienced staff whilst working shifts. At the end of the induction period a lead senior member of staff would assess competencies before signing the person off as able to work independently. We looked at two staff records. Staff files showed, and staff told us, this procedure was adhered to.

Staff we spoke with were positive about the management of Westgate House. Most staff we spoke with told us they felt supported to do their jobs to a good standard. Relatives told us they found the registered manager “helpful and approachable” and “she’s really nice- she’s always around.”

Westgate House had asked relatives of people who used the service to complete a satisfaction survey. The results had been analysed and we saw the results were positive. We also saw that feedback forms were available in the reception area and these were reviewed as and when a form was completed. We saw an example of a completed form and saw that positive comments had been made.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9(1)(b)(i) and (ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare of people who use services. The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care as they had not taken action to meet the service user's individual needs or ensure the welfare and safety of service users. Regulation 9(1)(b)(ii).

Regulated activity	Regulation
	Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18.