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Westbury House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Westbury House Nursing Home on 31 May and 6 June 2016 as a result of concerns raised during previous inspections in March and April 2016. We inspected the service against three of the five questions we ask about services: is the service Safe, Effective and Well led. This inspection was completed as we had increasing concerns regarding the care provided to people living at the home. These included concerns regarding the lack of appropriate reporting of incidents which had posed a significant threat to people's health and wellbeing and risk assessments not being appropriately detailed to manage risks to people's safety. Concerns also included insufficient staffing levels to be able to meet people's need safely and staff not being in receipt of the most up to date and appropriate training to be able to meet people's individual needs. We were also concerned that the home was not appropriately well led by a visible registered manager.

We carried out an unannounced comprehensive inspection of this service on 22, 23 March and 4 April 2016 where eight regulatory breaches were identified. Following these inspections the provider wrote to us to say what they would do to meet these legal requirements. During the inspections we checked whether the provider had completed their action plan to address the concerns we had found. The provider had made inadequate improvements to address the original concerns; and at these inspections additional concerns were also raised. At this inspection we found that the provider continued to be in breach of Regulations and had not made necessary improvements to ensure people's safety and welfare.

As a result of our inspection on 31 May 2016 we wrote a letter to the provider to highlight our concerns and to request written confirmation that sufficient numbers of suitably trained staff would be deployed to ensure people's safety by 2 June 2016. The provider met and spoke with the Care Quality Commission (CQC) on 2 June 2016. Following this meeting the provider submitted a staffing plan on 3 June 2016 showing the staffing levels which would be deployed in order to meet people's needs safely.

We revisited the home on 6 June where it was identified that our concerns had not been appropriately addressed. We were not assured that people were receiving safe and effective care from sufficient numbers of suitably trained staff. As a result action was taken by the CQC to ensure people's safety, health and welfare.

Westbury House Nursing Home provided accommodation and nursing care for up to 35 older people who had physical disabilities and neurological related diseases and disorders. These included Huntingdon's disease and acquired brain injuries as a result of illness or accident. This also included people who required care on a short term basis referred to as 'respite' care. At the time of our inspection 31 people were using the service.

Westbury House is a large four storey period building set in expansive grounds on the outskirts of West Meon. West Meon is a small village situated between the towns of Winchester and Petersfield in Hampshire.

The house comprised of two units where both residential and nursing care was provided. A wing of the house separated by a locked door was used as living accommodation for those with the most complex behavioural needs for their own and other people's safety.

This report will refer to the two units collectively as 'the home' throughout this report unless individually specified.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.
At previous inspections in March and April 2016 we had identified that the registered manager was regularly absent from the service. They were not in day to day control of the service providing consistent managerial support for staff. During our inspections in May and June 2016 neither the provider or the registered manager were present at the home.

Our inspection of 21 and 22 March and 4 April found a number of breaches of the Health and Social Care Act 2008 and associated regulations.

These breaches were across a number of regulatory areas. Safeguarding concerns were not appropriately reported or investigated therefore external agencies could not assure themselves that appropriate action was being taken to address the identified concerns. People's risk assessments were not completed fully or identified as necessary where required to ensure staff knew how to give safe care. There were insufficient numbers of suitably qualified and experienced staff deployed to meet people's needs. Communication between people using the service and staff was not always clear due to a lack of English language known and English language skills training provided to staff from non-English speaking countries. Recruitment procedures were not robust and did not fully and accurately determine that people were suitable for their role of providing safe care. People were at risk of infection due to insufficient cleaning practices and Medicines were not always appropriately secured placing people at risk of accessing medicines not prescribed to them.

People at risk of weight loss had not been appropriately identified and steps taken to ensure they were appropriately referred to healthcare professionals so the reason for this weight loss could be addressed. The provider had not complied with the requirements of the Mental Capacity Act 2005 (MCA). There was a lack of documented processes to identify when someone should be receiving care in their best interests. Staff had not received specialist training in areas such as Huntingdon's disease and motor neurone disease to be able to effectively meet the needs of the people they were supporting. People were not always involved in their care planning therefore care was not always provided in the way people wanted or needed.

The registered manager had not appropriately recorded notifications to the CQC advising us of serious incidents and allegations as part of their regulatory function to enable us to monitor the safety of the service. There were no regular checks or a system of quality monitoring in place to ensure that improvements could be made to the quality of the service provided to people.

As a result of the concerns identified on 8 April 2016 we wrote an urgent letter to the provider advising them they would no longer be able to admit or readmit people to Westbury House without our prior consent. This was to ensure that we could check that appropriate care planning and support documentation was in place prior to people's moving into the home.

