Care Quality Commission

BLHC Westwards House Limited

Westwards House Residential Care Home

Inspection report

BLHC Westwards House Limited
18 Croston Road
Garstang
Lancashire
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Tel: 01995602055

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21 January 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 and 21 January 2016, the first day was unannounced. We arranged to come back on the second date to ensure that the registered manager and owner were present. 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.

We last inspected Westwards House Residential Care Home on 30 July 2014 and the service was judged to be fully compliant with the previous regulatory standards.
Westwards house residential care home is registered to provide personal care for up to 19 people. Accommodation is on two floors with a stair lift for access between the floors. There are two lounges and a large dining room and a large garden for people to use. The home is situated close to shops, buses and the local facilities of Garstang.

There were 17 people at the home on the two days the inspection took place of which four people had been transferred from the organisations sister home in Lostock Hall, near Preston, due to the boiler breaking down. The registered manager was registered for both homes therefore knew the four people well and we saw that all the necessary care documentation was present at Westwards House for them. Due to the issues at the home in Lostock Hall the registered manager and owner were not present during the first day of the inspection. Both were present on the second day of the inspection. The newly appointed Deputy Manager was present on both days of the inspection.

The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns. Staff members spoken with said they would not hesitate to report any concerns they had about care practices. However we saw some incidents had occurs that should have been notified as safeguarding issues to the local authority.

Body maps detailing people's injuries were not completed with any frequency and those we did find were in different locations, some being in people's care plans and some in a separate file in the office. Body maps we did find did not inform changes to care plans.

Risk assessments that were in place that we reviewed did not have sufficient information within them to be effective.

People told us they felt safe at the home and with the staff who supported them.

We spoke with the deputy manager of the home regarding staffing levels. They were confident that staffing levels were in place at all times to meet the needs of the people in the home. This was observed to be the case during the inspection and the feedback we received from people, their relatives and staff also

confirmed staffing levels to be sufficient to meet people's assessed needs.

We looked at how medicines were ordered, stored, administered and recorded. We spoke with the deputy manager who had responsibility for administering medication on the both days of the inspection and observed medication being given to people on the morning of the second day of our inspection.

We observed a number of recording issues whilst reviewing the controlled drugs records, this was mainly around missed signatures.

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 were being met. We reviewed care plans and associated documentation for people who used the service. We found no records of people's consent to care and treatment, nor any assessment of people's capacity to make a decision around consent.

We talked with people who used the service about the quality and variety of food provided. The responses we received were positive and people were seen to enjoy the food on offer. We observed lunch being served in a relaxed manner. Tables were set appropriately and people were offered a choice of hot and cold drinks.

People who lived at the home were very complimentary about the approach of the staff team and the care they received.

People told us that staff respected their privacy and treated them with dignity. We observed staff interactions with people during our inspection and found them to be warm and compassionate.

Staff we spoke with were knowledgeable and passionate about end of life care. Some staff had attended specialist training via the 'Six Steps' course in end of life care. This involved demonstrating that the service met a number of specific standards including enhanced training for care staff.

We examined the care files of five people, who lived at Westwards Residential Care Home. We found documentary evidence to show that people had their care needs assessed both externally by healthcare professionals prior to moving to the home, and by staff at the home.

A bath rota was in place at the home. The rota was assigned to room numbers as opposed to people. This was institutional in approach as when a new person came into the home they would be assigned a particular day to have a bath or shower instead of being able to choose themselves.

People we spoke with told us they knew how to raise issues or make complaints. They also told us they felt confident that any issues raised would be listened to and addressed.

The service had not submitted some statutory notifications, as required, with regard to significant events at the service, including death notifications and accidents and incidents which affected people who used the service.

We saw that audits took place at the service which highlighted some issues. However it was not always clear how audits feedback into making improvements for people at the home.

We spoke with people who lived at Westwards House Residential Care Home about the culture of the home. The responses we received were positive.

We found several breaches of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. These related to; Person centred care, Need for consent, Safe care and treatment, Safeguarding service users from abuse and improper treatment and Staffing. There was also one breach of the Registration Regulations 2009 relating to Notifications of other incidents.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always safeguarded from potential harm, we saw examples of people not being referred to the Local Authority Safeguarding team following a series of falls and referrals to other professionals, such as the falls team or occupational therapy, were not always made.

Appropriate risk assessments were not always in place for people or they were not detailed enough to fully mitigate risks to people's health and wellbeing.

