Westfield Lodge Care Limited

Westfield Lodge Care Home

Inspection report

Weston Coyney Road
Stoke On Trent
Staffordshire
ST3 6ES

Tel: 01782336777
Website: www.fshc.co.uk

Date of inspection visit:
06 September 2017

Date of publication:
19 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 6 September 2017. At our previous inspection in April 2017 we had concerns about people's safety and wellbeing. We found several breaches of Regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had rated the service as Inadequate and placed it into special measures. At this inspection we found that improvements had been made, however further improvements were required. This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures .

Westfield lodge provided accommodation and nursing care for up to 54 people. At the time of the inspection 38 people were using the service.

There is was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although we saw improvements in the way that risk of harm to people were being managed, we found that some risks had not been recognised and responded to, to keep people safe.

There were sufficient numbers of suitably trained staff, however they were not always deployed appropriately throughout the building to meet people's needs in a timely way.

People had enough to eat and drink to maintain a healthy diet, however the dining experience was chaotic and at times potentially unsafe due to an overcrowded dining room.

People did not always receive care that met their individual assessed needs and preferences as staff were not always aware of people's needs and consistent in their approach.

People were not always treated with dignity and respect.

New systems had been put in place to monitor and improve the quality of the service. However further improvements were required to ensure a consistent approach to people's care was achieved.

New potential staff were employed using safe recruitment procedures to ensure they were fit and of good character.

People's medicines were being stored and managed safely. The registered manager monitored and

investigated medication errors.

People were being protected from the risk of abuse as staff and the registered manager knew what to if they suspected abuse.

The provider was following the principles of the Mental Capacity Act 2005 to ensure that people who lacked mental capacity were supported to consent to their care.

People received health care support when their needs changed or they became unwell.

People's right to privacy was upheld. People were offered choices and these choices were respected.

There was a complaints procedure and people and their relatives knew who to speak to if they had concerns.

The provider had responded and took action to improve the service. The registered manager and deputy manager had worked hard to implement the new systems and improve the quality of care.

People, their relatives and staff told us that the management was approachable and supportive.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Not all risks of harm to people had been recognised and responded to, to keep people safe.

There were sufficient numbers of suitably trained staff, however they were not always deployed safely around the building to meet people's needs in a timely manner.

New potential staff were employed using safe recruitment procedures.

People's medicines were stored, administered and managed in a safe way.

People were protected from the risk of abuse as staff and the registered manager knew what to do if they suspected abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The dining room was not conducive to a pleasant dining experience.

The principles of the MCA 2005 were being followed to ensure that people who lacked mental capacity were being supported to consent to their care.

People's health care needs were met and they were being cared for by staff who were supported and trained to fulfil their roles.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respected.

People were offered choices and their choices were respected.

People' s right to privacy was being upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their individual needs and preferences.

There was a complaints procedure and people and their relatives knew what to do if they had concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had responded and took action to improve the service. The registered manager and deputy manager had worked hard to implement the new systems and improve the quality of care.

New systems to monitor and improve the quality of the service had been implemented and these had been effective in bring about improvement. however further improvements were required.

People, their relatives and staff told us that the management were approachable and supportive.

Westfield Lodge 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. We inspected the service to look for improvements following our previous inspection.

This inspection took place on 6 September 2017 and was unannounced. It was undertaken by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the information we held about the service. This included notifications the home had sent us. A notification is information about important events which the provider is required to send us by law. We also reviewed the provider's action plan in relation to what action they told us they would take to improve the service provided to people.

We spoke with seven people who used the service, five visiting relatives and friends. We spoke with four care staff, the activities coordinator, the registered manager and deputy manager.

We observed people's care in the communal areas. We looked at six people's care and medication records. We looked at the recruitment files for two members of staff, training records and the systems the provider had in place to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found that care was not always safe and people were at risk of harm. We had observed unsafe moving and handling practice, the environment was cluttered which presented a risk of tripping and medication was not always managed safely. There was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we had served a warning notice.

