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:
11 April 2017

Date of publication:
09 May 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 11 April 2017 and was unannounced. This was the provider's first inspection since registration in September 2016. We found that people were not always receiving care that was safe, effective, caring, responsive and well led. We found four breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is Inadequate which means it will be placed into special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Westfield Lodge provides accommodation and nursing care for up to 54 people. At the time of the inspection 46 people were using the service.

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

Care being delivered was not always safe. Risks of harm to people had not been minimised through the effective use of risk assessments.

The systems the provider had in place to monitor and improve the service were ineffective. Action was not always taken to keep people safe following incidents and accidents.

People's medicines were not always managed safely. People were at risk of not receiving their prescribed topical creams.

Staff we spoke with all knew what constituted abuse and told us they would report it if they suspected abuse had taken place. However, incidents of potential neglect and poor practise were not always investigated.

There were sufficient numbers of staff, however people told us there were delays when they called for assistance.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so and the DoLS ensures that people are not unlawfully restricted. We found that people could not be assured that decisions were being made in their best interests when they were unable to make decisions for themselves and some people were at risk of being unlawfully restricted.

Staff told us they felt supported however they did not receive adequate supervision to ensure they were effective in their roles.

People had sufficient amounts to eat and drink but they were not always supported to eat and drink safely.

People had access to a range of health care agencies. However health care advice was not always followed or gained in a timely manner.

People told us that they were treated with dignity and respect. However we saw some practises that did not always demonstrate respect and uphold people's right to privacy.

People did not always receive personalised care due to their care needs not having been assessed and records did not reflect their current care needs.

There were a range of activities and hobbies available for people to participate in. Activity staff did what they could do to involve as many people as they were able to throughout the service.

The provider had a complaints procedure and people felt able to complain if they needed to. New staff were employed using safe recruitment procedures.

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 protected from the risk of harm as the risks were not reduced following incidents and accidents.

Equipment to meet people's needs was not always being used safely or was always safe for use.

People's medicines were not being managed safely.

Not all incidents that had resulted in harm to a person had been recognised as potential abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the MCA 2005 were not always followed and understood by staff.

People had access to health care agencies however their advice was not always sought and followed in a timely manner.

Staff were not always supported and supervised to be effective in their roles.

People were offered sufficient amount to eat and drink however not always in a safe way.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

People's right to confidentiality was not always respected.

There were some positive interactions and relationships between people and the staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

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

People were offered opportunities to engage in hobbies and interests of their liking.

There was a complaints procedure in place and people felt able to complain.

Is the service well-led?

Inadequate

The service was not well led.

The systems the provider had in place to monitor and improve the quality of the service were ineffective.

Lessons were not learned and risks reduced following incidents and accidents.

There was a registered manager in post supported by a deputy manager who people liked.

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.

This inspection took place on 11 April 2017 and was unannounced. The inspection 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 and the previous inspection report. A notification is information about important events which the provider is required to send us by law.

We spoke with seven people who used the service and six visiting relatives. We spoke with three care staff, two nurses, the registered manager, deputy manager and a visiting health professional. 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.

Inadequate

Is the service safe?

Our findings

We looked to see if people were receiving safe care and treatment and found that risks to people were not always adequately assessed, managed and planned for. Some people required support with their mobility with the use of specialist equipment such as hoists and slings. We saw people's risk assessments did not inform staff which hoist or sling was safe to use with the person. We saw that it was recorded that one person had recently slipped through a sling. If the sling had been assessed as being correct for the person this would not happen. They had come to no harm however the person's risk assessment had not been up dated to reflect the accident. A member of staff told us: "I would imagine we wouldn't use the same sling again but I don't know". This meant that this person was at continued risk of injury as action had not been taken to minimise the risk of them slipping again.

We observed another person being supported to move with a hoist and a sling which was too big for them. We heard the person say that the sling was hurting them. We intercepted and informed the staff and deputy manager. The staff proceeded to find another smaller sling which they used to move the person. People had not been appropriately assessed by a person who was qualified to assess needs in relation to the equipment they required to be mobile and people were being harmed and at risk of harm of injury.