Medicines management processes needed to be improved, particularly the recording procedures in place.

The home had effective recruitment policies and procedures in place which we saw in operation during our inspection.

There were enough suitably qualified and trained staff to care for the assessed needs of the people at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not working within the principles of the Mental Capacity Act and staff were confused as to whether some people had been referred to the Deprivation of Liberty Safeguarding team at the Local Authority.

Staff were not supervised or appraised with any consistency.

People we spoke with were happy with the food and drink offered at the home and we observed lunchtime to be a calm and pleasant experience.

Is the service caring?

Good

The service was caring.

Staff were knowledgeable about the people they cared for and

spoke passionately about them to us.

We observed staff during our inspection and they displayed a caring, attentive and professional approach.

Visiting professionals we spoke with were complimentary about the home and staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was little evidence that people were involved in care planning and some practices were found to be institutionalised in nature.

Evidence that regular activities took place was seen and people we spoke with confirmed this to be the case.

A keyworker system was in place which meant that people had a name care-worker.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some statutory notifications had not been submitted to the Care Quality Commission in line with statutory obligations.

We saw that audits were taking place however they did not always feed into the care planning process and/or evidence was not seen that issues found within audits always resulted in improving the quality of the service at the home.

People we spoke with talked positively about the management and culture within the home.

Care Quality Commission

Westwards House Residential Care Home

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 inspection took place on 15 and 21 January 2016, the first day was unannounced.

The inspection was carried out by the lead adult social care inspector for the service. An expert-by-experience was present during the first day of the inspection and spent time talking with people who lived at the home, their relatives who visited and also had lunch with people. 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 provider sent us a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with a range of people about the service; this included seven people living at the home, one visiting relative and six members of staff including care workers, the chef, deputy manager, registered manager and owner. We also spoke with a visiting GP and visiting community matron.

We spent time looking at records, which included five people's care records, four staff files, training records and records relating to the management of the home which included audits for the service.

Inadequate

Is the service safe?

Our findings

The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns. Staff members spoken with said they would not hesitate to report any concerns they had about care practices to senior members of staff. Staff were also able to name external organisations to report potential safeguarding issues to such as the Care Quality Commission and Local Authority. Safeguarding procedures were on display on the notice board in the reception area.

There had been two safeguarding issues raised during the previous 12 month period with regard to Westwards House, both had been investigated by the Local Authority safeguarding team and had been concluded. We found a number of incidents that were potential safeguarding issues that had not been reported by the home. These included medication errors and falls resulting in hospital admissions. We discussed these issues with the deputy manager on the first day of our inspection. They told us that these incidents had been investigated internally however we found little evidence of this within people's care plans. Were people had fallen, most of which were unwitnessed, there had been little in the way of analysis to determine why people had fallen, we did see a 'Fall monitoring file' but this had not been used for some time as the information within it was dated. We could not see any referrals to safeguarding, the falls prevention team or Occupational Therapy service. The guidance for staff was limited, with standard statements on how to help avoid falls such as 'observe changes in mobility' or 'gentle reminder to use frame'. There were no specific environmental risk assessments for individuals, no analysis of falls or simple steps taken such as looking at the appropriateness of people's footwear. This meant that people could potentially still be at risk as they were not safeguarded appropriately from the risk of falling.

Body maps detailing people's injuries were not completed with any frequency and those we did find were in different locations, some being in people's care plans and some in a separate file in the office. Body maps we did find did not inform changes to care plans.

We found an accident report book that detailed any incidents of accidents within the home. Some forms were in the book and some were in peoples care plans. As with body maps there was little evidence to suggest that these were used to inform care planning. Some forms were not signed and the level of detail within some was poor with descriptions of incidents limited and no detail of actions recorded. Again some incidents should have resulted in safeguarding referrals to the Local Authority, for example unwitnessed falls resulting in injuries that needed treatment in hospital. By referring people through the safeguarding process this would potentially trigger additional support from the Local Authority due to the number of falls people experienced.

We found the registered person had not effectively safeguarded all service users from abuse and improper treatment. This was in breach of regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where they were able to people move about the home independently. There was a stair lift between the

ground and first floor. However, there was no guard on the staircase to protect people at night when leaving their room at night. The second floor housed an office and a staff area. There was a gate to prevent access at the bottom of this staircase but this was frequently left open and was easy to open as it was not locked. This could also have presented a risk to people with dementia. We discussed this with the deputy manager who told us that if anyone was prone to getting up in the night then they would be moved to one of the ground floor rooms. This was happening with one person who had begun to get up at night. One person we spoke to had moved from upstairs to downstairs and they told us, "I moved from upstairs. It's much better. You can get about easier with no help." Whilst we did find evidence that people were moved who may be at risk we did not find any specific risk assessments to support these decisions.

