Westminster House Residential Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Westminster House Residential Care Limited is a residential care home providing the regulated activity of accommodation and personal care to up to 12 people. The service provides support to adults who are living with dementia and/or have a mental health diagnosis. At the time of our inspection there were 12 people using the service.

People's experience of using this service and what we found
The delivery of care for people was not always safe. Not all risks to people's safety and wellbeing provided enough detail as to how identified risks should be mitigated. Suitable arrangements were not in place to ensure the proper and safe use of medicines. The deployment of staff was not always suitable or safe to meet people's care and support needs and improvements were required to the provider's recruitment practices. People were not always protected by the prevention and control of infection. We have made recommendations about staffing levels, recruitment practices and infection, prevention, and control. Lessons were not learned, and improvements made when things went wrong.

Staffs' training was not embedded in their everyday practice and staff did not receive a robust induction. Although staff received supervision, information had not been examined to ensure where issues were highlighted these were escalated and addressed. We could not be assured if people's hydration needs were being met as people's fluid targets were not always met or monitored. The premises did not meet people's needs, particularly for people living with dementia and those people who had mental healthcare needs. We have made a recommendation about the premises.

The leadership, management and governance arrangements did not provide assurance the service was well-led. There was a lack of understanding of the risks and issues and the potential impact on people using the service. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service worked with other organisations to ensure they delivered joined-up care and support and people had access to healthcare services when needed. People were happy with the quality of meals provided. Relatives were happy with the care and support provided for their family member. Staff felt supported and valued.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 23 July 2019)

Why we inspected

This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The inspection was prompted in part due to concerns received about safeguarding people from harm and abuse. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-Led only.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to risk, medicines management, safeguarding, staffing, governance, and quality assurance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the Local Authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Westminster House Residential Care Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by 1 inspector.

Service and service type
Westminster House Residential Care Limited is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Westminster House Residential Care Limited is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. The registered manager was also the

provider.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 4 people who used the service and 5 people's relatives about their experience of Westminster House Residential Care Limited. Primarily, we spoke with the provider's representative of the service [Admin Manager] and 4 members of staff. We spoke with the provider on the third day of inspection.

We reviewed a range of records. This included 4 people's care records and 6 people's medicines administration records. We looked at 7 staff files in relation to recruitment, staff training and supervision. A variety of records relating to the management of the service, quality assurance information and policies and procedures were viewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection in 2019, we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• The provider failed to ensure all risks to people's safety and wellbeing provided enough detail as to how identified risks should be mitigated. This referred specifically where people could become anxious, distressed and exhibit behaviours which could place themselves and others at risk of harm. This put people at potential risk of not having risks to their safety met in an appropriate and safe way.
• Staff were observed on 3 separate occasions to place their hand under a person's underarm when assisting them to mobilise. This technique is unsafe, can cause injury and placed the person at risk of harm.
• Staff attempted to assist 1 person to move to a standing position from their chair by using a supportive transfer belt. However, staff placed the transfer belt around the person's chest and over their breasts. The person did not verbalise their discomfort, but their facial expression showed the placing of the transfer belt around their chest and over their breasts was uncomfortable. Information showed this person had not been assessed for use of the transfer belt. This is unsafe and demonstrated staff did not understand what constitutes safe moving and handling practices.
• Control of Substances Hazardous to Health [COSHH] chemicals were stored within the ground floor shower room on a shelf. Information recorded on the bottles referred to them being highly flammable, if swallowed medical help should be sought and the liquid could cause serious eye irritation. Although most staff had received COSHH training in 2022 and 2023, these items were easily accessible to people posing a serious risk to people's safety. This was brought to the immediate attention of the admin manager. However, when we returned to the service 4 days later, these items had not been removed and remained exactly where they had been seen previously. This placed people at risk of harm.