Prior to our inspection on 28 May 2016 the local authority supported Westbury House by providing three additional members of staff to support the current staff working at the home. This included one nurse and two members of care staff for both the day and the night shift. This was to ensure that there were sufficient numbers of staff to meet people's needs.

During our inspection on 31 May we focused our attention on a number of people who had been identified at risk of not receiving safe and effective care and treatment. As a result a number of concerns were identified.

Despite our letter to the provider on 8 April stating that they were not able to provide care to people without our prior authority one person had been readmitted to Westbury House on three separate occasions without CQC written permission. Another person had also been admitted since 8 April again without CQC written permission. This was in direct breach of our Notice of Decision to restrict admissions.

During our inspection on 31 May we could not see that people were being supported to maintain their independence. One person we had previously identified on 4 April as not being supported to leave the home to visit friends when requested were still not having their needs met. This person expressed their desire to leave the home however we could not see that provisions had been made to support them with their choice to leave the home.

There was insufficient equipment available to meet people's needs safely. Those who required additional support with their moving and handling needs which required the provision of equipment had not always had their needs met.

We could not see that people had always consented to receive care from Westbury House Nursing Home. Not all the people living at the home had provided written consent to live at the home. No action had been taken to identify whether or not their placement at the home was as a result of a best interest decision when people were unable to make their own decisions.

People who were losing weight had not received appropriate referrals to healthcare professionals to ensure their needs in relation to their weight loss were appropriately assessed. No specific guidance had been provided to staff on how to make sure that people's nutritional and hydration needs were being met.

The provider did not ensure that people who were at risk of dehydration had effective care plans in place which provided the appropriate guidance to staff as to how much fluid a person should be consuming in a day to ensure their on-going health and welfare.

People living with diabetes and at risk of suffering hyperglycaemic or hypoglycaemic episodes did not have their conditions managed effectively. This led to people being at risk of suffering a diabetic coma which if untreated could lead to a serious deterioration in a person's health eventually resulting in death.

Staff were not always provided with sufficient guidance to maintain and support people's health and wellbeing needs in an effective way. People at risk of skin breakdowns due to their medical condition did not have appropriate wound specific care plans in place. We could not see that detailed information was in place to ensure that staff were able to meet people's needs appropriately to ensure no further deterioration in their health.

During the inspection during the 6 June 2016 we could see that there were insufficient numbers of staff available to meet people's needs safely for the for the next two weeks.

The provider did not ensure that the service was well led. The registered manager did not provide day to day support to staff or offer strong leadership.
At this inspection we identified seven continued breaches of The Health and Social Care Act (Regulated Activities) Regulations 2014.

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

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.

There were insufficient numbers of suitably qualified and experienced staff deployed to meet people's needs safely.

The provider did not ensure that people had access to the moving and handling equipment required to enable them to maintain their independence and ensure their needs were met safely.

Risks to people had not been identified or appropriately recorded. Individualised risk assessments were not always in place to ensure that people were protected from the risk of harm.

Is the service effective?

Inadequate

The service was not effective.

People were not supported to eat and drink enough to maintain their nutritional and hydration needs. Those at risk of dehydration and malnutrition were not supported to regain and maintain a weight which assured their health needs were met.

People were supported by staff who did not have the most up to date knowledge available from detailed care plans to know how to best support their needs and wishes.

People were not supported to make their own decisions. The provider did not ensure that consent was obtained and documented by people before care was delivered.

People were not supported by staff who sought appropriate and timely healthcare advice and support for them as required.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not ensure the registered manager was providing strong management, leadership or direction at the service. As a result people's care and treatment was unsafe and

they were at risk of harm.

Despite the increasing concerns regarding service delivery the provider and registered manager did not take appropriate action to address these serious concerns to ensure people were safe.

Westbury House Nursing 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 function. These inspections checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
We carried out this focused inspection on a number of key areas in response to concerns raised at previous inspections in March and April 2016.

This inspection took place on the 31 May and 6 June and was unannounced. The inspection was conducted by two adult social care inspectors on both days.

Before our inspections we looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We also reviewed the provider's action plans to ensure that they had taken the action they had detailed as completed.

We also spoke with a health and social care professional regarding the care delivery at the home.

During the inspection we spoke with three people, the provider, the provider's Clinical Lead who was responsible for nursing care decisions, a member of agency staff, a regular member of care staff, the receptionist and a visiting GP. We also looked at seven care plans and associated daily care notes. During the inspection we spent time observing staff interactions with people as they moved around the home. On the 6 June 2016 we spoke with the receptionist, two nurses, the provider's financial controller, a relative and two staff.

