Leisure Care Homes Limited

Westcotes Residential Care Home

Inspection report

70 South Parade
Skegness
Lincolnshire
PE25 3HP

Tel: 01754610616

Date of inspection visit:
26 October 2017

Date of publication:
22 January 2018

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

The inspection took place on 26 October 2017 and was unannounced.

Westcotes Residential Home provides residential care for up to 17 people, including older people and people living with dementia. There were 17 people living at the home on the day we inspected.

There was a registered manager for the home. 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.

At the last inspection the service was rated as requires improvement.
At this inspection the rating remains as requires improvement.

The provider was not meeting the legal requirements in relation to good governance and the safe management of medicines. They had not ensured that the systems to monitor the quality of care were effective and had not taken action when they had gathered the views of people living at the home. In addition the systems in place to manage medicines did not support people to received as required medicines in a consistent manner or to monitor the effectiveness of the medicines. You can see the actions we have asked the provider to take at the back of this report.

There were enough staff available and staff received training to ensure that they delivered people's care safely. Staff knew how to raise concerns if they had any worries over people's safety. However, at times due to breaks staff were not in the communal areas monitoring people's needs. In addition people were felt staff were not able to spend time chatting to them and there was not enough planned activities to keep them engaged and entertained.

Risks to people's care had been identified and care was planned to keep them safe. In addition care plans contained the information needed to provide safe basic care to people. However, risks assessment and care plans did not contain the information needed to personalise care to people's individual needs.

People's rights under the Mental Capacity Act 2005 were respected and where people had capacity they were supported to make decisions and to take positive risks. However, the registered manager had not consistently identified where people were unable to consent to living at the home and were under constant supervision. Therefore some referrals to the Deprivation of Liberty Safeguards supervisory authority had not been made.

The environment and furnishings were not always safe and did not support the needs or ensure the privacy of people living at the home. Some equipment was not working correctly and this impacted on the care people received. There were no secure outside space for people to enjoy.

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 consistently safe.

Medicines were ordered and stored safely. However, there were no protocols in place to support staff to administered medicines prescribed to be taken as required in a consistent manner.

Risks to people were identified and care was planned to keep people safe.

There were enough staff to meet people's care needs.

Staff knew how to keep people safe from abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The environment and furniture did not support people to receive safe effective care.

People were happy with the food provided. However, systems to monitor people's weight did not always identify concerns.

People's ability to make decisions was assessed. However, people's ability to retain information was not always considered when assessing if they could make an informed decision.

Staff received training and support to enable them to provide safe care.

People were supported to access healthcare professionals and advice when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People who spent time in their bedrooms felt isolated.

People's choices around food were limited.

People's privacy was not always supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not always reflect how care could be tailored to people's individual needs.

People's well-being was not supported with engaging activities.

People knew how to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to monitor the quality of care provided were not effective and action was not always taken to improve the quality of care.

Surveys to gather the views of people using the service had been completed but no action had been taken to drive improvements forwards.

Care and health and safety concerns were not always meeting best practice guidelines.

Westcotes Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 26 October 2017 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care home.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During the inspection we spoke with five people who lived at the home, one visitor to the home and spent time observing care. We spoke with the registered manager, the cook, the senior care worker and a care worker.

We looked at four care plans and other records which recorded the care people received. In addition, we examined records relating to how the home was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

Systems to ensure people received their medicines in a safe consistent manner were not always adequate. For example, systems in place to support staff when medicines were prescribed to be taken as required were not always in place. Where people were asked if they wanted pain relief the member of staff did not ask them about where their pain was and how badly it hurt. This meant that they would be unable to monitor if the person was regularly in pain from a certain area and may benefit from medical advice and support. In addition, a person had been prescribed a medicine to help them manage their emotions when they became distressed. There was no information in their care plans or in the medicine administration records of when this medicine should be offered to the person. We checked other people's as required medicines and they also did not have a protocol in place to show when they should be given. Furthermore there was no record to show why they had been given and if the outcome for the person had been positive.

Some medicines were not used in line with the prescription. For example, a cream which had been prescribed to be administered every day was being administered on an as required basis. There was no explanation of why this was happening. We also saw a painkiller for a person was prescribed to be taken every day but was also being offered on an as required basis.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

There were systems in place to ensure that medicines were reordered in a timely fashion. This meant that people's medicines were available for them when needed. Medicines were stored safely so that there was no unauthorised access to them. The temperature that medicines were stored at was monitored to ensure that it remained within the appropriate ranges. Medicines that had been dropped or were no longer required were returned to the pharmacy.

People told us that they felt safe being in the home. One person said, "I feel safe with all the staff."

Care plans considered peoples' well-being and the risks of them being abused. This was reviewed monthly to ensure action was taken to keep people safe. Staff we spoke with had received training in safeguarding people from abuse. They knew what signs to look out for which may indicate signs of abuse. The number for the local safeguarding authority was available to staff in the office. Staff told us that they were happy to raise any concerns or worries they had with the registered manager.

