Akari Care Limited

Westerleigh

Inspection report

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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 inspection took place on 20, 21 and 22 February 2018 and was unannounced. At our last inspection in May 2017 we rated the service as 'Good'. There were no breaches of the legal requirements. During this inspection we found four breaches of regulations 11, 12, 17 and 18. The breaches appertained to consent not been obtained by the service to provide people's care. People were at risk of receiving inappropriate care and care records were not accurate or up to date. Staff were not supported through supervision and appraisal.

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

Westerleigh is a purpose build care home and can accommodate up to 55 people across three floors. One of the floors specialised in providing care to people living with dementia. It is registered to provide accommodation for people who require personal care. Westerleigh does not provide nursing care. At the time of our inspection 45 people were using the service.

At the time of our inspection there was not 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.

Records throughout the home were incomplete and failed to document accurate and contemporaneous information about people's care needs. This in turn meant people were put at risk of receiving care which was inappropriate.

We found there were gaps in people's topical medicines records. People had a number of topical medicines on one document and we were unable to discern what topical medicines had been applied. Improvements were required to medicine records to guide staff on when to give people 'as and when' required medicines.

Although the home was generally clean and tidy we found some areas of the home needed improving to reduce risks of cross infection. This included bedding provided by the service which we found to be stained.

The risk of a fire in the home was reduced through regular checks. However we found consistent assessment of risk was not applied throughout the home. For example emergency pull cords in bathrooms and toilets were not accessible to people who may fall to the floor.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However we found care and treatment of people who used the service was not always provided with the consent of the relevant person. We saw staff understood the concept of making

decisions in people's best interest but failed to document the rationale for decisions.

Staff had not been supported through the regular use of supervision and appraisal as prescribed in the provider's policy. The service had a training matrix in place. We saw staff had not been trained in end of life care and diabetes. The acting manager told us they had requested diabetes training from a training provider.

Audits had been carried out by the provider. However the regional manager and the acting manager were unable to provide us with audits the previous regional manager had carried out prior to December 2017. We saw an audit carried out by the provider's quality improvement team. The audit had led to improvements in the service.

Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We found we had not been notified of serious injuries to people. This regulatory breach is being dealt with outside of the inspection process.

We found there were sufficient staff on duty to meet people's needs. However we recommended the provider reviews the deployment of staff during busy times to ensure people's needs are met.

Staff confirmed to us they had received safeguarding training and were aware of their responsibilities to report any concerns.

People had the opportunity to give their views about the service and a complaints procedure was available in the service. Information on the complaints process was available in people's bedrooms.

Staff who were employed in the service had undergone a number of checks to ensure they were appropriate to work with older people in a care home.

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

Requires Improvement

The service was not always safe

Emergency pull cords in toilets and bathrooms were not accessible to people if they were to fall to the floor.

Although we found the home to be generally clean and tidy we found certain areas of the home to require improvement in cleanliness and reduce the possibility of cross infection.

Staff recruited to the service underwent vetting checks to ensure they had the appropriate background, experience and qualifications to work in the home.

Records showed regular fire checks were carried out on the building to ensure the risk of fire was minimised.

Is the service effective?

Requires Improvement

The service was not always effective

Staff were not provided with support through supervision and appraisal as prescribed by the provider's own policy.

Consent had not always been obtained by the service to provide people's care.

Improvements had been identified by the provider's quality team to make the home more suitable for people with dementia.

We found that whilst there were enough staff on duty to meet people's care needs staff were not always usefully deployed at times of greatest pressure for example meal times. We made a recommendation about this issue.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst we found care staff were generally caring we found the actions of some carers did not promote the dignity of people living with dementia.

Staff supported people to be as independent as possible.

Relatives were involved in people's care and had been provided with the opportunity to contribute to the service by attending relative's meetings.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found records of people's care and care reviews were not always accurate. This meant people were at risk of unsafe care.

Activities in the home were displayed on a notice board. People participated in a range of activities in the home.

The provider had in place a complaints procedure. Complaints were documented and complainants were provided with an outcome of investigations into their complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led

The service did not have a registered manager and was managed at the time of our inspection by an acting manager.

