Weatherstones House Care Limited

Weatherstones House Nursing Home

Inspection report

Chester High Road
Neston
Cheshire
CH64 7TD

Tel: 01513368383

Date of inspection visit:
13 May 2021

Date of publication:
07 July 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Weatherstones House Nursing Home is a residential care home providing personal and nursing care to 14 people aged 65 and over at the time of the inspection. The service can support up to 31 people in one adapted building.

People's experience of using this service and what we found
The governance and oversight of the service was inadequate. Insufficient arrangements had been put in place by the provider to ensure safe and effective oversight of the quality and safety of the service people received. This placed people at risk of harm and of not receiving care to meet their needs.

Quality assurance systems were not robust and had not identified areas that needed improvement. Records relating to people's care, staff training and the overall management of the service were not all up to date and had not always been accurately completed. Systems in place to check the completion of medication administration records (MAR) were also not effective. There were no systems to routinely analyse accidents and incidents for themes and trends or to check that documentation relating to fire safety was up to date and accurate. These failures increased the risk that the support people received would not meet their needs.

The provider had not fully implemented COVID-19 guidance to reduce the risk of infection. People were not consistently monitored for signs and symptoms of COVID-19; Personal Protective Equipment (PPE) was not always disposed of appropriately. Although visiting was taking place, there were no cleaning schedules for the 'visiting pod' or high touch points and deep cleaning schedules were not being followed. Visitors were not screened for signs of COVID-19 or asked to produce evidence of a negative test and the provider had no records to demonstrate staff were completing COVID-19 rapid result tests, in line with government guidance.

We raised our concerns with the provider and sought assurances they would address these issues. On the second day of the inspection we found improvements had been made however the issues relating to cleaning schedules had not been addressed. This placed people at increased risk of infection.

People were not always protected from harm. The management of 'as required medicines' (PRN) and topical creams was ineffective, and records did not demonstrate they were administered as prescribed and intended. Care plans did not always contain up to date and appropriate risk assessments and guidance for staff to follow. Accidents, incidents had not been reviewed and associated risks minimised. Documentation relating to fire safety including fire risk assessments and peoples' personal evacuation plans (PEEPS) were not up to date. This placed people at increased risk of harm in the event of a fire.

The recruitment of staff was safe. Relevant identity and security checks had been completed before staff were employed and staff were deployed in sufficient numbers to meet people's needs. Staff knew people well. People told us staff were kind.

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 29 November 2018).

Why we inspected
We undertook a targeted inspection as part of CQC's response to the COVID-19 pandemic to look at the infection control and prevention measures the provider had in place.

We inspected and found there was a concern with the overall management of the service and the lack of provider oversight so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safety and governance of the service.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

Inadequate

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Weatherstones House Nursing Home

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 Care Act 2014.

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 carried out by one inspector.

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

The service had a manager registered with the Care Quality Commission. However, they were no longer working at the service and the day to day management of the service was overseen by another manager.

Notice of inspection
We gave the service 48 hours' notice of the first day of the inspection. This was because we needed to be sure that the provider or manager would be in the office to support the inspection.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with people who used the service about their experience of the care provided and one person's relatives. We spoke with 12 members of staff including the provider, manager, a nurse, an agency nurse, four care workers, the housekeeper, activities organiser, kitchen, laundry and domestic staff. We sought feedback from the local authority and the local clinical commissioning group (CCG) who also shared with us feedback from the local GP.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures, were reviewed.

After the inspection
We requested records and documentation to be sent to us and reviewed these following the inspection visit. We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection; Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

- Policies and procedures in relation to COVID-19 had not always been implemented and followed. The service was not always clean. There were insufficient cleaning schedules and deep cleaning was not taking place. This placed people at increased risk of infection.
- The management of 'as required medicines' (PRN) was ineffective. Staff did not have access to guidance for when PRN medicines, such as painkillers, could be administered. In addition, the rationale for administering these medicines had not been recorded. Therefore, we could not be assured they had been administered as prescribed and intended and the provider had no way of monitoring their effectiveness.
- There were many gaps in the medication administration records (MAR) for topical creams. Therefore, it was not possible to assess if these had been administered or not.
- Care plans did not always contain up to date and appropriate risk assessments to meet people's care and support needs. This meant people were exposed to a risk of harm and staff did not have appropriate guidance on how to manage and mitigate risk to people.
- Accidents, incidents and unexplained injuries were not always recorded appropriately. Those that had been recorded had not been reviewed to look at how risks could be minimised in the future. This placed people at risk of the possibility of harm.
- The fire risk assessment, emergency evacuation risk assessment and peoples' personal evacuation plans (PEEPS) were not up to date. This placed people at increased risk of harm in the event of a fire.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- On the first day of the inspection we found used Personal Protective Equipment (PPE) disposed in multiple bins within bathrooms/toilets rather than within designated clinical waste bins. Visitors were not screened for COVID-19 or asked for their contact details to support track and trace. Peoples temperatures were not routinely monitored, and the provider had no overview of the rapid result test results for staff. We wrote to the provider asking for an action plan outlining how they would address these issues. On the second day of the inspection we found improvements had been made.
- We also identified an internal door to the 'visiting pod' within the conservatory, which had been in place for six months, was blocking a fire exit. We raised this issue with the provider who took immediate remedial action.
- People received their regular medication from appropriately trained staff. These medicines were stored securely and managed safely.