Using medicines safely
• The provider failed to ensure the proper and safe use of medicines at the service.
• Where people were prescribed PRN [when required] medication, protocols were not in place. A PRN protocol provides information about what the medicine is for, symptoms to look out for and when to offer the medicine. This meant staff did not have guidance to prevent medicines being used excessively or inappropriately as a form of restriction and control.
• We identified medicines used to provide PRN [when required] symptomatic relief when a person experienced episodes of distress and agitation were being misused. This medication should only be used as a last resort and not as a stand-alone method of de-escalation. No information was recorded to show staff's interventions to provide psychological support prior to the medicines being administered.
• Codes used in Medication Administration Records [MAR] forms were inconsistent and confusing. Some staff used their initials to record when PRN [when required] medication was administered, but other staff used the letter 'X' or left the MAR form blank. It was not clear if 'X' was used to depict when medication was administered or not required. Therefore, we could not be assured if people using the service were receiving

their medication as intended.
• We observed 2 separate occasions whereby staff directly handled people's medication with their fingers. This was not good practice and meant poor hygiene methods were being used and there was a potential risk of cross-infection. In addition, staff directly handling people's medication with their fingers could change the original properties of the medication, making them less effective.

Arrangements were not robust to manage and mitigate risk for people using the service and improvements were required to the management or medicines. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• Appropriate fire detection, warning systems and firefighting equipment were in place and checked to ensure they remained effective. These ensured the provider was able to respond effectively to fire related emergencies that could occur at the service.
• Hot water outlets were tested at regular intervals to ensure the water emitted remained safe and within recommended guidelines. An analysis for legionella had been carried out and this confirmed no bacteria was detected.
• Following the inspection the provider confirmed staff had now received additional training relating to medicines management and moving and handling.

Systems and processes to safeguard people from the risk of abuse
• Robust processes and procedures were not in place to protect people from avoidable harm and abuse.
• Safeguarding concerns were not raised and escalated in a timely manner to the Local Authority or the Care Quality Commission.
• The provider failed to understand their role and associated responsibilities to protect and keep people safe from harm. The provider did not make sure allegations of abuse were investigated without delay and actions taken to investigate the issues raised, including any subsequent disciplinary action, or monitoring of the staff members involved. This did not provide assurance that effective arrangements were in place to protect people from abuse.
• Though staff had received safeguarding training, were able to tell us about the different types of abuse and describe what actions they would take to protect people from harm and improper treatment, this did not happen in practice. Therefore, placing people at a significant risk of harm and/or abuse.

Robust arrangements were not in place to safeguard people from abuse. This was a breach of Regulation 13 [Safeguarding] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Despite this, relatives told us they had no concerns about their family member's safety. Comments included, "I have no concerns about [relative's] safety", "When we visit, we do not leave concerned" and, "I am aware the service has CCTV cameras to watch over things."

Staffing and recruitment
• The provider failed to make sure suitable arrangements were in place to ensure staff employed had the appropriate recruitment checks undertaken and were suitable to work with vulnerable people.
• A full employment history and gaps in employment had not been explored. Where staff had previously been employed in a position whose duties involved working with children or vulnerable adults' information relating to why the employment ended had not been investigated. Not all written references were received prior to staff commencing in post.
• People's dependency needs were assessed, but there was no evidence to show how this information was used to inform the service's staffing levels.
• The deployment of staff was not always suitable to meet people's care and support needs. There was a

lack of staff on occasions within the communal lounge despite some people being at risk of falls and/or who could become anxious, distressed and exhibit behaviours that placed themselves and others at risk of harm.
• Observations throughout the inspection showed care provided by staff was primarily task and routine focused. This referred to people receiving task-based care rather than care that was person-centred.
• Most relatives spoken with told us there were sufficient staff available to meet their family member's needs. Comments included, "There is always someone around when I visit" and, "I don't know what the staffing levels should be, but whenever I go the home, there has always been enough staff in the communal lounge." Staff confirmed staffing levels were appropriate and agency staff were deployed when required to cover staff annual leave, sickness, and unforeseen circumstances.

We recommend the provider updates their practice accordingly relating to their recruitment practices and the deployment of staff at the service meets people's needs.