Records in the service were not always up to date and accurate.

Staff surveys had been carried out and the provider had arranged a human resources workshop to address staff concerns. Actions had been taken to improve the service. The provider's quality team had reviewed the service had put in place an action plan to make improvements.

Westerleigh

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.

The inspection was prompted in part by three RIDDOR notifications made to the Health and Safety Executive about serious injuries people had sustained whilst being cared for by staff working in the home. These incidents were subject to additional scrutiny which may have resulted in a criminal investigation and as a result this inspection did not examine the circumstances of each incident.

However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of falls in the home. CQC were also aware of a safeguarding concern which we referred to the police for their review as well as concerns raised by relatives in relation to the care provided to family members.

This inspection took place on 20, 21 and 22 February 2018 and was unannounced

Inspection site visit activity started on 20 February and ended on 22 February. It included speaking to people who used the service, speaking to their relatives, carrying out observations and reviewing documentation associated with the regulated activity.

The inspection team consisted of two adult social care inspectors, an expert by experience, a specialist advisor to the commission in occupation therapy. 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 expert by experience on this inspection had expertise in working with people with dementia.

Prior to the inspection we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service; including local authority

commissioners and the local authority safeguarding team. We spoke with the fire service.

During the inspection we spoke with 13 staff including the regional manager, the acting manager, senior care staff, care staff and kitchen, the activities coordinator, domestic and maintenance staff. We spoke with seven people who used the service and six relatives. We reviewed nine people's care files and other information in relation to the regulated activities including accidents and incidents, medication records and fire records. During our inspection we carried out observations of people who were unable to speak for themselves. We looked at six staff personnel files.

Requires Improvement

Is the service safe?

Our findings

People we spoke with who lived at Westerleigh told us they felt safe living there. One person said, "I fell a few months ago, they came in a flash and checked me over. I had tripped over my own walking stick, the nurse came and I had a roomful of carer's and examined from top to bottom but I was fine. Another person explained they had a health issue which had recently arisen; they said, "I've been checked over but an ambulance is still coming in half an hour's time - that gets a big 10 from me - because to be honest, although I said there was nothing to worry about I was frightened." One person told us how they had felt unsafe living in their own home; they told us, "At home I was frightened to answer my phone, never mind my door - I feel so safe here that I never lock my door."

Topical medicines were found by the inspection team in people's bedrooms. These are prescribed medicines which are applied to the skin. On the lower ground floor in five bedrooms and en-suite facilities we found topical medicines which if ingested or used incorrectly could cause potential harm to people. For example, in one bedroom, in an easily accessible cabinet, we found Conotrane Cream (used to protect the skin from irritants) with the storage instruction 'keep out of sight and reach of children' which implied it could be harmful if accidentally ingested. In the en-suite toilet of another bedroom we found a prescribed cream called Hydromol with the instructions 'this medicine ifs for external use only, avoid contact of this medicine with the eyes.'

Over the course of the inspection we observed one service user walk along the corridors and go into other people's bedrooms without the supervision of staff. We found that all bedrooms were unlocked and easily accessible. There were no other safeguards in place to minimise the risks of service users accidentally or deliberately ingesting potentially dangerous creams and medications designated only to be used externally.

We at looked people's care records and found, as a result of their dementia, some people could become agitated. We saw one person had been prescribed 'as and when required' sedative medication to be administered at such times. There was no indication in the care records of the threshold of behaviour(s) which would indicate to staff at which point medication needed to be administered or step by step guidance to inform staff about what they should do to support people in a positive way at such times other than to administer medication. We asked a senior member of staff when they would administer 'as and when required' medication for agitation for this person and they told us, 'Usually when they are shouting a lot." This placed people at risk of unsafe inconsistent care as they may receive medication inappropriately.