Risk assessments that were in place that we reviewed did not have sufficient information within them to be effective. Each section of peoples care plans indicated a risk rating of high, medium or low. It was not always clear what the rating was and some sections had no rating indicated at all. One person who had experienced several falls had a Falls Risk Assessment Tool (FRAT) in place but there was no evidence that this had been reviewed since May 2015. One person had a risk assessment in place for the treatment of a pressure sore; however the pressure sore was not graded. The care plan did state that the district nurse team were attending and that pressure relief was being given via specialist equipment but we found little in the way of guidance for staff. We discussed this with the deputy manager who informed us that care plan reviews, including risk assessments, had not been completed to the level they should have for a number of months due to the deputy manager post not being consistently filled, i.e. this post was job shared for approximately six months. They told us that now they were permanently in post this was a priority for them and they had a system in place to do so. We saw that some care plans had begun to be reviewed in early January 2016.

We found the registered person had not protected people against the risk of harm, because risks to people's health had not always been managed well. This was in breach of regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the home and with the staff who supported them. One person told us, "I feel safe - I felt safe at home." Another person we spoke with said, "I didn't feel safe at first. I slipped on the floor and cut my arm. I was a bit concerned about being on my own at the end of the corridor. I said about this but they (staff) said to call them. At night, if I put my light on they're there and make me a cup of tea. Another person told us, "If I need to go to the bathroom at night I ask for help. I use the call button. I feel a more secure now than when I first came."

We spoke with the deputy manager of the home regarding staffing levels. They were confident that staffing levels were in place at all times to meet the needs of the people in the home. This was observed to be the case during the inspection and the feedback we received from people, their relatives and staff also confirmed staffing levels to be sufficient to meet people's assessed needs. Due to the issues at the sister home four additional people had come into Westwards House several days prior to our inspection. Prior to this the home had been operating with four permanent vacancies, although two people were in the home receiving respite care. Staffing levels had not changed because of the vacancies and had therefore remained static when four additional people had arrived from the other home. Staff we spoke with did not see this as an issue and the deputy manager told us that people had been transferred to Westward House who needed 'less support' to ensure that staff could manage. The Registered Manager and owner had spent a full day at the home to ensure staff understood all care needs of the four new people to the home and so they saw familiar faces during their first day at the home. The home had two bank staff available to call on to cover short notice absenteeism. Permanent staff were also called on to cover sickness, holidays etc. The deputy manager told us that occasionally agency staff were used but that agency staff were from the same agency

in an attempt to get some consistency. We were told the quality of agency staff did vary so they were used as a last resort. Agency staff had not been used over the Christmas and New year period as all shifts had been covered with permanent staff.

We discussed with the deputy manager how staffing levels were determined. They told us that due to the small size of the home that staffing levels were set at two care assistants plus the deputy manager or senior carer from 8am to 10pm covered by two shifts. At night two care assistants were in attendance with on call assistance. A chef and housekeeper were also employed. We discussed the use of a staff dependency tool to ensure that staffing levels were set at the correct level based on the needs of people. We have made a recommendation about this.

Westwards House presented a pleasant environment. All shared areas were clean including toilets and bathrooms which were seen to be kept tidy. We looked in six people's bedrooms with their permission. Some had laminate flooring which meant others remain carpeted. One bedroom we looked at did have a slight odour, we discussed this with one of the senior carers who explained the reasons for this and we were told this was being addressed. All the other bedroom we were in were clean, odour free and people had brought furniture and ornaments with them to help personalise their own room.

We observed people moving about the home and going to and from their rooms as they wished. There were staff present to observe this however, there appeared to be a fair balance between protection and freedom for people. While moving to and from lunch staff helped to guide and support people where they needed it and we heard staff encouraging people by saying things like, "Turn this way" and "Get a little bit closer." One person told us, "I walk around on my own but the staff keep an eye on me. I don't get away with murder."