People told us that staff supported them to move safely and appropriate equipment was available. One person told us, "I'm happy with the carers, I always feel safe with them."

Risks to people's health were identified and managed appropriately. For example, assessments had been completed which highlighted people's risk of developing pressure ulcers. Where needed specialist equipment had been put in place and care plans identified when people needed support to reposition themselves during the day and night to relieve pressure.

We saw that the risks people faced when mobilising both indoors and outdoors had been assessed. Where needed equipment such as fames and hoists were used to support people to move safely around the home. However, where people needed the hoist to support them to move there was no record of the size of sling that they should use.

People's abilities in an emergency had been considered. Personal emergency evacuation plans were in place to support the emergency services to evacuate the home in a timely and orderly manner. There was a business continuity plan in place. This ensured staff were clear on what action to take and who to contact in an emergency. In addition, the provider and registered manager had identified safe accommodation for people if the home was unable to be occupied.

People told us that the staffing levels supported them to receive safe care. One person told us, "My bell is always within reach, I don't have to wait too long when I ring unless they're busy." Another person said, "I'm checked every two hours at night."

There was no formal assessment of people's needs and the numbers of staff needed to support people living at the home. However, the registered manager told us that they would monitor staffs' workload and if needed would schedule more staff to work. They told us that they did this if they had a person whose needs increase such as when people's dementia deteriorated or if people were at the end of their life.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. However, they had not always gathered a full work history from the person in line with our regulations. This meant that the provider may not have been able to see if the person had performed well in previous care jobs. The required disclosure and barring checks had been completed to ensure that staff were safe to work with people who live at the home.

Requires Improvement

Is the service effective?

Our findings

The environment did not support people to receive care that met their individual needs. At the time of our visit the stair lift was not working correctly and staff had to fiddle with the controls to make it work. One person told us, "My friend usually takes me out but couldn't today as the stair lift wasn't working."

In addition, the lift to support people to get in and out of the bath on the first floor was broken. One person told us that they had chosen not to have a bath for two weeks. They told us, "I don't like the downstairs bathroom." Another person said that they did not feel safe using the downstairs bath. They said, "The bath tips back too much." Following the inspection the registered manager contacted us to tell us that both the chair and bath lists had been repaired.

Furthermore the home did not have a lift and so the access to the first and second floor was by the stair lift. This had restricted people's ability to return home following treatment in hospital. The registered manager told us about a person who was waiting return to the home but at present was unable to due to them having a plaster cast on their leg and so they were unable to use the stair lift.

The outside of the home had recently been renovated and painted to ensure that it was all in good order. However, some areas of the home were in need of decoration. For example, where lights and other fittings had been moved around in people's bedrooms action had not been taken to make good the ceiling and repaint. We also saw that some of the wall plasterwork was cracked and in need of repair and redecoration. Some of the furniture was old and worn and a bookcase in the lounge was falling to pieces. Signage on the toilet and bathroom doors was poor and not dementia friendly. There were no shower facilities so that meant people were unable to choose if they wanted a bath or a shower.

There was limited access to outside space and there was no private secure garden area only concreted front patio. This meant that people living with dementia would be unable to access outside space without being monitored closely. One person told us, "There's not much chance to get out, we can sit out front but we're on view to everybody."

People's risk around being able to maintain a healthy weight were not always recorded. We identified several people who were at risk of malnutrition as their BMI was at the bottom of the normal range. Additionally some of these people had been losing weight recently. There was no care plan in place to support these people to consume enough calories to stay healthy. Records of food intake did not accurately record how much food people had eaten to allow staff to monitor people's intake. In addition, the registered manager had not identified these risks as they had told us that there was no one who was nutritionally at risk at present.

One person was waiting for their lunch while the rest of the people sat at the table were eating. This was because they were waiting for a member of staff to support them. The member of staff did not engage them in a conversation about their food or ask what they wanted to eat first. They said that they did not like the sausage and so did not eat it. No alternative was offered.

The cook and other staff told us that they were aware of knew people's food likes and dislikes and if anyone required a special diet, for example, vegetarian or diabetic.

The member of staff took none of the opportunities offered to engage with the person and encourage them to eat a healthy amount of food. They mashed the person's food up and offered each mouthful without saying what was on the fork. When the person said they did not want any more the member of staff did not encourage them at all. Records showed that this person was not eating and drinking well and needed support to maintain a healthy weight.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. No one living at the home had a DoLS in place. The registered manager told us that it was, "Clear everyone living at the home has the ability to make decisions." However, care plans showed that people may not always have capacity to understand their decisions. One care plan we looked at noted that the person was living with dementia and that while they understood what was being said they would forget shortly afterwards. The MCA assessment needs the person to be able to retain the information for them to be able to make a decision. Therefore we could not be certain that people living at the home were having their rights protected. Following the inspection the provider told us they would ensure that the required DoLS applications were submitted.