Overall we found the home to be clean. Bathrooms and toilets were bright, clean airy places and the home smelt fresh with no unpleasant odours. However, we did find some areas of the home where appropriate standards of cleanliness and hygiene in relation to the premises were not maintained. For example, in some bedrooms we found that the bedding was stained with unknown substances. The beds had been made ready to use that evening. We found three wheelchairs which were ingrained with dirt and debris. We saw two sensor mats (used to alert staff should a person with a high risk of falling get out of bed during the night) which were stained with dark/brown substances. A wall in one person's bedroom was badly stained

with what appeared to be splashes of tea. We found one dining room was dirty and in need of decorating and upgrading. We saw paint flaking off the walls, the floor was dirty and sticky, and drinks had been splattered up the walls and on the skirting board. A toaster, hot water jugs, and a dirty cutlery drawer had brown stains.

Emergency pull cords in en-suite bathrooms, communal bathrooms and toilets were of insufficient length and were inaccessible to people who may have fallen to the floor and needed to summon help. Risk assessments had not been carried out and actions taken to mitigate this risk. We passed this information onto the acting manager and the maintenance person who agreed to lengthen the cords.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

No one using the service was being treated for pressure sores. Staff used a 'Topical Medicines Administration Record' (TMAR) in which they documented when they applied people's topical medicines. Topical medicines are prescribed medicines applied to people's skin. On one person's TMAR we saw they were prescribed six topical medicines. On the back of the TMAR staff were given instructions to apply for example the Diprobase 'as required' and the Hydromol 'as directed'. There was only one TMAR for all the prescribed topical medicines. Staff had signed the TMARs from 27 November 2017 to 17 January 2018 without stating what they had applied. There were also gaps on the TMAR which indicated creams had not applied on those dates. We looked at the TMAR's for other people and found similar gaps.

Accident and incidents were monitored by the management of the home. Staff recorded accidents on accident report forms and these were passed to the acting manager for review. However we found one person had received an injury to their leg. We asked to see the accident form and found one had not been completed. We could not be reassured that all accidents in the home were documented to allow appropriate monitoring.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Risk assessments were in place to consider any risks associated with the staff and the use of the building. Maintenance checks were in place to manage risks. Personal risks were also identified in people's care documents. We found the practice of managing risks in the home was variable. Guidance was given to staff to reduce the risks to people for example to minimise the risk of falls. Staff had noted were one person's risks had changed and had agreed with them it was better that they no longer administer their own medication.

We looked in one person's bedroom and found two wheelchairs of different sizes in the doorway and adjacent to a sensor mat. We also saw boxes of incontinence pads which were between the dresser and wardrobe, but where protruding causing a trip hazard. On checking the person's risk assessment we found they were at risk of falls and guidance had been given to staff to ensure doorways and corridors should be kept clutter free. We spoke to staff who said the person may have used the wheelchairs to lean on. However the position of the chairs meant if they got into their room they would have been unable to progress further. We later checked the person's room and found the hazards had been removed.

The service used an electronic system to administer people's medicines. Senior care staff who administered medicines explained the use of the system to us and demonstrated they were able to use it. We found this group of staff had been trained in administration of medicines and were assessed as being competent to do so. People's medicines were stored appropriately and temperature checks were in place for the room and fridge storage. Appropriate arrangements were in place for the disposal of people's medicines.

Concerns had been raised with CQC by relatives and staff regarding the availability of showers and baths. Managers had confirmed to us people had been able to continue to have baths and showers, albeit not necessarily on the floor of the home in which they lived. They also told us whilst some showers were inoperable the home had alternative electric showers in place. At the time of our inspection we were informed by staff these showers had been removed. Prior to inspection we spoke with the fire service, who confirmed had been called out at night to stem the flow of water from a bath which had recently been installed after several months of waiting for installation. They told us the water had run down the other floors of the home. Repairs had been made to the home and bathrooms had been redecorated.

Records were in place which demonstrated health and safety checks were regularly carried out. These included fire alarm tests, emergency equipment checks and water checks. Regular water testing took place and we found water temperatures were within acceptable national guidance levels to minimise the risk of scalding.

The acting manager told us there were more staff on duty than what was actually required. They told us they had retained the same staffing levels despite a number of people passing away. We checked the rotas and during our inspection found there were sufficient staff on duty. During the inspection we did not see staff rushing about and they had time to sit and chat with people prior to lunch. We asked the staff if they felt they had enough time to meet people's needs and they said they had. However, we did note that at least one person required two staff to support them with their personal care needs. At such times, if the senior was not available on this floor, this meant that no-one had oversight of the remainder of people who used the service. We saw this happen on two occasions during mealtimes.