We looked at how medicines were ordered, stored, administered and recorded. We spoke with the deputy manager who had responsibility for administering medication on the both days of the inspection and observed medication being given to people on the morning of the second day of our inspection. All the medicines given were done so in a discreet manner and it was evident that the deputy manager knew people well and how best to approach people when administering their medicine. We checked medication administration records (MAR) to see what medicines had been given. The MAR was clearly presented to show the treatment people had received.
Medicines were stored in a locked metal drugs trolley which was chained to the wall. Controlled drugs were stored in a locked safe within a locked cabinet. No medicines were prescribed that needed to be refrigerated. All the people we spoke with told us they received their medicines on time and knew why they were taking their medicine. Nobody was given their medicines covertly and nobody had responsibility for taking their own medicines although a policy was in place in the event of either scenario.

On the first day of our inspection we observed one person being given their medicines. They were left to take their medicines whilst the member of staff assisted someone else. Whilst we observed the person to take their medication staff could not have been certain that this had happened although the MAR was signed as though they had. There were no issues observed on the second day of the inspection. The home carried out medication audits which had highlighted a few issues, mainly missed signatures. Processes were in place that meant the relevant member of staff was contacted to ensure that the medicine had been administered.

We observed a number of recording issues whilst reviewing the controlled drugs records. Again this was mainly around missed signatures. Controlled drugs should always be countersigned by a second member of staff and we found a number of missed second signatures. Controlled drugs that had been received into the home had also, on two occasions in the previous twelve month period, had not been signed in. We did see that one person had not been given their controlled medicine on two occasions in March 2015. This had

been the same member of staff and had resulted in the times of that person's medicine being administered for when a more experienced member of staff was on duty. This had been done in consultation with the person and their GP. However any instances when a controlled drug is not given should be reported under safeguarding procedures. We have made a recommendation about this.

During our inspection we looked at the personnel records of six people who worked at the home. We found that prospective employees had completed application forms and had attended structured interviews. This helped the management team to determine if applicants met the required criteria, in accordance with company policy. All necessary checks had been conducted, which demonstrated robust recruitment practices had been adopted by the home. This meant those who were appointed were deemed fit to work with this vulnerable client group and therefore people's health, safety and welfare was sufficiently safeguarded.

We recommend that a staff dependency tool is used to ensure that the needs of people are taken into account when setting staffing levels.

We recommend that procedures ascertaining to medicines management are reviewed to ensure that all staff are aware of the importance of observing medication and that recording systems are as robust as possible and follow NICE guidance on medication.

Requires Improvement

Is the service effective?

Our findings

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We reviewed care plans and associated documentation for people who used the service. We found no records of people's consent to care and treatment, nor any assessment of people's capacity to make a decision around consent. There were people at the home who had varying degrees of dementia and two DoLS authorisation referrals were in the process of being sent to the local authority. However when speaking to staff it was evident that there was some confusion about whether anyone in the home had a DoLS authorisation in place. Two of the staff we spoke with told us that two people did have a DoLS in place whilst others were unsure. When speaking to the registered manager and when looking at the care plans for the two people it became evident that no-one had a DoLS authorisation but referrals were to be made for two people.

We discussed consent issues with staff. All were very knowledgeable about how to ensure consent was gained from people before assisting with personal care, assisting with medication and helping with day to day tasks. People who used the service cited no issues when we discussed consent issues with them. However staffs knowledge of MCA and DoLS was poor and we found limited evidence that any formal training was done in this area. The registered manager told us that they would look into sourcing specialist MCS and DoLS training for staff.

Even though the service had made two applications under DoLS, which had not yet been reviewed by the Local Authority, no formal assessments of the two people's capacity had been undertaken, in line with the MCA code of practice and DoLS processes.

This showed the service was not working within the principals of the MCA. Additionally, the service had not sought and recorded people's consent to care and treatment.
This was in Breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records and certificates of training showed that a wide range of training was provided for all staff. These

included areas such as fire safety, medication, safeguarding, food hygiene and moving and handling. Staff confirmed they had access to a structured training and development programme. This ensured people in their care were supported by a skilled and competent staff team. One staff member told us, "Training is done face to face and at the end of each session I come away with a good understanding of the subject area every time."

Staff told us that they were well supported by the manager and deputy manager and that they could approach them with any issues they had. However we found that formal supervisions had not been happening for a number of months when reviewing staff files. The deputy manager confirmed that supervisions had not been happening but now they were in post formally this would be addressed. Annual appraisals had also not been completed with any frequency. This meant that staff did not have a formal way of discussing any concerns or issues they had and the management team were not regularly evaluating the performance of staff progress, training needs and their general welfare.