Systems and processes to safeguard people from the risk of abuse

● When incidents of unexplained bruising had occurred, these had not been reported to the local authority safeguarding team in line with local protocols. This is an area of practice that needs to improve.

●The manager and staff told us staff had completed training in protecting people from abuse.

● People told us they felt safe. One person told us; "Yes I feel safe. They come quite quickly when I use my call bell". A relative commented "I think my relative is safe here. They look well cared for. I have no complaints about that".

Staffing and recruitment

● There were sufficient numbers of staff on duty to meet people's needs at the inspection. However staffing levels were not determined by an assessment of people's needs and were inconsistent. Fewer care staff worked at a weekend and cleaning staff only worked five days a week. The manager explained they had experienced difficulty recruiting staff particularly at weekends but were in the process of recruiting more staff.

● Recruitment processes were safe. Appropriate pre-employment checks were carried out to ensure that only suitable people were employed.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;

- The registered manager had been absent from the service for a significant period of time and had now left the service. The provider failed to demonstrate any oversight of the completion of audits and checks on the quality and safety of the service people received during this period. This placed people at risk of harm and of not receiving care that meets their needs.
- The provider had not ensured the systems and processes for monitoring quality and safety were effective. Audits had failed to identify shortfalls and improvements needed in the quality of the service people received and in the safe management of risk to people. This meant people were not always protected from the risk of harm.
- There had also been a lack of provider oversight of the adherence to the COVID-19 government guidance and infection, prevention and control guidance for care homes. Some of the systems implemented during the pandemic to reduce the risk of COVID-19 had not been consistently followed; others had not been implemented at all.
- Records of people's care were not all up to date. Care plan audits identified if care plans were complete and had been reviewed but did not check whether the information, they contained accurately reflected people's needs. This increased the risk the support people received would not meet their needs.
- Medication audits had failed to identify gaps in the medication records administration records (MAR) for the administration of topical creams. Medication audits also failed to identify the lack of guidance for staff to follow for when to administer 'as and when needed' medicines. The reason why 'as and when required medicines' had been administered had not been recorded; therefore the provider had no way of monitoring the effectiveness of those medicines.
- The audits in place had not identified the shortfalls relating to the management of health and safety. There were no systems in place to routinely analyse accidents and incidents for themes and trends or to check that documentation relating to fire safety was up to date and accurate. There were no systems in place for monitoring whether staff had completed training essential to their role and had the skills they needed to meet people's needs. Therefore, risks to the health, safety and welfare of people had not been appropriately managed and mitigated.

There had not been sufficient oversight of the safety and quality of the service being provided for people. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider had not ensured that CQC and other relevant agencies had always been informed when accidents and incidents had occurred. This is an area of practice that needs to improve.

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

● Records in relation to people's care did not always contain adequate information and were not always fully completed. This meant it was not possible for the provider to assess if people received the care they needed and if this care promoted good outcomes for people. This is an area that needs to improve.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People's wishes to see their relatives were documented. Records of people's contact with their relatives and visiting professionals had been maintained.

● Records of discussions with the relatives and healthcare professionals of some people who lacked the capacity to make certain decisions, was documented.

Working in partnership with others

● The service worked closely with the local GP during the COVID-19 pandemic.

● Feedback from some health and social care professionals was that the service had not always engaged well in local initiatives and offers of support.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(1)(2)(a)(b)(d)(e)(g)(h)The provider had failed to ensure that risks to people's health, safety and welfare had been appropriately identified, assessed and mitigated or that medication was always administered as prescribed and intended.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1)(2)(a)(b)(d)(f) The providers governance, assurance and auditing systems had not effectively assessed, monitored and driven improvement in the safety of the services provided. The provider had not assessed, monitored and mitigated risks to people's health, safety and welfare. Records were not always accurate and complete.

The enforcement action we took:

A Warning Notice was issued.