We recommend the provider reviews the deployment of staff during busy times to ensure people's needs are met.

We spoke to a senior member of staff about training they had had in relation to safeguarding adults. They confirmed they had completed this training and were asked to regularly attend refresher training in this area. This was to make sure they were knowledgeable about the action to take if they had any concerns. We checked the training matrix and found a number of staff whose safeguarding training required updating or the matrix indicated they had not received such training. We found irrespective of our findings regarding training the service had raised safeguarding concerns about people, and staff and the acting manager knew what steps to take to report abuse.

Appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and two written references were obtained. The Disclosure and Barring Service (DBS) carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. We saw copies of application forms had been completed which detailed prospective staff member's previous experience and training. This meant the provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks.

Requires Improvement

Is the service effective?

Our findings

Staff told us they had received supervision from their line manager. In the provider's supervision policy staff were expected to have formal supervision at least four times per year. The provider's policy described supervision as a meeting to discuss all areas of practice with the provision of care to people who used the service, the application of the company's 'Philosophy of Care', the staff member's career development needs and reflection on practice or critical incidents.

We found there were gaps in staff supervision. In December 2017 the regional manager had carried out and audit and found improvements in staff supervision were required and all staff were to have a supervision meeting with their line manager by the end of January 2018. We found this had not happened. We asked to see a supervision matrix for 2017 to show when staff had supervision and found there was not one available. A new matrix had been set up for 2018 and the acting manager told us they were in the process of allocating staff to line managers for supervision purposes.

We found the document used for recording supervision was being used in lieu of training on one issue. Following an incident involving the use of equipment staff were being asked to sign pre-typed supervision records which told them what to do with the equipment. Not all staff had been supported in 2017 using appraisals. We found there were gaps in staff appraisals being carried out. This meant staff had not been provided with appropriate support, through supervision and appraisal as is necessary to enable them to carry out the duties

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 found staff had not been trained in MCA. Applications had been made to the local authority to deprive people of their liberty and keep them safe. CQC had been notified when these applications had been approved. Consent arrangements were in place in the home. The acting manager told us how people and/or their relatives signed a document to state they had consented to the care and the care plans in place. With the acting manager we sampled four care records and found only one consent form had been signed. This meant consent had not been obtained to deliver people's care.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service used the Malnutrition Universal Screening Tool (MUST) to screen people who were at risk of malnutrition. The tool gives guidance on what actions staff should take. Staff had not followed the guidance, but had continued to monitor people's food and fluid intake of those people. In some people's records we saw staff had been told how to use people's weights to calculate their fluid intake. This had not then been translated into actual amounts and put on a fluid balance chart so staff were aware of people's individual daily fluid requirements. People were provided with fluids throughout the day.

It had been identified that one person had not eaten any food for two days. We spoke to the staff and acting manager about this. The staff said "[name of person] is declining and will only drink." The acting manager stated this person had been seen by a dietician. There was no record of this, nor was there any information in this person's care plan to reflect their changing care needs.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People we spoke with and relatives told us they thought the staff were well trained to meet their needs or their family members. During our inspection staff training on moving and handling was taking place. A senior member of staff we spoke with confirmed they had completed training in dementia care. They told us they had found this training particularly beneficial as it had involved 'role play' and made them really aware of what it was like to be on the receiving end of care. Other staff we spoke with confirmed they had completed induction training when they first started working in the home. The improvement plan for the home included specific areas of training required for some staff for example fire warded training for maintenance staff. There were five people in the home living with diabetes and no care staff members had received training on the subject. This had been reviewed and an action put in place to train staff. The acting manager confirmed the training provider had been approached to arrange the training. Kitchen staff were aware of people with diabetes and described to us how they met their dietary needs.

Whilst we found efforts had been made to ensure staff were appropriately trained on looking at the training matrix we found there were significant gaps in staff training. For example the provider had described some training as mandatory and according to the matrix staff had yet to complete the training or it required updating. This included first aid, care planning and person centred care. The acting manager told us the matrix needed updating with very recent training.