At this inspection we found that improvements had been made in all these areas and the provider was no longer a breach of Regulation 12. However further improvements were required. We saw that risks of harm to people were mostly being reduced through the new accident and incident forms which had been put in place. These forms recorded what action had been taken to investigate the accident/incidents and what action had been taken to reduce the risk of it reoccurring. For example, we saw that one person had been found trying to climb over the bed rails and this put the person at risk of harm. We saw that the person's risk assessment had been up dated with actions to minimise the risk to this person. We checked and saw that these actions had taken place and this had reduced the risk. However, not all risks were being managed. We found that one person had been found with a call bell cord wrapped loosely around their neck. Although initially the call bell had been removed and 15 minute checks of the person had been implemented, we saw that the call bell was in reach of the person and a member of staff told us the person was now back on two hourly checks. The registered manager told us that the person was no longer at a risk of harm due to the call bell but were unable to tell us why. The rationale for this decision had not been recorded, their risk assessment had not been reviewed and it was unclear why the person was no longer at risk. This meant that this person was potentially at risk of harm.

The registered manager and deputy manager told us and we saw records that all people who used the service had had their needs reassessed in relation to what support they required when being supported with their mobility. One person who used the service told us: "The staff know what they are doing when they move me in the hoist, I feel safe". We observed staff moved most people safely using the correct equipment that they had been assessed as requiring. For example, one person's moving and handling plan stated that they required a hoist and a full 'green' sling when being supported to move. We saw that staff knew what this person needed and used the correct equipment in a safe way. However, we observed one person being supported to move with a small sling when their records stated that they required a full size sling. The member of staff we spoke with told us that they thought that the person's records were wrong and that they always used a small sling. We discussed this with the registered manager who told us they would check this person's records and ensure they were up to date.

At our previous inspection we had concerns that people who were prescribed 'as required' (PRN) such as pain relief and anti-anxiety medication did not have protocols in place to inform staff when the person may require this medicine. At this inspection we found that protocols had been put in place, however they lacked comprehensive detail to inform staff when people needed their PRN medicine administering. For example, one person was prescribed a medicine for anxiety, their protocol stated 'administer when agitated'. We discussed with the deputy manager that some staff may not know when the person was 'agitated' as they may not recognise the signs of the person's agitation. The protocol lacked sufficient detail to ensure that the

person was administered the medicine at the required times. We saw this person had been administered this medicine for four consecutive days. The nurse administering the medicine had not recorded why they had administered it and there was no justification for the administration of this medicine. Following our inspection the registered manager carried out an investigation into the administration of these medicines and found that the medicine had been given for reasons they were prescribed. However, the member of staff had not completed the medication records and as such the registered manager was arranging extra training and support for this member of staff.

Since the last inspection visit the upstairs lounge had been closed and we found that some people who were in upstairs bedrooms were not always getting the support or supervision they needed in a timely manner. A member of staff told us: "There is enough staff, but we are very busy, I preferred it when the upstairs was open as there was more room and it was easier to manage. Another member of staff told us: "Some people upstairs have to wait until about 11.30am until we can get their breakfast as we are up and down now". We heard one person upstairs at around 11.00am shouting for help and went to see if they were alright. We found the person in bed lying down and they told us they felt sick. We called the call bell and waited for staff however staff did not attend, so we intercepted a member of staff who was walking past and asked them to support the person. We looked at this person's care records and saw that this person was living with dementia, deaf and due to their breathing difficulties they should be sitting up in bed. They were unable to use the call bell and the only way they could make themselves heard was to shout. However, staff were now not always present upstairs as people were all going into the two downstairs lounges where staff support was required. The registered manager informed us that they used a dependency tool to assess the amount of staff they needed to care for the people who used the service. They told us that a new call bell system was being fitted throughout the service which would mean that they would be able to see how long anyone had to wait for support when they called their call bell. Following the inspection the registered manager completed a risk assessment of this person's needs and put in place precautions to minimise the risk to this person when they were sleeping or resting in their room.

