The Leaders Of Worship And Preachers Homes

Westerley Residential Care Home for the Elderly - Woodhall Spa

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

About the service
Westerley Residential Care Home for the Elderly – Woodhall Spa is a residential care home which provides accommodation and personal care for up to 30 older people. Accommodation is provided over 3 floors, with a passenger lift available. At the time of the inspection 28 people were living at the home.

People's experience of using this service and what we found
Risks to people's health and wellbeing were not being managed effectively and people did not always live in a clean, safe environment. Care documentation did not include up to date information about some people's needs and risks to guide staff. There were inadequate systems in place to ensure there were sufficient staff available to meet people's needs and monitor their safety. Medicines were not managed safely, in line with national guidance. Improvements were needed to staff recruitment processes, to ensure appropriate checks were completed before staff started working at the service.

People did not always receive support which reflected their assessed needs. Some people did not receive support when they needed it and people's safety was not always monitored effectively. Some staff had not received an appropriate induction or completed the training necessary to support people effectively. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. Some people did not receive appropriate support with their dietary and healthcare needs and risks. The home environment needed to be improved to ensure it met the needs of people living with dementia.

People did not receive personalised, high-quality care which resulted in good outcomes for them. Many audits of quality and safety were not being completed regularly. When audits had been completed and shortfalls identified, the necessary improvements had not always been made. Many of the shortfalls we identified during the inspection had either not been identified by the manager or provider or had not been acted upon. This meant that appropriate standards of quality and safety were not being maintained at the home. There was limited evidence of engagement with people or relatives to gain their views about the care provided. There was a lack of appropriate oversight of the service by the provider; their visits and telephone calls to the service had failed to effectively monitor how the service was being run, the quality of care people were receiving and standards of quality and safety at the home.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 November 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 25 August and 1 September 2022. Breaches of legal requirements were found. We issued the provider with a warning notice.

We undertook this focused inspection to check the provider had complied with the warning notice and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Westerley Residential Care Home for the Elderly – Woodhall Spa on our website at www.cqc.org.uk.

Enforcement and recommendations
At this inspection, we have identified breaches in relation to the management of risks to people's health and welfare, medicines management, infection prevention and control, the safety of the premises, staffing levels, staff training, safeguarding people from abuse and improper treatment and the provider's oversight of the service.

We have made recommendations in relation to staff recruitment and providing a dementia friendly environment.

You can 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 met with the provider shortly after our inspection to discuss our findings. We will continue to monitor information we receive about the service, which will help inform when we next inspect and will work with the local authority to monitor progress.

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 of 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 safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Westerley Residential Care Home for the Elderly - Woodhall Spa

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 carried out by two inspectors 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 service.

Service and service type
Westerley Residential Care Home for the Elderly – Woodhall Spa is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Westerley Residential Care Home for the Elderly – Woodhall Spa is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 not a registered manager in post. The previous registered manager had left the service in December 2022 and the deputy manager at that time had taken over as the manager of the service in January 2023. The manager who had taken over the running of the service in January 2023 left the service shortly after our inspection.

Notice of inspection
The first day of the inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 spoke with 7 people who lived at the home to gain their feedback about the care and support they received. Some people were not able to give us verbal feedback, so we observed their body language and interactions with staff to gain feedback on their wellbeing. We spoke with 5 visiting relatives/friends and several staff, including the manager, the deputy manager, care staff, housekeeping staff and an activities coordinator. We observed staff supporting some people in communal areas. We also spoke with the nominated individual, who is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records, including 12 people's care records and a selection of medicines records. We reviewed 2 staff members' recruitment files, staff supervision and training records and a variety of records related to the management of the service, including audits. We contacted 5 community healthcare professionals who had regular contact with the service, for their views about the care and support provided.