The service worked in partnership with other professionals included local GP's district nurses, opticians and chiropodists. We saw referrals had been made to other health professionals such as the Speech and Language Therapy (SALT). However, we found the guidance and advice provided by other healthcare professionals was not always acted upon by the care staff. For example we saw the SALT team had recommended a 'fork mashable diet, food cut up small with full supervision' for one person. During the inspection we saw this person was left unsupervised with a piece of cake which had not been cut up.

We observed lunchtime meals taking place during our inspection. During one lunchtime we observed the choice was egg, beans and chips or cheeseburger, beans and chips followed by rhubarb and custard. We found this was not an adequate choice; staff stressed to us people could have anything they wanted, omelette or sandwiches or jacket potato. On another inspection day we saw there was a choice of main meal, however, people were not offered a choice at the time of the meal. We asked staff when people were asked what they wanted for lunch. They told us they asked people for their menu choices the day before. This is not good practice in dementia care, as people with short term memory loss may not remember what they have chosen to eat and therefore does not give people meaningful control over daily decision making.

We saw that tables were not presented in the same was as in other areas of the home, for example, there were no tables cloths or napkins, and in this was people with dementia were not afforded an equal dining experience.

Staff supported people to eat and provided encouragement. One staff member commented to a person, "You're doing really well; you don't need my help at all." Music was playing in the background and people were allowed to eat at their own pace.

Staff weighed people on a regular basis and people had been referred to dieticians when concerns about weight loss had come to light. However, we found a number of people who regularly gained and lost weight which could not be explained by for example, illness. We queried this with the acting manager of the home who told us it was possible staff were not consistently weighing people in the same place. We asked to see when the scales had last been calibrated and found they had been due to be calibrated in September 2017. The acting manager made immediate arrangements for the scales to be recalibrated.

The service had in place documentation for staff to complete a pre-admission assessment of people's needs. This was to make sure the home was able to meet peoples care needs prior to their admission. We found pre-admission assessments had not always been completed to assist staff to provide the right care for people. People needs and choices were not always clearly identified in their care records. For example, one person had recently been admitted to the home. We found a small piece of paper stabled to the pre-admissions document alerting staff to 'avoid neat eggs/egg wash.' There was no nutritional care plan in place to include this information or to identify the risks should this person accidentally be given eggs. We drew this to the attention of the acting manager. We found pre-admission assessments had been completed on the next day of our inspection.

We saw that adaptations had been made to the physical environment on the lower ground floor to reflect best practice in dementia care. For example, pictures of toilets and bathrooms on doors as well as themed areas in corridors to help people with short term memory loss find their way. However, the adaptation of the environment did not extend to people's bedrooms and en-suites. In these areas there were no contrasting colours on light switches, grab rails and toilet seats. There was no evidence of any method being used, such as memory boxes or past photographs, to help people to find their personal room, other than the name of the person on their door and a photograph of the person as they are now, which some people with dementia may not recognise.

During the course of the inspection on the lower ground floor where people with dementia lived, the nurse call alarm and telephone were constantly ringing. We asked the staff about this. They told us if a nurse call was activated in any part of the home, it also sounded in each unit of the home. They said they had to keep checking to see which area of the home it related to. A similar system was in operation for the telephones. Staff told us telephones rang through the home. Noise is known to cause some people with dementia to become agitated or cause them distress. The constant ringing did not promote a therapeutic relaxed atmosphere for people living with dementia. The need for improvements had been identified in the checks carried out by the provider's quality team. Following the inspection the provider told us they are looking to change the alarm format. They wished to point out that the telephones rang throughout the home to ensure incoming calls could be responded to as quickly as possible.

Requires Improvement

Is the service caring?

Our findings

Although staff presented as kind and caring we found they were unable to provide a good caring service as the absence of accurate care plans meant staff were not given appropriate guidance on how to meet people's needs. We also found where this guidance was available for one person staff had failed to follow the guidance to protect a person's dignity; they had been left in their room and sustained serious injuries.