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.

Staff had received training in the MCA and told us how they supported people to make decisions and respected those decisions. Staff also ensured that people had all the information needed to make a decision. For example, a person at the end of their life was offered pain medicines, but were worried about taking them as they were concerned about the effect they would have. Staff explained to them what the medicine did and how it would support them to be pain free Once the person had all the information about how the medicine would affect them they chose to take the medicines. This was important as this support helped them to have a pain free dignified death. The person had expressed a wish to die at the home and using the pain relief enabled them to stay at the home instead of going to hospital.

People who had capacity were also supported to make decisions about their lives. An example of this was one person often went out of the home and crossed the road to sit on the seafront. We watched them cross the road and were worried for their safety. We discussed this with the registered manager who had the same concerns. However, they had discussed the risk with the person who had the capacity to understand the concerns and still wished to be independent when crossing the road. Therefore staff supported their decision and while they kept a watch over them so that they could go and offer support if needed the person retained their independence over this part of their life.

New staff were required to complete mandatory training and were offered the opportunity to complete the care certificate and a nationally recognised qualification. The care certificate is a set of national standards which cover the skills staff need to provide safe care. The registered manager made it mandatory that they

completed one of the two courses offered. Staff told us new members of staff completed shadow shifts and it would be planned that they worked with an experienced member of staff to start with. New staff met regularly with the registered manager to discuss their progress and so that more support could be offered if needed.

Refresher training was in place to support staff to remain up to date with changes in legislation and best practice. The registered manager had planned all the training required for the coming year to enable staff to provide safe care.

Staff told us the registered manager had regular meetings with them to discuss the quality of their work. In addition, this was a time staff could raise any concerns that they had with the registered manager. Staff were positive about the support they received from the registered manager and said that they were quick to complement staff on a job well done.

People were supported to access healthcare professionals when needed. One person told us, "If I need a doctor they arrange one for me without any delay." Individual care plans included all the information needed to support people's day-to-day health needs. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed. Hospital passports were in place to support people to receive appropriate care if they have to go to hospital.

Requires Improvement

Is the service caring?

Our findings

People told us that they had a good relationship with the staff at the home. However, those people who chose to spent time in their bedrooms told us that they felt a little isolated and that staff did not have time to meet their need to engage with people. One person told us, "I would like to see more people during the day, often it's only when they bring drinks round or fetch me for lunch." Another person told us, "There's no time for chat, they just seem too busy. I often don't see anyone all afternoon except when they bring drinks."

We saw at several times during the day that all the staff sat down and took their breaks together. This meant that there was no one supporting people in the communal areas, although staff did respond to call bells. This was not supporting people's needs. One person said, "They all take their break at the same time, it leaves the lounge unattended." We also saw that care staff sat together to eat their lunch, there was a person sat it the dining room with them, but they chose not to engage with the person at all.

In addition, some staff were not always caring. For example, one lady requested a cup of tea from a member of staff when they took their empty cup away. This member of staff did not bring the person a fresh cup of tea. They then asked the cleaner if they could have another cup of tea and the cleaner brought them one. Some staff were supportive of people's needs. These staff volunteered to work without pay to support people to access the community. For example, a Christmas meal had been booked and staff were supporting people to attend this unpaid.

People's independence was supported with their care plans. Each record had a clear description of what tasks people could still achieve themselves. Care plans also encouraged people to be independent. For example, one care plan recorded to increase a person's independence they should be monitored but not supported straight away. This was to allow them the time to complete the task themselves. One person told us, "I can use the stair lift on my own. I've been shown how they work and I feel safe."

People's communication abilities were recognised. For example, people's vision was noted and if they needed any glasses as well as their ability to hear. This maximised people's communication abilities which supported them to make choices.

Choice around the food was limited. There was a single main meal provided each day at lunchtime. In addition, the breakfast offered was cereal or toast. There was no access for people to have a cooked breakfast if that was their preference. People who were able to make choices about their lives told us that they were happy with the quality of the food provided. One person told us, "The only thing I don't like is lamb but I do get an alternative." Another person said, "The food is excellent, I'm quite satisfied with the single option for lunch." We saw that one person had requested a different pudding to everyone else and this had been provided for them. However, where people may not have been able to voice their choices we saw that their dislikes were not always respected. Two people commented that they did not like the sausage which was on their plate and refused to eat it.

Privacy was not always supported. One person was waiting to use the toilet. The registered manager

pointed them in the direction of another toilet they could use. The person told the registered manager, "I don't like that one as someone always walks in." We raised this with the registered manager who told us there was no lock on the door and no signage to show the room was occupied.