We saw one person trying to stand up from a wheelchair. Staff were supporting the person to stand from the chair to hold onto a walking frame. We saw the brakes on the wheelchair were broken so this meant that the wheelchair was moving whilst the person was trying to stand. This made the process more difficult and put the person and the staff supporting them at risk.

Records showed that one person had recently received a skin tear to their arm whilst being pushed through a door frame in a kirton chair. We observed the same person being pushed through a door and banging their elbow again. The member of staff supporting the person did not see that they had banged their arm and did not check for any injuries. This meant that no lessons had been learned from the previous incident and the person was still at risk of injury.

People did not always have or use the equipment they needed to keep them safe and reduce the risk of harm. We saw two people who should be sitting on pressure cushions to reduce the risk of sore skin did not have the cushions in place and one person who had pressure sores had been assessed as requiring 'repose' boots did not have them. Some people required 'air flow' mattresses when in bed. There were no instructions as to what setting the beds should be on so it was unclear whether they would be effective in maintaining pressure relief.

We had been notified of a previous accident where a person had tripped over a hoist which had been left in the corridor and they had received a serious injury resulting from the fall. We looked around the building and found that there was equipment stored in corridors, bathrooms and in one person's bedroom we found four people's wheelchairs and a pressure cushion which did not belong to them. We saw a hoover in the corridor and several wheelchairs lined up by a fire exit. All the equipment continued to put people at risk of tripping or falling over it and would impact on people's ability to leave the building in an emergency. The

registered manager and deputy manager told us that there was insufficient storage around the building to store everything safely. The provider had failed to take action to ensure people's health and safety in relation to the storage of equipment.

We looked at the way people's medicines were managed. We saw that one person was regularly being administered a 'PRN' as required medication which had been prescribed for when they became anxious or agitated. We could not see why the person was being administered this medicine as their care records stated that the person had been fine, with no issues. The person's medication administration record did not have recorded any justification for the use of this medication. The same person had been regularly refusing their morning medicines over a three week period and no health advice had been sought to ensure that no harm would come to the person. When we discussed this with the registered manager and deputy manager they recognised that this person required a review of their medication.

Some people were prescribed external creams to be applied to their skin to prevent it from being sore. The creams were stored in people's bedrooms and applied by the care staff. We found some creams did not have any prescribing labels on it so it was unclear whose cream it was and where and when it should be applied. We found one person had three tubes of unlabelled creams in their room however they were not prescribed any creams. A nurse told us that they signed to say that the cream had been applied although it was the care staff that were applying the cream. There were no records instructing staff where and when people's external creams were applied. This meant that the provider could not be sure that people were having their prescribed creams as instructed.

These issues were a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that the provider had agreed to increase the staffing levels in the mornings and this had been successful. Staff we spoke with told us they felt there was enough staff to meet people's needs in a safe and timely way. However, some people told us they experienced delays when they called for assistance. Three people who used the service and four relatives told us they had experienced delays of up to 30 minutes to be supported when they had used their call bell. One person told us: "I've got a buzzer in my room but I haven't in the lounge, they do come round ask if you need the toilet though". We observed that in two lounges at times during the day there were no staff members present for up to 15 minutes. One person asked us if they could use the toilet. This person was unable to mobilise without staff support and they were unable to reach the call bell which was situated on the wall. We called the call bell and staff did not respond, we intercepted two staff who were walking past the lounge and asked them to support the person. A member of staff told us that at times they left another lounge unsupervised even though they had been told not to. They told us: "I just tell a couple of the residents that I'm popping out to do the 15 minute checks on people". This meant people were unable to call for help and sometimes had to wait for staff to be available to support them.

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.