Inadequate

Is the service safe?

Our findings

Our inspection in March and April 2016 found that people were not always adequately supported by staff to ensure their independence was maintained. People who had expressed their wish to not live at the home did not have their views respected and appropriate action was not taken to mitigate their distress.

During our inspection on 31 May 2016 we found that one person continually expressed their desire to leave the home. This person's care plan had been amended since the April inspection to state that they agreed to stay at the home as they enjoyed it there. However since this amendment had been made the person had taken active steps to leave the home on four separate occasions. They also continually voiced their unhappiness at living at the home. This person had placed themselves at risk of significant harm of being involved in an incident or an accident when leaving the home. The home was situated in a rural area with no pavements or effective street lighting available. Leaving the home meant they were travelling on a non-restricted 60 mile an hour road. This placed them at significant risk of collision with motor vehicles. No further assessment had been completed as to whether or not the home was able to meet this person's needs safely. The provider did not ensure that people's wants and needs were respected and did not provide support that prevented people from placing themselves at risk of significant harm.
The provider did not provide care and treatment in a way that appropriately managed and mitigated the risk to people's health. This led to serious risks in relation to the life, health and welfare for people using the service. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People did not have appropriate moving and handling equipment available to meet their needs safely and to promote their independence. The provider did not ensure that people unable to mobilise independently had their needs met by assisting them to receive the appropriate equipment required.

One person who was at risk of falls as a result of their medical condition required the use of a hoist to support them when they had suffered a fall to the floor. This person was situated on a floor where there was no working hoist in place to meet this person's needs. They had recently suffered a fall to the floor however they were on the top floor of the home and unable to utilise equipment to stand independently and safely as a result of the incident. Staff told us they had not been able to assist this person to stand safely using the appropriate equipment as the home's one working hoist was not on the top floor. They told us this hoist would not fit in the home's lift to allow its transportation between floors. As a result of this person's fall they had then been moved to the floor where the working hoist was available however no documentation was produced to show that this move was agreed by the person to whom it related. The provider did not ensure that there were suitable numbers of operational moving and handling equipment to be able to meet people's needs. As a result people and staff were at risk of physical injury when assisting people to move around the home.

One person who was unable to use a manual wheelchair was not being supported by staff to mobilise independently. On two occasions the person's new electric wheelchair had been arranged for delivery via email with the provider. However the person had not been aware that it was due to be delivered those days and therefore was not present to receive them. This meant that this person was reliant on staff to assist their

movement within and outside of the home. During this inspection we did not see that this person was assisted to leave the home as they wished as they were not able to do so using a manual wheelchair. The provider did not ensure that people were supported to be in receipt of the appropriate equipment to ensure their need for independence was respected and supported safely. This was a continued breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on 6 June we identified that people were not safe because there was not enough staff planned or deployed to meet people's needs to keep them safe and there was no adequate management of the staff or the home.

In anticipation of the withdrawal of local authority staff, who had been supporting the home, we asked the provider to supply suitable rotas to evidence appropriate numbers of staff were deployed in order to meet people's needs safely.

A detailed needs assessment had been conducted by the local authority to determine the minimum numbers of staff required in order to provide safe care. As a result it had been determined that a safe level of staffing was two nurses and six to seven care staff deployed for a day shift and two nurses and five staff deployed for a night shift.

We understood that the provider may need to use agency staff to meet this staffing level. The provider supplied rotas to us, after the agreed deadline, which did not demonstrate this level of staffing consistently across all shifts for the week beginning 6 June 2016.

On the 6 June 2016, we visited the home to determine whether the required staffing levels had been met to keep people safe and whether adequate staffing levels could be sustained for the following week and going forward. On arrival in the home we were told by staff that the provider had visited the home the previous day and changed the rota again. We were also told that the clinical lead had called in sick and that staffing levels on the day did not match the rota we had been given by the provider the previous day. We requested an up to date rota but were told that one could not be found. Therefore the provider could not demonstrate how safe staffing levels were planned to meet people's needs.

When we arrived on the 6 June 2016 we were told that two nurses and seven staff were on duty. However one of the nurses and one member of staff had been planned for a night duty that night. As an up to date rota could not be supplied it was not clear which staff would cover the gaps in the night duty which had arisen as a result of using night staff to support the numbers of day staff deployed. In addition one member of staff was not seen by us during our visit and we were later told they had gone home sick.

The rotas also demonstrated that there were insufficient staff planned to cover the rest of the week. For example on Tuesday 7 June there would have been no nurse on duty at all until 12 noon and no nurse on duty between 6pm and 8pm. On Thursday 9 June 2016 only four members of staff had been planned to work, instead of the required six or seven. The rota failed to evidence sufficient staff would be available throughout the week to ensure people's safety and that their needs would be met.