Previously action had not always been taking when people were refusing their medicines. At this inspection we saw that a system had been put in place to ensure that prompt support was gained from the person's GP when people were refusing their medicines for a period of three days. This often led to a review of people's medicines and some medicines being stopped as they were deemed unnecessary. Since the last inspection there had been improvements in the way in which external creams were managed. Creams were now clearly labelled in people's rooms and care staff were recording on specific forms which informed them when and where they needed to apply the creams. This meant that there was a clear audit trail of when and by whom the cream had been applied.

At our previous inspection we had found that the corridors, some bedrooms and bathrooms were cluttered with equipment such as wheelchairs and hoists. We saw that the service was now tidy and items were stored in designated areas and no longer presented a risk to people. We found that there was a new clinical room where the medicines were kept which was well maintained and organised. A new sluice had been put in place to aid the control of infection control within the service and we saw that the home's last infection control inspection had improved from a 52% fail rate to a 85% pass rate.

Previously we saw that people did not always have the equipment they required such a pressure cushions and some equipment was not being checked for its safety of use. At this inspection we saw that systems had been put in place to check that equipment was safe and we observed that people had the equipment they required. New equipment had been brought such as several wheelchairs and mattresses when identified that there was a fault or there was wear and tear.

New staff were employed using safe recruitment procedures to ensure that they were of good character and fit to work with people. Pre-employment checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant.

A relative told us: "We don't go home worrying as we have with other homes. We don't have to come back later to check up as we feel our relative is safe". Staff we spoke with knew what to do if they suspected someone had been abused. One staff member told us: "If I see bruises or marks I record them and pass it onto a manager straightaway. If I thought nothing had been done about it I would whistle blow as these people are people's family". Since the last inspection we saw that unexplained injuries were being investigated and the registered manager made safeguarding referrals as necessary. This meant people were being safeguarded from the risk of abuse.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found that the provider was not always following the principles of the Mental Capacity Act 2005 (MCA) as people who lacked mental capacity were not always being supported to make decisions with their representatives. The MCA 2005 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. There was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that improvements had been made and the provider was no longer in breach of Regulation 13 as when people lacked mental capacity they were being supported to make decisions about their care in their best interests. For example, one person who was living with dementia had been putting themselves at risk of harm whilst in bed. There had been a meeting with the person's representatives and a decision had been made to lower the bed and put other precautions in place to reduce the risk. This decision had been made following the principles of the MCA in the person's best interests.

The Deprivation of Liberty Safeguards (DoLS) is part of the MCA 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. At our previous inspection we had concerns that people's mental capacity was not being assessed prior to a DoLS application being submitted. At this inspection we found that people's mental capacity had been assessed and the registered manager had sought support from the local authority to review people's DoLS applications. However staff we spoke with had limited knowledge about the MCA and DoLS and were unable to tell us who was being restricted and who had been referred for a DoLS authorisations. One staff member told us: "We've had training but it's E learning (Computer learning) and it's difficult to take in". We discussed this with the registered manager and they told us the training in the MCA and DoLS procedures was being arranged. This was also evident on the provider's action plan.

At our previous inspection we saw that there were sometimes delays in gaining health care support for people when they became unwell or their health care needs changed. At this inspection we found that improvements had been made in this area and systems had been put in place to ensure that health care advice was sought in a timely manner. We saw that when at times people were refusing their medication there was system to ensure that this was reported to the person's GP and action was taken to review the medicines. We saw when people's needs changed the staff sought the support of the appropriate health care agency. For example, one person had experienced increased anxieties and this was causing them to become aggressive during personal care. We saw that this person had been referred to a community psychiatric nurse for help and support in managing their behaviours. We saw other people received health care when they needed it such as GP, dentist and opticians.