The registered manager and staff knew what constituted abuse and what to do if they suspected a person had been abused. One staff member told us: "I would report anything suspicious to the manager and they would deal with it or come to you (CQC)". However we had concerns that not all accidents and incidents

that involved people receiving injuries were being investigated to ensure that people were not receiving poor or neglectful care.

Requires Improvement

Is the service effective?

Our findings

The principles of the Mental Capacity Act 2005 (MCA 2005) were not being consistently followed. 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. 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. We saw that people's mental capacity was not always assessed prior to decisions being made. For example, one person had not had their capacity assessed in relation to wearing certain clothes that the staff had deemed in their best interest to wear. The registered manager told us that the person did not have the mental capacity to agree to how their care needs were met yet there had been no formal assessment carried out. This meant that this person was having decisions made on their behalf with no formal assessment of their mental capacity to agree to this action.

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. The registered manager told us they had refered everyone for a DoLS authorisation. This had been completed without people's mental capacity to consent being assessed. The registered manager and staff lacked comprehensive understanding of the MCA and DoLS process. Staff we spoke with were unsure who had capacity and what restrictions were in place for people. One staff member told us: "I think [Person's name] has capacity I'm not really sure, I don't really understand MCA and DoLS". We saw one person's relative had consented to the use of bed rails for their relative. However, the person's mental capacity had not been assessed and there had been no best interest discussion about the bedrails being used. We saw people were restricted in other ways such as kirton chairs that people would not be able to move out of and the use of anti-anxiety medicine for which with no justification was recorded. There were no mental capacity assessments or best interest discussions evident to ensure that these restrictions were in people's best interest.

These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to health care professionals however referrals for health care advice was not always sought in a timely manner and professional advice was not always followed when gained. We saw that one person had received advice from a tissue viability nurse to use 'repose' boots which would keep the skin from touching surfaces and making them sore. This person had sores to their legs and feet and they had to take pain relief for the pain the sores were giving them. We saw that there had been a six day delay in ordering the 'repose' boots. We were told that this was because they were waiting for a specific day that they did the ordering of equipment. Another person's regular refusal of medication and the use of a regular PRN medication had not been referred to their GP for advice. This meant that these people were not always having their health care needs met in a timely manner.

People were encouraged to eat and drink sufficient amounts to remain healthy and referrals were made for

advice and support when people experienced difficulty in eating and drinking. One person told us: "There's a big improvement in food now, there is a good selection. We usually choose from a list at breakfast. The food is hot enough when you get it, although this depends on where you sit, if you're further away it's cooler. You can choose an alternative. You're given tea and biscuits in the morning and afternoon". However, we saw several people had been assessed by a speech and language therapist (SALT) as requiring their drinks thickened due to the risk of choking (dysphagia). Those with dysphagia must have just the right amount of thickener in all their drinks to prevent a painful and embarrassing coughing fit. We saw one person had a thickened drink in a beaker with a lid and the drink was too thick to come out of the beaker smoothly. We asked three members of staff about how much thickener should be in the person's drink and they told us three different amounts. Some people's thickening powder had run out of stock and staff were using one tin of thickener for several people. There are many different brands of thickeners available and the recommendation to prescribe a thickener should come from a SALT and should be based on the person's degree of dysphagia, the desired consistency required, the texture required and palatability. This meant that people may be not of been able to drink sufficient fluids due to the consistency of the liquids they were being given.

Staff told us they received training and support from the provider; however they told us that they did not enjoy the on line training that was in place. We saw that staff were not always following the training they were given and were not being supervised and observed to meet people's care needs safely. We saw that staff were using the incorrect equipment to move people and this had not been noted or addressed. Staff were not always aware of people's health needs or did not follow people's care plans such as how much thickener people required in their drinks and ensuring that people were receiving the pressure care relief they required. A relative told us: "You never see the manager walking about checking things, there is not enough supervision of staff. This meant that staff were not always effective in their roles in maintaining people's health and care needs safely.

Requires Improvement

Is the service caring?