We discussed the handover sheet with a nurse on duty. The handover sheet recorded the needs of people living in the home. The sheet showed that of the 30 people living in the home, on our inspection on 6 June 2016, 15 required the support of two members of staff to mobilise. This meant that by not planning and deploying enough staff on duty at each shift, the provider placed people with high needs, such as those needing two members of staff to mobilise, at risk of not have their needs met.

During the inspection on the 6 June 2016 we observed that one person demonstrated behaviour which may challenge. They decided to leave the home and due to the risk to their personal safety, staff left with them. This was initially one member of staff who was later supported by another member of staff. The incident lasted 15 minutes; during this time there were only four members of staff on duty to support the needs of the remaining 29 people. The incident took place over lunchtime, a key time for staff who were needed to serve lunch and support people to eat. Extra staff had not been deployed to take account of the needs of people with behaviour which may challenge.

The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of people living in the home. This meant there were serious risks to people's life, health and welfare. This was a continued breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The provider did not ensure that people who expressed a desire to leave the home were being supported to do so. As a result the person was also being unlawfully deprived of their liberty.

Our inspection in March and April 2016 found that people had not always had their consent to live and receive care at the home obtained and documented appropriately.

At this inspection we again found that people's consent to living at Westbury House Nursing Home was not always obtained and appropriately recorded. Records did not appropriately identity whether or not people receiving care had agreed to its delivery or that those with the appropriate Power of Attorney (POA) to make those decisions had been appropriately consulted. For example, during this inspection we found that one person had been asked to sign their consent to living at the home to receive full time care. This person had not completed any of the questions on the consent form therefore it could not be established that this person had agreed to receive care prior to its delivery.
The provider did not ensure that consent was obtained from all people living at the home to ensure that they, or their legal appointed POA, were in agreement that it was in that persons best interest to remain at Westbury House Nursing Home.
This meant that there was a risk that people were receiving care which they had not agreed and were living at the home without providing consent. One person continually expressed their wished to leave the home however were not supported in doing so. As a result this person was being unlawfully deprived of their liberty.
The provider had not ensured they had gained consent from people regarding the care and treatment they received. This was a continued breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection in March and April 2016 identified that people did not always have condition specific care plans in place to manage their health needs. At our inspection on 31 May 2016 we identified that the provider had not always ensured that health specific care plans were in place or when available the guidance was followed appropriately.

One person living with diabetes became hypoglycaemic during the week prior to our inspection in May. Hypoglycaemia, also called low blood glucose or low blood sugar, occurs when blood glucose drops below normal levels. This person was at risk of falling into a potentially fatal diabetic coma and rescue medication had to be administered to ensure their blood sugar levels stabilised and brought them around from their hypoglycaemic episode. One member of staff told us that they had spoken to the agency nurse to make them aware that this person must eat food after their injection of insulin. However on this occasion the person had been left with their breakfast without the appropriate checks being made to ensure they had eaten sufficiently. As a result this person had therefore suffered an adverse and potentially fatal reaction to their insulin injection.

This person's care plan stated that their blood glucose monitoring should be recorded three times a day

however their records showed there had been significant variations in their blood glucose levels indicating that their diabetes was not being managed effectively. This placed this person at significant risk of harm as a result of not following the specific instructions of this person's diabetes care plan.

This person's care plan stated that their blood glucose levels should remain with a specific range and identified the correct amounts of insulin to be provided for each reading provided. This range was from 5 to 10 milimoles per litre of blood (mmols). Of the 48 readings taken from 16 May to 31 May on 19 of these occasions this person's blood glucose levels had been excessively high (reaching 26) and excessively low (dropping to 1.1). Both these extremes of blood glucose levels placed this person at significant risk of harm. This person had become hypoglycaemic as a result of their blood glucose levels being low and without the appropriate monitoring of their condition they were at significant risk of deterioration to their health and wellbeing.

During our inspection in March and April 2016 we identified that not all people at risk of physical deterioration owing to their health needs were supported safely or effectively. People's health needs were not appropriately assessed or managed and guidance on how to deal with people's needs effectively. When guidance was provided this was not always followed by staff.