We spent time observing care practices on the lower ground floor where people with dementia lived. Staff at times were respectful when interacting with people who used the service. For example, we saw staff walk with people at a pace that was comfortable for them. However, some care practices did not always promote the dignity of people living with dementia. For example, responses such as 'what you shouting for' and '[name of person] don't shout' and 'don't scratch' did not demonstrate an understanding of the nature of dementia and memory loss and the anxiety people might be feeling as a result of this. Entries in daily statements such as 'spent time wandering' did not indicate staff understood the needs of people with dementia. Daily statements, containing confidential personal information, were kept in the lounge area on top of a cabinet and easily accessible to everyone. People's moving and handling needs were stuck on the sides of their wardrobes for everyone to see. We saw eye drops being administered to one person in the communal dining room in front of other service users. Such practices do not promote privacy and dignity.

We found people's bedrooms for the most part had been personalised with their own possessions so people were surrounded by familiar items. One person invited us into their room; we found their room lacked personal items. A notice board which was enclosed had a pinned message which was lopsided stating the person had their laundry done by the service. The person became distressed and told us they were tired. They asked the inspectors to take two of their treasured photographs out of a drawer. We found one frame was broken and another frame had broken glass. We spoke with the acting manager about repairing these frames and putting them up on the wall for the person. They told us the person did not always want the photographs on the wall.

People who lived at Westerleigh were relaxed and comfortable with staff. People told us they were well cared. One person said, "Nothing seems too much trouble for them", and "We are waited on hand and foot." Another person said, "I wouldn't change any of them " and " The atmosphere here is great." One relative said "I think the standard of care here is excellent." In the feedback forms recently completed by people who use the service we found opposing views. One person had written, "All staff are very pleasant and helpful at all times." Another person wrote the home needed more caring staff as they found some staff were, "Disrespectful and rude."

Staff promoted people's independence. One person told us, "I choose my own clothes and can get up or go to bed when I want." Another person said, "Everything is private and dignified, I wash my own front. They do the places I can't reach- although I can shower myself they help me become more independent." A third person said, "They are gradually putting more and more on to me so that I can do things myself more."

People told us staff provided encouragement and support to make improvements. One person said they

had moved into the home using a walking frame and were now using a walking stick. Another person said, "The carer's can't be faulted and have helped me make this my home."

Relatives were involved in people's care. We met with relatives who were awaiting ambulances with their family members to take them to hospital appointments. One relative described the staff as, "Lovely" and told us they were very happy with the standards of care. They described to us how staff kept them informed about their family member's care needs. Some relatives we spoke with did not attend the relative's meetings. One relative told us they did not need to attend as they do not have any problems. Another relative told us, "I don't have any problems to discuss, because if I did I would see the manager and it would be sorted.

An advocate is someone who assists people speak up and represent their views to other professionals. We saw one person had an advocate who had recently visited to seek their views about continuing to live at Westerleigh. One person felt confident they relative would speak up on their behalf; they told us, "My nephew speaks up for me but I've nothing to complain about." A suggestions box was available for people to comment on the service. People had been invited to resident's meetings and asked for their views.

Requires Improvement

Is the service responsive?

Our findings

One person told us, "The [acting manager] is very approachable, my bulb went last night; the maintenance man came in at that moment and replaced the bulb. That's service."

Staff completed two types of daily records about the care they delivered to people. Firstly, there was an A4 sized notebook for each of the floors in which staff wrote daily events for example if a person had a fall or a hospital visit. These books contained information about everyone but did not contain a consistent record of what had happened to everyone who used the service. Secondly, we saw staff completed 'daily statements' which outlined the care provided each day. These were one page documents in a separate file which used different tables for staff to complete for example, food and fluid intake. There were boxes on the statement for staff to make notes. These were not written in a person centred way (Person centred means written in a way to describe in an individualised way the support each person has been provided taking into account their individual choices, preferences and life histories) as they consisted of charts and a brief statement of how the person had been that day. There was little information recorded on these forms whereby an effective evaluation of the care plans could take place.