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 we rated this key question requires improvement. 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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● The provider had not ensured the home environment was safe. Water temperature was not being controlled to keep it at safe levels and not all checks completed to protect people from the risk of legionella, which can cause legionnaire's disease, a flu-like illness, had been documented. Window restrictors were not being checked to ensure they were secure, access to the kitchen area and substances that could be hazardous to health (COSHH) was not restricted and radiators did not have covers where appropriate to prevent people from being burnt.
● People were not always protected from the risk of fire. For example, the laundry door was propped open, fire drills were not being completed regularly and actions from a fire risk assessment had been completed after the required deadline.
● Risks to people's health and safety were not always managed effectively. When some people had fallen, their health and wellbeing had not been monitored effectively following the fall. This put people at risk of further harm.
● People's care documentation did not always include accurate information about their risks to guide staff about how to support them safely. For example, some people were at risk of falling and this was not reflected in their care plans and risk assessments. This meant staff may not know how to support them safely.
● Keypad locks had been fitted to two of the staircases in the home to keep people safe, but three staircases remained without any restrictions. This put people at risk of falling. Some people had bed rails in place, but no risk assessments had been completed to ensure this was the safest and most effective way to support them.

The provider had failed to ensure the safety of the home environment and that risks to people's health, safety and welfare were managed appropriately. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the manager, who arranged for water temperature issued to be resolved;

this was completed on the third day of our inspection. The manager assured us that following the inspection, fire drills would be completed regularly and all legionella checks would be documented. This meant that quality checks of these areas had not been evidenced during the inspection and we could not be assured they were embedded into practice.

Preventing and controlling infection

● Cleanliness and infection prevention and control practices at the home needed to be improved. Three bedrooms had not been cleaned effectively, we saw cobwebs on one person's bedroom window and the toilets in two people's en-suite bathrooms were unclean, with dried excrement.

● Kitchen cleaning records had not been completed consistently to evidence that appropriate cleaning had been completed. There were strong malodours throughout the home on day one of the inspection, including urine. This was better on days two and three, though there were some areas of the home with lingering odours.

● A number of people living at the home, visitors and staff raised concerns about the cleanliness of the home environment. A relative told us, "The floor (in their family member's room) is often unclean and the en-suite is sometimes smelly." A staff member commented, "There aren't enough staff to keep the home as clean as it should be."

The provider had failed to ensure that people were protected from the risks associated with poor infection prevention and control practices. This placed people at risk of harm. This was an additional breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager assured us that the issues we identified would be addressed with increased cleaning being undertaken and some flooring being replaced. We will assess this at our next inspection.

Staffing and recruitment

At our last inspection, the provider had failed to ensure that staffing levels met the needs of people living at the service. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The provider had failed to ensure there were enough staff available to meet people's needs. Staffing rotas showed the service was often not staffed at the level set by the provider, which included care staff and ancillary staff. The manager explained the staffing levels that should be in place during the day and night and we noted from the staff rotas and agency staff records we reviewed, that those levels were not always maintained. This meant that the service was not being staffed at the level the provider felt was appropriate to meet people's needs.

● The staffing calculator we received from the manager was unclear and related to staffing levels for 19 people, not 28 people, which was the number of people living at the service at the time of the inspection. Not all care documentation included clear, up to date information about people's risks and needs, which would have affected the accuracy of any staffing tool being used. For example, two people were at risk of falling but records showed that no falls risk assessments had been completed. This meant the number of staff felt by the provider to be appropriate to meet people's needs, was not based on up to date, accurate information about the needs and risks of everyone living at the service.

● Many of the people living at the home, relatives and staff we spoke with told us staffing levels were not

appropriate to meet people's needs and monitor their safety. People told us, "The staff are nice. They try their best, there's just not enough of them. I have to wait for support to the toilet and I can't have a cup of tea when I want one because they're too busy" and "The staff never have time for anything." A relative told us, "Lots of things are not done as they should be because the staff are very busy." Two visiting professionals told us the home was sometimes short staffed.

The provider had failed to ensure there were always sufficient staff available to meet the needs of people living at the home. This placed people at risk of harm. This was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns regarding staffing levels with the manager and the provider. They told us staffing levels would be reviewed.

● Some improvements were needed to staff recruitment practices. We looked at two staff recruitment files and found that appropriate criminal record checks had been completed before staff started working at the service. However, both files had information missing, including references and identification documents.

We recommend the provider considers current guidance on the safe recruitment of staff and takes action to update their practice accordingly.

Using medicines safely

● Medicines were not managed safely, in line with National Institute for Health and Care Excellence (NICE) guidance. Stock levels of some people's medicines did not match the records kept by staff, handwritten medication administration records (MARs) were not signed, and medicines errors were not managed appropriately.
● Information about PRN (as required) medicines was not clear and consistent in people's records. Documentation did not always include necessary information about people (name, date of birth, allergies, photo etc.) and medicines which should have been dated on opening were not dated. This meant we could not be sure that people had received their medicines safely.
● The provider's systems for auditing medicines at the service were not effective; the audits completed had not identified some issues found during the inspection, and actions from previous audits had not always been completed.