At our previous inspection we found that although people were being supported to eat and drink sufficient amounts to remain healthy people who required a specialist diet were not always receiving it in a way that met their needs. We had found that several people had been assessed by a speech and language therapist (SALT) as requiring their drinks thickened due to the risk of choking (dysphagia. They were not always

receiving this in safe and consistent way. Since the last inspection staff had attended 'dysphagia' training which the registered manager told us they had enjoyed. However, we saw in one person's care plan that it stated they had diabetes. We saw in their food and fluid records that they had been given and eaten a jam doughnut. We spoke to the cook about this who confirmed that the person who lacked mental capacity should not have been offered a doughnut. We asked a member of staff about this person's needs and they told us: "[Person's name] diabetic? I don't think so, I'm not too sure, and it is a lot to remember everyone's needs". This meant that staff were not always aware or following people's care plans to ensure their assessed needs were being met.

People told us they liked the food and we saw people's weight was monitored and action was taken if there had been a significant weight loss. We saw that people were supported to have their prescribed food supplements when required. However, we saw that since the upstairs living area had been closed the dining room had become overcrowded and the dining experience slightly chaotic. The environment was not conducive to a pleasant dining experience. The registered manager told us that there were plans to build an orangery and to split the dining areas. However no consideration had been made for the interim period until the orangery was built.

Staff we spoke with told us that they felt supported and received training and supervision to be able to fulfil their roles. One staff member told us: "Things have improved, the paperwork is getting better and we are on top of things like mattresses and pressure cushions". We saw that there was a regular programme of training and that training had taken place since our last inspection in areas that we had identified as areas of concern.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we found that people were not always treated with dignity and respect. There was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and the provider was no longer in breach of this Regulation however further improvements were required.

We found that during meal times people were having to be moved from the dining table whilst they were eating to allow other people to pass because the area was overcrowded. We observed one person sitting at the table with a meal in front of them which they were not eating. We asked a member of staff about this person and they told us: "[Person's name] doesn't like being around food. Food repulses them, they have supplements". We asked them why the person was brought to the dining room and the staff member told us: "We just thought we need to try". This was not demonstrate respect for these people.

Since the last inspection all staff had attended training in 'dignity and respect'. People who used the service told us that they were treated with dignity and respect. One person told us: "The staff are kind without being patronising". Another person told us: "The staff shower and wash me very gently and carefully. I choose what I want to wear and they help me make sure everything matches". A relative of one person told us: "I always stop and look in the window before I come in. I can see my relative and I can see a carer sitting with her and it's ever so nice here".

We observed that interactions between staff and people who used the service were kind, caring and compassionate. We saw where previously people who were being support to move with the use of a hoist had on occasions been left in a undignified manner we observed that staff now used a blanket to cover people's modesty. We saw that staff reassured people when helping them move. For example, one person was being lifted in a hoist, a member of staff said: Don't worry we have got you", whilst holding their hand throughout the transfer.

People told us and we saw that they were offered choices about their care. People told us they could get up and go to bed when they wanted, one person told us: "I sometimes like to be able to stay to finish watching a long film in the lounge. The carer will come back at the end of the film for me". We observed that people were offered aprons at meal times to keep their clothes clean and if they refused this was respected. We observed that staff members offered people pillows and blankets to make them comfortable whilst sitting. There were choices of food and drinks, some people chose to have a snack at lunchtime and a main meal at night, while other people had their main meal at lunchtime. We observed that staff offered to cut food up for people if they felt they needed help.

Staff chatted and laughed with people; one staff member was heard to say to one person: "You look lovely today". Staff we spoke with demonstrated a kind value base. One staff member told us: "I always ask what people want, for example if someone wants to put their nightclothes on after a bath that's what they do. That is like what I would do at home".

People's right to privacy was respected. We saw that there were vacant and engaged signs on the toilet doors and people were able to spend private time in their bedrooms when they wished to. We observed a member of staff discreetly asked one person if they wished to use the toilet. This was done in such a way so as not to draw attention to the person.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found that people did not always receive care that met their individual needs and preferences. At this inspections we found that improvements had been made however further improvements were required.