At our inspection on 31 May 2016 we again found that staff were not always being provided with sufficient guidance to maintain and support people's health and wellbeing needs in an effective way. One person had been admitted to the home and was in receipt of respite care for a two week period. Upon their admission they were found to be suffering from an open wound which required specific care on a continuing basis. The provider did not ensure that an appropriate care plan was in place to manage this person's condition for a week after their admission. During this time the person's wound was due to be dressed every three days however this was not always happening with five days in-between dressing changes on one occasion. This exposed this person to the risk of significant breakdown in their skin integrity which placed them at risk of infection and associated health related issues. The provider did not ensure that appropriate support plans were in place for people with specific health needs and these needs were being met by staff at all times to promote people's health and wellbeing.
The provider had not ensured that they had appropriately assessed the risks to the health and safety of those receiving care placing them at risk of suffering a severe deterioration to their health. This was a continued breach of Regulation 12 (Safe Care and Treatment) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection in March and April 2016 we identified that not all people living at Westbury House Nursing Home were receiving sufficient food and drink to be able to meet their nutritional and hydration needs.

At our inspection of 31 May 2016 we found that people who were at risk or had lost weight did not always have appropriate referrals made to healthcare professionals to ensure these risks were appropriately managed. One person's care plan identified they had lost 9 kilos in a month however no further referrals or advice had been sought as a result of this significant weight loss to ensure this persons hydration and nutritional needs were being met.

Another person at risk of malnutrition and dehydration was not supported appropriately to ensure their needs were being met. Records did not show that this person was being offered a drink every hour as part of their specific care plan. No guidance had been provided to staff to ensure that a target had been identified regarding how much this person should be drinking a day to maintain their health and wellbeing. In the week prior to the inspection this person had been sick on two occasions which meant they would have lost

an amount of fluid consumed. No healthcare professional referral had been made to ensure that the risks to this person of inadequate food and drink were assessed and managed to ensure their wellbeing.

Another person had lost 5.5 kilos in a month however this was not accurately reflected in the care records, therefore; it had not been identified that action needed to be taken to ensure this weight loss did not continue. This person's care plan stated that they were 'Eating and Drinking well' despite losing 5.5 kilos in a four week period. This person had been last been assessed using a Malnutrition Universal Screening Tool (MUST) in February 2016 before their rapid weight loss had commenced. This is a five-step screening tool to identify persons who are malnourished, at risk of malnutrition or obese. It allows providers to quickly and accurately assess those persons who require additional support to remain their health. No appropriate referral had been made to ensure that this person's weight loss was appropriately documented and managed so it did not continue.
The provider did not ensure that people were always receiving the food and drink they required to ensure their health needs were being met appropriately. This was a continuing breach of Regulation 14 (Meeting nutritional and hydration need) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Since our inspection on 21 and 22 March and 4 April 2016 we had reported to the provider multiple breaches of regulations. The provider had submitted action plans telling us how they would meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014. However the registered manager was not managing the home on a daily basis and we could not see that the actions had been fully completed. As a result, the lack of management had impacted on the care people received and had contributed to the continuation of the multiple breaches identified.

In addition we had been in regular contact with the provider in the days leading up to our visit on 6 June 2016 about our concerns in respect of staffing levels and how they would ensure people would be kept safe. However, when we arrived in the home on 6 June 2016 the registered manager and the provider were not present and the clinical lead (who was also expected to carry out nursing duties as well as manage the home) had called in sick. The provider had not ensured there was suitable managerial support for staff delivering care. They were not able to provide assurances of how staffing levels would be deployed to ensure people's safety and well-being.

During our inspection on 6 June 2016 the provider's financial controller told us he was managing the administration of the home; however he had no clinical or care qualifications or experience of managing a nursing home. They were unable to answer any of our queries about the staff rota, such as which staff were currently on duty and how the night shift staffing gaps would be covered. He referred these questions to the receptionist who demonstrated they were unable to provide the answers to our concerns. On the day of the our inspection on 6 June, there was no clear management or effective leadership in the home to direct staff and ensure the care being delivered was safe and effective. People were at risk of serious harm because staff were unaware of which staff were covering shifts and how care would be planned to mitigate risks to people.

The provider and the registered manager said they were unable to attend the home on 6 June because they were in London. The provider and the registered manager failed to d respond appropriately to serious staffing issues and the resulting concerns identified during this and previous inspections.

Staff on duty had failed to provide a duty rota on request because it had been lost. It was not clear why there would be only one copy of the duty roster as staff would need access to this information in order to attend their shifts. By not maintaining suitable accurate records of staff rotas, the provider had caused confusion, as it was not clear which staff were supposed to be working and when. An hour after our request, and just as we were leaving the home, we were provided with a rota which included crossings out and changes but crucially still did not demonstrate the staffing levels required for each shift to provide safe care.

The provider did not assess and mitigate the risks to people and did not maintain accurate records of the management of the regulated activity, particularly in relation to staff levels. This led to serious risks in relation to life, health and welfare for people using the service. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.