The lack of formal supervisions and appraisals amounted to a breach of regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.
We saw evidence that staff received a thorough induction when they started work at the home. We spoke with staff who confirmed this to be the case even though a number of the staff we spoke with had been at the home for a significant period of time.

People we spoke with were very complimentary about the staff team. One person told us, "They do everything for me, get me up, put me to bed. I love it, – they're all very kind." Another person said, "It's alright. I like being here. We're very well looked after." The one relative we spoke with told us, "I've no real issues about their care. They had a bit of a do a while ago. The contacted me, called the doctor and ambulance. Everything's grand."

We talked with people who used the service about the quality and variety of food provided. The responses we received were positive and people were seen to enjoy the food on offer. We observed lunch being served in a relaxed manner. Tables were set appropriately and people were offered a choice of hot and cold drinks. Most people had their lunch in the dining room but some people who needed assistance, ate in their own room. Staff members were attentive to the needs of people who required assistance or who wanted to ask questions regarding the food that was being served. We received lots of positive comments about the food served as follows; "I've no complaints about the food. There's too much for me as I only have a small appetite", "The food is absolutely perfect, better than I can make it", "We have a fabulous cook. I like the food. They don't over face you" and "It's very good food. (The cook) is very good. There's a menu on the wall. If you don't like it they'll give you something else."

We spoke with the cook who told us that the home catered for any specialist diets, whether that be for health, religious or cultural needs. One person at the home had a diabetic controlled diet and this was catered for appropriately. Nobody at the time of our inspection needed a soft diet as there was no-one assessed as at risk of choking or with swallowing difficulties. The cook was knowledgeable about people's needs and they told us that they had met with people and/or their relatives to find out about people's preferences although there was little in the way of documentation to show this either in people's care plans or elsewhere. We were told that if people did not like what was on offer then a substitute could be made, there were forms for people to fill in which we were shown or this was done via a conversation with the cook.

One person was having their food and fluid intake monitored. We saw that these forms were filled in well with staff recording the amounts of fluid taken in millilitres and good explanations in terms of the type and amount of food the person had eaten.

Good

Is the service caring?

Our findings

People who lived at the home were very complimentary about the approach of the staff team and the care they received. One person told us, "The staff are nice and kind, I am happy here I am well looked after." Another person said, "I like it here, There's some nice ones. You can have a laugh with them" and another person said, "They're very, very kind here."

The one relative we spoke with also told us they thought the staff were kind, caring and compassionate and that they were consulted about their relatives care. They told us, "They're treated well here, I am involved in care. They do tell me. They plan to move (name) downstairs which will make it easier for them." People we spoke with, who wanted to be, told us they were involved in designing the care they received although we saw little evidence to support this within care plans.

People told us that staff respected their privacy and treated them with dignity. We observed staff interactions with people during our inspection and found them to be warm and compassionate. Staff were friendly, patient and were discreet when providing personal care interventions. We found people's privacy was maintained during personal care interventions, for example, by closing doors and curtains. Staff we spoke with were able to talk through how they delivered personal care and how they protected people's privacy and dignity when doing so.

Staff we spoke with were knowledgeable and passionate about end of life care. Some staff had attended specialist training via the 'Six Steps' course in end of life care. This involved demonstrating that the service met a number of specific standards including enhanced training for care staff.

We were told that no-one at the home used an independent advocate and that people had the involvement of family. We did see some information for people on local advocacy services within the reception area of the home and were told that this was a discussion held with people and the local authority as necessary, if they had no family or friends to assist them.

We received positive comments from the two visiting professionals who visited the home when we asked for feedback during our inspection. These included comments such as; "Staff always appear competent, they are visible and give me the information I need", "I get good information over the phone", I have seen improvements to people's health, people eating better and looking better" and "Staff are always helpful, they always inform us of any changes."

Requires Improvement

Is the service responsive?

Our findings

We examined the care files of five people, who lived at Westwards Residential Care Home. We found documentary evidence to show that people had their care needs assessed both externally by healthcare professionals prior to moving to the home, and by staff at the home. We saw some evidence that people had input into their care plans. There was a section entitled, 'About Me' at the beginning of each person's care plan which gave brief details of people's histories such as where they were born, family and any hobbies and interest they may have. However this was generally poorly filled in with little detail. For example care plans tended to list family members only and did not expand any further. It was the same for hobbies and interests; this was in the main in the form of a list. We discussed with the manager and owner the benefit of exploring people's backgrounds so that staff could discuss their interests and background with them.