The provider had failed to ensure that people's medicines were managed safely, in line with national guidance. This placed people at risk of harm. This was a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Safety monitoring and management was not effective in ensuring that people were protected from the risk of abuse or avoidable harm. There were not sufficient staff available to monitor people's safety, people did not live in a safe environment, and people did not receive appropriate care when they had fallen.
● When safeguarding concerns had been raised about the service, investigations had not always been completed and the local authority and CQC had not always been notified when appropriate. We discussed this with the manager and provider who addressed it during the inspection.
● Records showed that only 46% of staff had completed the provider's safeguarding training. The staff we spoke with were aware of the action to take if they had any concerns about abuse.

Visiting in care homes

● Friends and family were able to visit people in line with Government guidance. We spoke with a number of visitors during our inspection and saw that when relatives and friends visited, they were made welcome by staff.

Learning lessons when things go wrong

● The provider's systems to learn lessons when things went wrong and share learning with staff were inadequate. When concerns were raised, investigations were not always completed appropriately. Accidents and incidents were not monitored effectively and when audits identified that improvements were needed, action was not taken in a timely way. We have addressed this in the well-led section of this report.

Inadequate

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 requires improvement. The rating for this key question has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care did not always reflect their assessed needs and risks; they did not receive support when they needed it and their safety was not monitored effectively.
- Some people's care documentation did not include accurate, up to date information to guide staff about people's individual needs and risks. Some care files had sections missing, for example falls or medication risk assessments. We noted that a summary of people's needs and risks was not available to guide new staff and agency staff, who did not always know people or how best to support them.
- People's NHS continence aids were stored centrally and were shared between people. This meant we could not be sure people were receiving the appropriate type and size of aid and people's individual stock of aids could not be monitored effectively. We discussed this with the manager who told us they would address it.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People's dietary needs were not managed effectively. There was a lack of clear, consistent information in some people's care documentation about their nutritional needs and risks, including their risk of choking. The information available to kitchen staff did not reflect the information in some people's care plans. Care staff and kitchen staff had not been given accurate information about some people's dietary needs and risks. This meant that people at risk of choking did not have the support they required to have their nutritional needs met safely.
- Where there were concerns regarding people's diet and nutrition, for example due to weight loss or swallowing difficulties, appropriate monitoring was not always in place and appropriate referrals for specialist assessment or support had not always been made. For example, one person had experienced swallowing difficulties but had not been referred to the Speech and Language Therapy (SALT) service for an assessment of their risks and needs. Another person had lost weight and their care plan advised their weight should be monitored weekly but they were being weighed monthly.
- People did not receive appropriate support with their healthcare needs. Referrals were made to community professionals when people needed specialist support with their healthcare needs, for example from community nurses. However, people were not always monitored appropriately after accidents or falls.

The provider had failed to ensure people's dietary and healthcare risks and needs were managed appropriately. This was a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection, the provider had failed to ensure that staff had received adequate training. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff did not receive an appropriate induction. We reviewed two staff members' files and found no evidence that they had received an induction at the service. The manager told us there was no formal, documented induction process in place.
● The provider had failed to ensure staff had the knowledge and skills to meet people's needs. The manager advised that compliance with the provider's mandatory training was at 61%. Training that had not been completed or was overdue, included fire safety, dysphagia, falls awareness, food hygiene, infection control and safeguarding. There were people living at the home with complex needs, but some staff told us they had not received any training in supporting people with complex needs.
● Staff had not completed the training necessary to be able to use the electronic care planning system effectively. This had resulted in incomplete care records, which impacted on staff members' ability to support people safely and effectively.
● Staff were not supported appropriately. The manager had completed recent supervisions with some staff but told us supervision records for staff prior to that were not available. Some staff told us they had not received supervision for a long time, so were unable to discuss concerns or their training needs on a regular basis.

The provider had failed to ensure that staff had the knowledge and skills to meet people's needs effectively. This placed people at risk of harm. This was a further continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most people and relatives were happy with the care provided and the competence of staff working at the home. One person commented, "It's fine here, I'm happy with the care. Staff know what they're doing, they treat me very well."