Learning lessons when things go wrong
• There was no strategic oversight of incidents, complaints, and safeguarding concerns to explore and examine trends and lessons learned, in order to reduce the risk of reoccurrence. This led to people being at risk of harm, abuse, and improper treatment.
• During the inspection we identified people were at risk of continued harm due to COSHH items being easily accessible to people living at the service. We raised concerns about staff using a supportive transfer belt for 1 person when assisting them to transfer from a comfortable chair to a wheelchair and vice versa. Despite raising the above with the provider's representative at the earliest opportunity, on the third day of inspection we saw no action had been taken to reduce these risks. This demonstrated little evidence of learning from events or action taken to improve people's safety.

Preventing and controlling infection
• We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. On the second day of inspection not all food stored on the kitchen worktops was covered to prevent contamination from dust, insects, and pests. Not all food items in the fridge were dated to demonstrate food was within its 'best before' or 'use by date'. The above did not minimise the risk of food being contaminated by harmful bacteria or demonstrate the food was safe to eat.
• We brought our concerns to the immediate attention of the admin manager, who told us staff had been given several reminders about the importance of good food hygiene practices. However, this had not been effective as it was not being followed in practice, placing people at continued risk of becoming unwell through unsafe food storage.
• We were assured the provider was using PPE effectively and safely. Staff told us there were always enough supplies of PPE available.

We recommend the provider refers to current guidance or seeks advice from a reputable source relating to their infection, prevention, and control practices.

Visiting in care homes
• Relatives were able to visit their family member without restrictions imposed and in line with government guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills, and experience; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

• Observations of staff practice did not provide assurance staff were skilled and competent to effectively apply their learning in their day-to-day practice. Not all staff's understanding of dementia and mental health care was effective, or person centred to meet the needs of people using the service.

• Some staff members had been given the role of 'champion' in key subject areas. The role of a champion is to promote, identify and signpost their colleagues to 'good practice' initiatives and to act as a good role model. None of these staff had attained a higher level of training in these key areas. This meant we could not be assured staff were suitably qualified and competent to lead on these key roles and to effectively support their colleagues.

• Newly employed staff at Westminster House Residential Care Limited had not received a robust induction. Not all staff had completed the 'Care Certificate' as part of their induction. The 'Care Certificate' is a set of standards that social care and health workers should adhere to in their daily working life. This meant there was a risk staff were not enabled or supported to understand the organisation, expectations of their role and ways of working.

• Although staff had received formal supervision information had not been analysed to ensure where issues were highlighted these were escalated, followed up and addressed. Not all staff who supervised others had received appropriate training to effectively undertake this role. This meant concerning issues were not picked up and actioned at the earliest opportunity.

Robust arrangements were not in place to ensure staff had the skills to deliver effective care and support and received an appropriate induction. Improvements were required to ensure staff supervision was consistent. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

• Some areas of the home environment were cluttered, tired and worn. The décor needed updating and this was reflected from comments made by people's relatives through our discussions with them and the completion of satisfaction surveys. No action plan was completed detailing how this was to be addressed. Following the inspection the provider wrote to us and confirmed the communal lounge and dining area had been painted 6 months previously and pictorial signage was in place on toilet doors.

• The environment was not appropriate for people living with dementia. There was a lack of visual clues and prompts, including signs using both pictures and text to promote people's orientation. The physical

environment did not promote and enhance people's wellbeing, particularly for people who were living with mental health needs.

We recommend the provider refers to current guidance or seeks advice from a reputable source relating to the premises.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• The service was not working within the principles of the MCA. Where restraint was used it was not always recognised and less restrictive options were not always used where possible. This included the inappropriate used of sedative medications.
• Where people were deprived of their liberty, the registered manager submitted applications to the local authority to seek authorisation to ensure this was lawful.

Supporting people to eat and drink enough to maintain a balanced diet
• People had access to food and drink throughout the day and meals were well presented.
• However, fluid intake records viewed showed people's fluid targets were not always met. No information was recorded to demonstrate how this was being monitored and addressed to mitigate their risk of dehydration.
• People's comments about the food provided were positive. Comments included, "Yes, I like the food" and, "The meals are always lovely."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The service worked with other organisations to ensure they delivered joined-up care and support. People had access to healthcare services when they needed it and relatives confirmed their family members healthcare needs were met.
• Relatives told us they were kept informed about their family member's healthcare needs and the outcome of any healthcare appointments. Comments included, "I am kept up to date with what is happening" and, "Staff send an email with updates."
• Although relatives had access to the 'family portal' of a well-known electronic software system and this updated them on their loved one's care, wellbeing and health, access to some areas had been reduced without explanation by the provider. Comments included, "I recently cannot get into all areas, I do not know why" and, "Originally, I was able to see information about [relative's] behaviours, food and fluid intake and

weight records, now I can't, and no reason has been given. It was very useful to keep track on what was happening with [relative]."