We saw some good examples of how the service prevented social isolation. One was the use of pictorial communication. For example one person was helped with his communication difficulties by the use of pictures which they used to indicate items of clothing or parts of the body.

There was another section in care plans entitled 'Daily Living Needs'. This detailed people's daily routines and preferences in how their care was delivered. For example on person's plan stated that they liked to go to bed straight after tea however they wanted to be encouraged to stay up a little later to socialise with other people. It also stated that they preferred female carers. Again though there was little in the way of detail and we discussed again the need to explore this further in order for people's care to be truly person –centred.

We saw that a 'Bath/shower/bed change rota' was in place at the home. This had last been updated on 22/12/2015. This showed that people were assigned to have a bath or shower once per week in either the morning, afternoon or evening time. We were told that preferences had been discussed with people although we saw no written confirmation of this. The rota was assigned to room numbers as opposed to people. This was institutional in approach as when a new person came into the home they would be assigned a particular day to have a bath or shower. The rota did state that 'extra baths or showers can be given if requested' although it was unclear as to whether people knew this as when we spoke with them they were unsure as whether such a request could be made. The deputy manager in the first day of our inspection told us that this would be changed with immediate effect and that people would be consulted about their preferred times for bathing and showering.

This type of institutional approach to care amounts to a breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014: Person-centred care.

People we spoke with told us they knew how to raise issues or make complaints. They also told us they felt confident that any issues raised would be listened to and addressed. One person told us, "If I wasn't happy I'd complain. It wouldn't worry me." Another person said, "I'd talk to (name), the one (care staff) who looks after me. I could ask her if I had any concerns. I'd talk to her. I'd also tell my (relative)."

Information was displayed on how to make complaints in the reception area and within people's bedrooms

as part of their welcome pack. Complaints were kept on the homes computer system which the deputy and registered manager had constant access to. We were told that a hard copy file would be introduced to assist with keeping track of complaints and for ease of access. We saw that the home had an up to date complaints policy.

Although there were no organised activities taking place on the days we visited we saw that activities were organised because of notices in the reception area and what people told us. One person said, "There's always something going on", and another person said, "There is a man who comes for exercise. We all do it, he's very good." Other people told us about activities such as; Carols at Christmas, Birthday parties, the church choir, a comedian's visit, dominoes, jigsaws and books to read
In the reception area there were notices announcing craft sessions each Monday, exercise sessions on Tuesday and a mini market on Wednesday where people could buy toiletries, sweets, tissues, birthday cards and so on. The notice stated, 'If you can't see it, ask and we will get it for you'.

A weekly newsletter had been introduced for people entitled 'The Weekly Sparkle'. It was ten pages long and contained facts under the headings, 'Today in History' and 'Do you remember'. It also contained word searches and quizzes and was a useful tool to engage people in and to reminisce with.

A keyworker system was in place so people and their families had a named member of staff who knew their care needs in detail. Keyworkers were detailed at the front of people's care plans. Care staff we spoke with confirmed that they had read the care plans for those they supported, to ensure they knew what each individual required although they said that by speaking to people and getting to know them over time meant they knew people's needs and preferences and that as it was a small home staff knew all the people living at the home well.

Requires Improvement

Is the service well-led?

Our findings

Prior to the inspection we checked to see if the home had submitted information to the Care Quality Commission in line with its statutory obligations. In the previous 12 month period prior to the inspection only one notification had been received in December 2015 when a person living at the home had passed away. Following discussion with the owner and registered manager it became apparent the service had not submitted some statutory notifications, as required, with regard to significant events at the service, including death notifications and accidents and incidents which affected people who used the service.

This was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We reviewed governance arrangements at the home and found that a number of audits were being carried out. For example medication audits were taking place and some issues had been highlighted as a result, as referred to in the 'Safe' domain of this report. However it was not always clear how these issues had been addressed and by whom. The audit stated that medication was not being signed for on a number of occasions and contained comments such as; 'All month staff not signing', '17th and 18th October not signed for (name of medicine) again' and 'Staff still not signing'. The last action stated that the deputy manager would speak to the owner to complete more in-house training but it was not clear who was to receive further training and how this would address the issues raised.