Our findings

Not all observed practises and interactions between staff and people who used the service were dignified and caring. A relative told us: "My relative won't drink because they feel using the hoist is undignified and they need the hoist when they need the toilet". On two occasions we saw people being supported with a hoist and we saw that their underwear was on show as they were being supported.

Several people and their relatives told us they had to wait to go to the toilet. A relative told us: "It took 20 minutes for staff to respond to the bell for a toilet call. When my relative was having bed rest a carer told her to 'use your pad'. At that time my relative had to wait 40 minutes and by then they had soiled themselves and the bed. It was very upsetting for my relative to go through this and unacceptable to have to wait that long".

Staff did not always demonstrate respect for the people who used the service. We heard staff refer to people as room numbers instead of their names. We observed that on one occasion a group of staff stood in front of the TV in the lounge talking between themselves and we observed two people trying to watch the TV were straining their necks to look around the staff. The staff did not recognise that they were restricting people's view and disrupting their television viewing.

We saw one person had been left without a meal at lunchtime. We informed the staff that the person had not had their lunch. A member of staff said: "Have they not given her anything yet?", and went to get their dinner. The person was then given a red hot plate of food which resulted in them almost scolding themselves if we had not intercepted. We observed another person banged their arm whilst being supported to leave the lounge area. This person had this happen previously and no action had been taken to stop this happening again this demonstrated a lack of thought and consideration for these people.

People's private and confidential information was seen around the service in communal areas such as outside people's bedrooms and in the lounge and dining areas. Although they were in folders, staff did not ensure that the folders were closed and we saw people's private information was often visible to visitors. This did not respect people's right to privacy.

We saw staff had stored several people's wheelchairs in one person's bedroom. Staff were unable to tell us why they were being stored in the room and whether the person had been asked if they were happy with this. One staff member told us that they were probably put in the room out of the way. This did not demonstrate respect for this person and their bedroom.

These issues constitute a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people and their relatives told us they felt cared for and that staff generally treated them kindly and we observed some kind and caring interactions. We observed staff and people laughing and chatting about the daily events. Relatives told us they were kept informed and involved in their relative's care. One relative

told us: "We could see that some friendships between staff and people had been formed. One person told us: "Staff treat me with respect and always ask my permission saying things like 'would you mind before doing things, but you lose all your dignity when you come to live somewhere like this, especially with the hoist".

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that met their individual needs and preferences. One person told us: "I feel a little rushed especially at a busy time when I would like a little perfume on or a bit more time spent with me. Same when I have a shower, I'd like one more often but they have a lot of other people who need one (a shower) every day." Another person's relative told us: "My relative would prefer more than one shower a week even if it was just two showers a week, but we know the staff are pushed." However another person told us: "I've got my faculties and have control over my life. I have a shower every Friday morning; they would give you another shower if you asked. I have my meals on a tray on my bed. There are alternative choices to what's on offer, I had toasted cheese today."

People told us they experienced less personalised care when there were agency staff and nurses who did not know them. One person told us: "With agency staff the dressing process can take longer than usual because they don't know your routine or preferences. I like them to start at the bottom end, then I like my nightdress to come off and I like to do this myself, some of them let me. This morning, the girls were beginners and they started at the top end."

People's care plans and risk assessments lacked specific details about their individual care needs. For example, there were no instructions as to what setting the air flow mattresses should be set at dependent on people's weight or which equipment staff needed to use to hoist people safely. This put people at risk as the equipment may not be effective. Staff were not always recording when they had carried out care tasks and this made it difficult to evidence whether people had received the care they had been assessed as requiring in relation to repositioning people who required pressure relief. We saw that care plans were reviewed by a member of staff on a monthly basis however we saw the information within the care plans had not been up dated following an incident or change in people's needs. This meant that people were at risk of receiving care that did not meet their individual needs.

There was a complaints procedure and people and relatives we spoke with told us they knew how to complain if they needed to. There had been no formal complaints however we saw two informal complaints in one person's daily records where they had complained about the length of time they had to wait when they had used the call bell and that they had been ignored on another occasion. The registered manager was not aware of these complaints, however the person had been offered an apology from the member of staff who had recorded the complaints.