Adapting service, design, decoration to meet people's needs
● The home environment was not suitable to meet the needs of people living there, as it was not always safe.
● The environment needed to be improved to meet the needs of people living with dementia. We found a lack of dementia friendly signage and equipment to support people living with dementia to be as independent as they could be. For example, there was a lack of adapted cutlery and crockery to support people at mealtimes.

We recommend the provider considers current guidance on providing a dementia friendly environment and makes the necessary improvements to ensure the home environment meets people's needs.

● People told us they liked their rooms and the home environment.

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).

At our last inspection, the provider had failed to ensure that people were being supported in line with the MCA. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

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.

- People were not being supported in line with the principles of the MCA. Information in some people's care plans about their capacity was not clear and consistent. Where people lacked the capacity to make decisions about their care, capacity assessments had not always been completed and documentation had not been kept of the decisions made in their best interests.
- Where some people were being deprived of their liberty to keep them safe, the necessary applications for authorisation to do this had not been made. The manager had a list of 9 people who were being deprived of their liberty to keep them safe, but applications for authorisation to do this had only been submitted to the local authority in respect of 3 people.

The provider had failed to ensure people were supported in line with the principles of the MCA and the necessary authorisation had been sought to restrict people's liberty. This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 requires improvement. 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.

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

At our last inspection, the provider had failed to ensure the effective governance of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The manager was responsible for the day-to-day running of the home, with support from two assistant managers. The manager lacked a clear understanding of their role and was not aware of some of their responsibilities, including around environmental safety issues. The manager told us they had not received supervision since starting in their role in January 2023. This meant they may not have received the support necessary from the provider to carry out their role effectively.
- Many of the issues and shortfalls we found during our inspection had not been identified by the manager or provider, so improvements had not been made when needed. This included staffing levels not being sufficient to meet people's needs, issues with the safety and cleanliness of the home environment, falls not being managed appropriately and care documentation not reflecting people's needs and risks.
- Some audits were not completed or were not effective. We were told that no audits of care documentation were available. Audits showed that where shortfalls had been identified, for example with medicines, the necessary improvements had not been made in a timely way. We noted the same shortfalls identified over a number of consecutive months without improvements being made. This meant that the audits and checks being completed were not effective in ensuring appropriate standards of quality and safety at the home.
- There was a lack of effective oversight by the provider. Records showed that the nominated individual and the operations manager had telephoned the manager regularly, and there had been some recent visits to the home. However, the checks completed during those phone calls and visits had been inadequate, as many of the issues found during the inspection had not been identified by the nominated individual or operations manager or addressed.
- Statutory notifications about people using the service had not always been submitted to CQC in line with current regulations. A statutory notification is information about important events which the service is required to send us by law. We discussed this with the nominated individual who agreed to submit the required notification retrospectively.

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

● We found limited evidence of the manager or provider engaging with people who lived at the home. Residents' meetings were held at the home monthly; however, some people told us the meetings were pointless because no improvements were made. No-one we spoke with could remember having received satisfaction surveys to complete and the manager told us none were issued. This meant the provider had not ensured people could provide feedback about the care and support they received, especially if they wished to do so anonymously.

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

● The provider's processes to ensure people received high quality, person-centred care were inadequate. There were insufficient staff to provide people with support and to monitor their safety, the home environment was not safe and clean and some people's care documentation did not reflect their needs and risks to guide staff about how to support them safely and effectively.

● We received mixed feedback about the management of the home. Many people and relatives we spoke with felt the management of the home needed to improve. Most told us they would not recommend the home to others. Most staff we spoke with also felt that management arrangements needed to improve. Some staff told us they did not feel listened to and the necessary improvements were not made when they raised concerns.

The provider had failed to assess, monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 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 a duty of candour policy, and the manager was aware of their responsibilities. No incidents had occurred that we were aware of that required action under the provider's duty of candour.

Working in partnership with others

● We saw some evidence of management and staff working in partnership with community agencies. Two community professionals who visited the home told us most staff were friendly and approachable, and people seemed well cared for, but there were occasions when the home was short staffed. One community professional told us they had regular contact with the manager and the manager was keen to take on board any help or information provided.