There was no clinical room in the home. We saw that the community nurse came to see a person to give them an injection. The person was taken to the nearest bathroom to have an injection in their stomach. The door was not closed and we could hear everything that was said to the person this did not respect their privacy or their dignity. A member of staff was with the person and at no time did they take action to support the person's need for privacy.

One of the bedrooms is a shared room. People's privacy was protected with a screen. However, it was not large enough to support people's dignity. In addition, people's care plans did not show that they had made a positive choice to share their bedroom.

Requires Improvement

Is the service responsive?

Our findings

People living at the home all told us that they were happy there. People had been involved in planning their care. Care plans had been regularly reviewed by the registered manager, staff and the person living at the home or their representative.

Care plans contained the information staff needed to provide the basic personal care that people needed. However, more information was needed to ensure staff could tailor the care to people's individual needs. Care plans also contained the information needed to provide safe care to people with long term conditions. For example, some of the people person living at the home had diabetes. Their care plans recorded how often their blood sugars should be checked and information about their diabetic medicine. Staff were able to tell us about people's needs and how they liked to receive their care and this reflected the information that was recorded in their care plans.

In the care plan each risk assessment contained an objective around what the person would like to achieve in this area. For example, we saw one person's mobility risk assessment showed that they wished to increase their independence with their mobility when outdoors. However, there was no corresponding care plan in place to show how this improvement was going to be achieved.

When people were at the end of their lives the registered manager and staff worked with other healthcare professionals to keep them comfortable and safe. Where ever possible people's wishes to remain at the home were respected. Anticipatory medicines were available at the home for healthcare professionals to access if the person's pain levels increased.

People were not always supported to be busy and engaged. There was no dedicated activity coordinator, the staff were expected to provide activities to keep people engaged. The only regular activity was a weekly visit by a fitness instructor and by a hairdresser. The staff arranged activities such as bingo when they had the time. People living at the home had noticed the lack of activity and interaction at times. One person told us, "The only regular activity is the fitness lady."

Prior to our inspection we received information that a relative was not happy about the way their complaint had been handled. We reviewed this information with the registered manager and could see that they had followed their policy and had engaged with the ombudsman when the relative escalated their complaint

Information on how to make a complaint was available to people in their care plans and displayed in the entrance hall. People we spoke with all knew that they could take to staff or the registered manager to raise a concern. None of the people we spoke with had felt the need to raise any concerns.

Requires Improvement

Is the service well-led?

Our findings

The provider had not ensured that there was good governance in the home. Audits to monitor the quality of care provided were completed on a monthly basis. Some of the concerns we found had been identified by the regular audits and the registered manager had identified the actions needed to improve the quality of care provided. We could see that these actions had not always been completed and there were no timescales planned. We discussed this with the registered manager who explained that they had taken all the actions that they could but that some actions needed to be approved by the provider. However, the audits had not identified all of the concerns we found during the inspection. For example, the concerns over people's ability to maintain a healthy weight had not been identified.

Good practice guidelines had not always been put in place. Appropriate action had not been taken to ensure improvements in the kitchen were made. The home had been visited by the local authority that had inspected the kitchens on 13 October 2017. They found that the provider had not made any improvements since their last visit and had downgraded the scores on the doors food hygiene rating from four to three out of five. The cupboard used to store chemicals was unlocked. Although it was not in an area of the home people would often go into there was a risk that people could accidently access these products. We discussed this with the registered manager who found the key to the cupboards and told us they would ensure that it was always locked going forwards.

The registered manager attended the local infection control meetings to ensure that they kept up to date with any changes in legislation. However, they had not complied with the health and safety regulations around the testing of the water systems to reduce the risk of legionella. In addition, the cleaner did not have a cleaning schedule to work to so we could not be sure that all areas of the home were cleaned in line with current infection control standards.

People's views on the quality of care provided were gathered at residents' meetings and by using surveys. Residents' meetings were held every three months. The registered manager told us that during the meetings people always commented that they wanted to go out in the community more. However, the ability of the provider to support this was limited as they would need to hire a mini bus and schedule more staff to support people.

We saw that residents' and relatives' had been surveyed for their thoughts on the home. However, there had been no analysis of the responses and no plans put in place to drive areas identified for improvement.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

People living at the home and their relatives knew who the registered manager was and felt comfortable talking to them. They told us they could speak with the registered manager at any time as they were always available.

Staff told us that they felt supported by the registered manager and were confident about raising concerns with them. Staff meetings were held every three months or sooner if there was anything urgent to discuss.

The provider's registered office address on companies house was different to their registration address with the CQC. We raised this with the registered manager and asked that they ensure that both addresses are the same.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured the safe management of medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured that the quality assurance systems were reliably managed so as to enable them to identify and resolve any shortfalls in the service provided for people. Regulation 17 (1) (2) (a) (b) (f)