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The provider failed to ensure formalised arrangements were in place to enable them to have effective oversight of the quality of care and support being delivered to people using the service. There was no formal mechanism or expectation in place for the admin manager to formally report on issues relating to the day-to-day management of the service so the provider could be assured the service was running smoothly and in line with regulatory requirements.
- There was no written Service Improvement Plan in place for the provider to identify where the service needed to improve, to help drive improvement and to implement any required changes. Following the inspection the provider confirmed a Service Improvement Plan was in place, but the provider's representative was not aware of its existence.
- There was no robust audit and governance arrangements in place to effectively monitor the service, to identify where the service was compliant with regulations and to identify shortfalls, including non-compliance with regulatory requirements. Audits were not routinely completed in line with the provider's scheduling activities. For example, the schedule referred to medication audits being completed each month. We found the last audits were completed in August and September 2022. Similarly, the infection, prevention and control audit was last completed in June 2022. Following the inspection the provider confirmed these audits were in place, but the provider's representative was not aware of their existence.
- We identified multiple signs of a closed culture at Westminster House Residential Care Limited. For example, restrictive practices and punitive approaches to care were in place. People were not being safeguarded and protected against the risk of harm and abuse. There was a lack of openness and transparency by the provider, and they did not lead by example.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Suitable role models were not available to provide support and guidance to staff to enable them to effectively carry out their roles and responsibilities. The provider had failed to recognise the importance of this.
- Staff were not able to demonstrate an understanding of the provider's vision and values for the service. Four out of 5 members of staff were not able to describe this or knew where the information was recorded and located.
- The provider had failed to identify and respond to complaints and safeguarding concerns. As a result, they

had not been investigated to identify any wrongdoing and lessons learned. This meant they were unable to be open and honest with people and apologise where necessary.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Arrangements were in place for gathering people's and relatives' views about the quality of service provided. The satisfaction questionnaire for people's relatives was completed in February 2023. Comments were positive apart from those relating to the décor of the service. However, no action plan was devised detailing how issues raised were to be addressed. The satisfaction questionnaire for people using the service and staff was last completed in March and April 2022. The admin manager confirmed this was due to be repeated in 2023.
• Staff meetings were not routinely held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. The admin manager told us meetings were not undertaken for people using the service as these had been previously attempted but people "tended to argue". This was not a respectful way to describe people sharing their views. It was confirmed that 1-to-1 meetings were held with the provider but there were no records to confirm this as stated and people spoken with were unable to verify this.

Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff told us communication was good. Regular handovers were completed throughout the day to ensure relevant information was transferred across all team members through shift changes.
• Despite the concerns we identified during the inspection, relatives and staff spoken with told us they believed the service was well managed and led by the provider and admin manager. Relatives confirmed they were happy with the care and support provided for their family member.
• Staff confirmed they enjoyed working at Westminster House Residential Care Limited. Comments included, "It's a good place to work" and, "I absolutely love it here."

Working in partnership with others
• Information demonstrated the service worked closely with others, for example, the Local Authority, healthcare professionals and services to support care provision.

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 18 HSCA RA Regulations 2014 Staffing Robust arrangements were not in place to ensure staff had the skills to deliver effective care and support and received an appropriate induction. Improvements were required to ensure staff supervision was consistent.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Arrangements were not robust to manage and mitigate risk for people using the service and improvements were required to the management or medicines.

The enforcement action we took:

Warning Notice Served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Robust arrangements were not in place to safeguard people from abuse.

The enforcement action we took:

Warning Notice Served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations.

The enforcement action we took:

Warning Notice Served