People and their relatives all spoke highly of the activities coordinator. People told us there were opportunities to be involved in hobbies and interests of their liking. People had the opportunity to play games and watch planned entertainment. One person told us they went out to the theatre when it was arranged. Another person told us: "I used to get involved in activities but not now because my needs have changed. The activity co-ordinator brings things to me now. I like animals and she's brought in a pet owl and dog to see me". On the day of the inspection everyone was offered the choice to join in with an afternoon entertainer that was singing in the dining room and we saw that people appeared to enjoy this.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a deputy manager. They told us that they were both new to their roles and were working closely together to identify and make improvements. They told us that the new provider was supportive and had plans to improve the service; however there was no recorded action plan for improvement. We found that the governance systems the provider in place to monitor and improve the quality of the service were ineffective.

We found that although accidents and incidents were recorded that there was no analysis of the events and no lessons were learned to prevent or reduce the risk of the incident occurring again. For example, we saw records of incidents which included one person who had recently slipped out of a sling whilst being hoisted and another person who received a skin tear where their arm had hit the doorframe when being pushed in a chair. We observed that both these incidents occurred again on the day of the inspection. Action had not been taken and there was no action plan to reduce the risk of them happening again.

We had been notified of a serious injury to one person which had been caused by the action of staff. The provider had not conducted an internal investigation into the accident and we saw that people remained at risk of the incident occurring again as we saw that no precautions had taken place to reduce the risk. The registered manager told us that they had spoken to staff informally about the incident; however two staff we spoke with had no recollection of having discussed the incident.

There was a record of people's pressure sores and skin tears. The records stated whether the injuries had occurred whilst at the service or at another establishment. However there was no root cause analysis conducted to ascertain how the injury had occurred and how the risk could be reduced. We found that equipment was not always assessed as suitable or in use to reduce the risk of pressure sores. This meant that areas for improvement in the care of pressure areas were not being identified.

People's care records were not clear and comprehensive and contain specific information to keep them safe. This meant that staff did not have the relevant information to be able to care for people safely. People's needs had not been assessed in relation to the equipment they required to keep them safe and how it should be used. This meant that people were at risk of harm through the use of the incorrect equipment being used dependent on their individual needs. We observed staff follow unsafe practices in relation to moving and handling and this had not been identified through supervision from the management team.

People's care records did not always evidence that they had the support they required at the time they required it. Repositioning charts and observational checks had gaps in their recordings. This meant that the provider could not be sure that people were receiving the care they had been assessed as requiring.

The provider had arranged for an external agency to complete one quality monitoring visit since registration. We saw that the record of this had not identified any of the findings at our inspection. The management team conducted monthly audits including medicine management and mattress audits however the audits had not identified the issues we identified in relation to the regular use of PRN for one person and that the

provider could not be sure that people were having their external creams as prescribed. This meant the audits were not effective in identifying issues and driving improvements.

Feedback from some people and their relatives were in the process of being collated although this was only being collated from a small ratio of people. This meant that not everyone was being asked their views on the service. There had been no analysis of the feedback they had received so there was no evidence of action taken if issues had been raised.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that the provider was supportive and had agreed an increase in staffing and to improve the quality of the food at the service. However, we could not see how much time the provider had spent at the service since registration as there were no records of their visits.

The provider is required to display their CQC rating of the service. We saw that the previous providers rating was being displayed. This meant that this was not a true reflection of the quality of service being delivered.

The staff told us that the registered manager and deputy manager were approachable and supportive. Following the inspection we the deputy manager sent us an action telling us how they planned to address our findings at the inspection.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were at risk of being unlawfully restricted as the principle of the MCA 2005 were not always being followed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving safe care and treatment that met their needs.

The enforcement action we took:
We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to monitor and improve the quality of the service were ineffective.

The enforcement action we took:
We issued a warning notice.