We found in another person's care records their care plan and risk assessments had not been evaluated on a monthly basis. People who were admitted on a short term basis and whose records were all in one file had not had their plans reviewed. One person had been admitted in October 2017. This meant people's needs had not been reviewed or updated and the records held by the service were not contemporaneous.

In addition to this, where care plans had been evaluated, there was conflicting information. For example, in one person's care plan it stated they needed the support of one carer to help with transfers, yet in the evaluation of the same care plan reference was made to this person requiring the assistance of two care staff. We saw one person had a wound which was covered by a dressing. There was no body map available to monitor whether this was improving or deteriorating. Topical medicine records failed to document people's medicines had been applied at the required intervals. This meant people were at risk from unsafe care as information in the care records was either missing, out-of-date or provided conflicting information.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found as a result of dementia, one person may have become agitated. There were 'behaviour' charts which were completed by staff whenever this happened. However, there was no analysis of this information to help identify possible triggers to the behaviour (s) or help to identify the threshold of behaviour(s) which would indicate to staff at which point medication needed to be administered. There was no step by step guidance to inform staff about what they should do to support people in a positive way at such times. This meant the person was at risk of receiving inappropriate care.

We spoke with one person in their bedroom and observed them to be uncomfortable with poor posture as they constantly moved to their left side. We asked them if they comfortable and they told us they, "Just put up with it." We later spoke to their family members who confirmed they had a left sided weakness and extra

support would prevent them from leaning over to the left which in turn enabled them to use their arm more. Additional support had not been sought or provided. The family members also told us the person struggled to eat fully independently as they were unable to cut up food or hold their cutlery. We spoke to the acting manager who said the person had a plate guard, but we found staff on duty were unaware of this.

People who were admitted to the home on a respite basis had a shortened care plans in place. The plans for a number of people were stored in the same file. We found these records to be confusing. On one person's records we found the words, 'for long term care'. One family member spoke with us and believed their family member was living in the home permanently. We saw that there was no care plan in place for one person who had been admitted to the care home over two months earlier.
We found there was no information in people's care plans we looked at to describe the type of dementia people had been assessed as having, how this may affect them and the support they may require as a result of this.
This meant in the absence of care planning people who were admitted for short term periods were at risk of unsafe care.

Information about people's daily care was held in different places. There were no individual daily records recorded in one place in the home which demonstrated that people's care needs were being met. Care plans were evaluated each month by senior care staff. In one person's review record we found a falls record which had not been updated. In the A4 notebook we found the person had further falls. In the notebook inspectors saw there were a further four falls. At tea time during our inspection we observed the same person was left in their room in a chair by the window. The floor sensor mat was on the opposite side of the bed to where they were sitting. This was reported to the acting manager who agreed it was in the wrong place.

People were supported by their relatives, some of who visited the home on a daily basis and supported the care of their family members. We found care records did not show how the relatives provided the care and the associated risks. For example, one relative supported their family member to bathe. Staff had not engaged with the relative to manage their care and reduce risks.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff were not always able to locate information and acknowledged that they were behind on updating care plans and documentation. They showed us some care plans which had been updated.

People had their end of life wishes and choices recorded in care records. However, we found people who were towards the end of their life did not have plans in place which gave guidance to staff. A training matrix obtained during the inspection showed staff had not been trained in end of life care. The provider had sent a notification to CQC regarding a safeguarding alert raised with the local authority safeguarding team in respect of equipment used with one person at the end of their life. We found, whilst the equipment used was the responsibility of the district nurse staff had not been provided with guidance on what checks they needed to carry out in case they need to alert the district nursing team. Following the incident staff had been required to sign a pre-typed supervision record in which was documented what they needed to do with the equipment. In the provider's last medicines audit carried out in January 2018 we saw the training for staff involved in the use of the equipment was described as not applicable. We found the arrangements in place in the home for people on end of life care to be unsatisfactory.

The complaints procedure was displayed in people's bedrooms so they and their relatives knew what to do if they were unhappy with the care being provided. We saw complaints were documented and responses

were provided to complaints. One relative raised a concern with us that they had complained about a manager in post, but it was the manager who had responded to their complaint. Other people who used the service and their relatives told us they were aware they could make a complaint but they had no cause to raise any concerns.