We found that people's care plans and risk assessments were in the process of being up dated and reviewed. There was a new handover sheet that had been put in place which highlighted the day to day needs of people who used the service such as Do Not Attempt Resuscitation (DNAR)'s, health care needs and dietary requirements. However, we saw that one person had a recent DNAR order put in place. This was in the person's care plan however this was not highlighted on the handover sheet. This meant that this may have been missed if the person suffered a cardiac arrest.

We saw another person was also not eating their meal. One staff member said to them: "What is wrong with your food"? The person responded by saying they didn't want it and the staff member walked off. Another member of staff offered the person a bowl of soup which the person happily agreed to have. We spoke to the registered manager about this person and they told us that they had recently been assessed as requiring a soft food diet and they did not like it. They told us that the person would currently only eat soup yet the one staff member had not known or responded to the person's individual preference.

There was a range of activities available for people who used the service. People played games and there was outside entertainment which came into the service. There were the occasional social community outings such as theatre trips which people told us they enjoyed. People told us that the staff arranged activities based on what they liked to do. A relative told us: "Once the staff knew my relative likes to watch formula1 racing they ensured that they organised that they could watch it every time it was on".

The provider had a complaints procedure and people were reminded about this through regular meetings and quality surveys. Following our last inspection the registered manager had written to all relatives and people who used the service informing them of the outcome and their action plan to improve. We saw the letter contained the contact numbers for the local authority and us (CQC) and a reminder of the internal complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found that the systems the provider had in place to monitor and improve the quality of the service were ineffective. We had found that the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had served a warning notice. At this inspection we found that improvements had been made however further improvements were necessary to ensure that people's risks were continually assessed and staff delivered a consistent standard of care which met people's needs and preferences.

Following the last inspection the provider had employed a consultant to support the registered manager to make the required improvements. We saw that there was an action plan in place and most actions had been completed and this was evidenced in the improvements we saw throughout the service. The registered manager and deputy manager had worked hard implementing new systems which ensured that the quality of care was monitored and action was taken when issues were identified. This showed that the provider had been responsive to our findings and was working towards improving the quality of the service for people.

People's care records were in the process of being up dated to ensure that the information within them was current and reflective of people's needs. However staff did not always appear to know people's assessed needs and preferences and this may result in them not receiving the care they required. The registered manager told us how they were instilling in staff the need to complete people's daily records, however further improvement was required as staff were not always signing to say when they had applied people's external creams.

We saw that the registered manager conducted and recorded daily walk rounds and checks of the building. The checks included making sure that people had the equipment they required such as pressure cushions. The registered manager told us and we saw that when issues were identified on the checks they held 'flash meetings' with staff to remind and reinforce staff about good practise. The new accident and incident forms that had been implemented had driven improvement and ensured that action was mostly taken following an incident to reduce the risk of further incidents. When people developed sore skin and pressure damage we saw that there was a root cause analysis completed to identify how the damage had occurred and whether it could have been avoided. This meant that the provider was ensuring that they were learning from and reducing the risk of further harm or injury.

An internal quality inspection was being completed by the consultant and actions arising from that were being completed. We saw that the home's infection control rating had improved since the previous inspection as the management had implemented new cleaning schedules and regular checks of furniture and equipment.

People and their relatives were regularly asked their views on the quality of service through quality surveys. Feedback we saw was positive with no necessary action to take to improve. Since the last inspection there had been a relatives and residents meeting which informed people of the outcome of our last inspection. There were regular meetings arranged however the registered manager told us that the last two meetings no

one had attended.

Staff we spoke with felt supported by the management team and told us they were approachable. One staff member told us: "We've seen improvements, people all have their own slings now and we have had new training". Another member of staff told us: "The management help out when they are needed and I can go to the office if I need them". We saw that there were regular staff meetings to update staff and encourage staff to follow good practise at all times.

The registered manager knew their responsibilities within their CQC registration and was notifying us of significant events. Following the inspection the registered manager had been responsive to our feedback and took immediate action to improve the service. For example, investigating the administration of 'when required' medicine to one person and ensuring that the staff member was supported to learn and improve their practice.