We saw that thorough cleaning audits took place, the last of which was completed on the 11/1/16, shortly prior to our inspection. Some minor issues were picked up relating to tasks in the evening not being signed as done but there was no evidence to suggest this was anything other than an error in filling in paperwork as the home was clean and tidy and people we spoke with told us this was always the case. We saw that infection control audits had taken place, the last of which was in November 2015 with no issues highlighted.

The owner carried out their own quality checks when they visited the home and produced a service quality report. This included talking with people who lived at the home, any visiting relatives, staff and reviewing paperwork. We reviewed the latest report which was dated September 2015. The report looked in detail at the overall care and paperwork in place for five of the seventeen people who were living at the home at that time. Other issues were reviewed such a medication, cleaning, maintenance and staff. Recommendations and actions were noted that did align with some of our findings during our inspection, such as the completion of accident and incident records. However care plans generally were reported to be good, no issues were highlighted in respect of staff supervisions not taking place and no issues were found when reviewing medicines management records, therefore the quality checks could only be used as a general gauge of people's care and not as an effective auditing tool for the service. We have made a recommendation about this.

We saw that a staff meeting had been held on the 11/11/2015. Individual people at the home were discussed as was the correct completion of paperwork such as daily reports and topical cream applications. The notes were brief and did not raise any major concerns or issues. The last staff meeting notes prior to this were from 2014.

The owner had also begun to produce briefing notes for staff for issues such as the new inspection methodology used by the Care Quality Commission, medication processes and the Mental Capacity Act and Deprivation of Liberty Safeguards. The briefing notes were newly introduced and contained good detail for staff to help them understand key issues.

We spoke with people who lived at Westwards House Residential Care Home about the culture of the home. The responses we received were positive. One person told us, "I know the owner. I've met her. The Deputy Manager is great as are the staff. I can't knock the place." Another person told us, "It's a good place to live, the atmosphere is relaxed and you can ask for help at any time."

A registered manager was in place at the home. They were also the registered manager of another home at which they spent the majority of their time as the people living there had greater needs and the home was larger in size. The registered manager told us that they spent the beginning and end of each day at Westwards House as they lived locally to the home. They told us that they worked long days but that they felt being the registered manager for both homes was manageable. They also told us that now they had a deputy manager in post this would help in terms of ensuring systems were being followed and kept up to date, e.g. audits, supervisions, meetings etc. They also informed us that the deputy manager at the other home was there for guidance to the newly appointed deputy manager at Westwards House as they were very experienced and were able to offer advice when necessary.

The registered manager also told us that they were happy with the staff team and admitted that they had struggled with recruitment but with some recent appointments this issue was improving. They were confident that improvements would be made quickly to the issues identified during the inspection.

All the staff we spoke with told us they had a commitment to providing a good quality service for people who lived at the home. Staff confirmed that they had handover meetings at the start and end of each shift, so they were aware of any issues during the previous shift. We found the service now had clear lines of responsibility and accountability although this had been an issue whilst the deputy manager role was being shared.

Comments from staff we spoke with were positive in relation to management and how information was passed on to them. Staff told us that management were approachable and were available when they needed them. One member of staff told us, "I haven't got a problem going to anyone. I get the necessary support." Another member of staff told us, "I get the support I need, I get to speak to the owner as well if I ever need to, she is heavily involved."

We recommend that governance systems are reviewed to ensure that issues highlighted through auditing is acted upon in a timely and consistent manner and evidence is in place to show that issues have been resolved and impacted on people's care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 18 Registration Regulations 2009 Notifications of other incidents The service had not submitted some statutory notifications, as required, with regard to significant events at the service, including death notifications and accidents and incidents which affected people who used the service. This was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured that individualised assessments reflected people's needs and preferences, and that in designing services, these needs and preferences were taken into account. We also found some instances of institutional practice in operation. This was in breach of regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service had not carried out formal assessments of people's capacity within the service, even for those people who had been

identified as needing DoLS referrals. This showed the service was not working within the principals of the MCA.

This was in breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always fully complete risk assessments based on the needs of individuals living at the home. Where risks are identified, then risks assessments must always be robustly completed so as to ensure people's health and welfare are protected and promoted. This was in breach of Regulation 12 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always safeguarded due to referrals not being made appropriately to the local authority safeguarding team. Referrals to other services were no always made which would have assisted people, and staff in managing people at risk of falling. This was in breach of regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that staff received regular formal support, via supervision and

appraisal.

This was in breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.