An activities coordinator was employed in the home. They had a timetable of events and told us the regional manager had initiated a meeting for the coordinators employed in the region. They found this meeting useful to share ideas on activities and fundraising. The activities coordinator had care plans in place and maintained records on the activities people had been involved in. We saw the activities coordinator ran group activities and spent time with people on an individual basis. On one morning of our inspection we saw staff engage people in a painting activity. Staff described how they often used the easily accessible garden in the warmer weather. They also described the recent visit of a therapy pony. One person told us they wanted to get out more. Outings had been planned but these were subject to weather conditions. People told us they had been taken to a garden centre and a pantomime. They spoke with us about enjoying bingo, chair exercises, dominoes, cards, craft and going out for a meal.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager for the service. The person who had been appointed to manage the service was absent. We had been notified they had been absent for more than 28 days. An acting manager had been appointed to run the service. During the inspection we saw the acting manager was active in the day to day running of the home. We saw they interacted and supported people who lived at Westerleigh. From our conversations with the acting manager it was clear they knew the needs of the people who lived at Westerleigh.

The staff we spoke with were complimentary about the acting manager. They told us they would have no hesitation in approaching the acting manager if they had any concerns. They expressed concerns about the style of appointed manager and felt they were being asked to carry out more managerial tasks which had impacted on their ability to carry out their work and make the necessary improvements in the home.

Documents used by the service did not always have the date completed as a reference point therefore difficult to know which documentation was most relevant, unless staff had signed and dated it which was not always the case. We found care plans were incomplete and had not been reviewed to provide the most updated information. Plans for people's 'as and when' required medicines were not evident in the service. This meant the service did not have in place accurate and contemporaneous records for people who used the service.

An audit had been carried out by the provider's quality improvement team in November 2017 which had led to an improvement plan in place. The required improvements were being monitored and were reviewed in February 2018. The review showed improvements were being made in the home. However, we found some audits were not effective in identifying the deficits we found in the service. For example the medicine's audits did not include a review of topical medicines. In the same audit the use of certain equipment was described as not applicable. However we found people had been given the equipment and staff had not had the required guidance in place.

We asked for the last three audits of the home carried out by the regional manager. The current regional manager told us they came into post in November 2017 and carried out their first audit in December 2018. They examined seven out of the fourteen areas for review. Following the inspection they explained to us they had dovetailed their visits to monitor the service with the quality team. Neither the regional manager nor the acting manager were able to provide us with the regional manager's audits prior to December 2017. We were unable to assess if the systems and processes used to monitor the home were effective in preventing further breaches of the regulations.

This is a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Prior to the inspection we had received three notifications via the Health and Safe Executive which concerned serious injuries to people who used the service. CQC had not been notified of two of these people's injuries. This issue is being dealt with outside of the inspection process.

This is a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

A dining audit had been carried out on 7 February 2018. Westerleigh has three dining rooms and the audit did not describe which floor the auditor was reviewing. They have described tables as being set which was contrary to our observations on the lower ground floor. Other audits such as health and safety and fire audits were carried out on a regular basis and dated.

Completed surveys to monitor the quality of the service were last carried out in 2016. A new survey had recently been started to seek people's views about the service.

A staff survey carried out in December 2017 and January 2018 highlighted a number of serious concerns in the home including the actions of management, staff roles and responsibilities, relationships between staff and staff sickness levels. The provider had summarised the staff concerns and held a human resources workshop. Actions had been put in place to make immediate improvements and when required staff had received personal apologies and explanations.

There were clear partnership arrangements in place with local health care services. A hairdresser visited the service on a regular basis.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to seek consent to provide care and treatment to people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to the health and safety of service users of receiving the care or treatment had been assessed. The provider had failed to.do all that was reasonably practicable to mitigate any such risks

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate, complete and contemporaneous records were not held by the provider in respect of each person who used the service. Systems and processes used by the provider to monitor the service were not always effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not been provided with appropriate support, through supervision and appraisal as is necessary to enable them to carry out the

duties they are employed to perform