Westmorland Healthcare Limited

Westmorland Court Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

Westmorland Court Nursing and Residential Home (Westmorland Court) 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.

Westmorland Court provides accommodation for up to 48 adults, who require help with personal and nursing care needs. The home is located in a semi- rural setting, a short distance from the picturesque village of Arnside. A small car park is available at the front of the building. The home is arranged over three floors with communal bathing and toilet facilities being appropriately located throughout the building. A number of stairwells are available for access to the upper floors, although a passenger lift is also installed.

Shortly before our inspection the registered manager had left employment. The deputy manager was acting as manager at the time of our visit. She was in the process of applying to the Care Quality Commission to be the registered manager of Westmorland Court. 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.

This comprehensive inspection was conducted on 18 January 2018 and it was unannounced.

Our last comprehensive inspection of this service was conducted over two days on 4 July 2016 and 6 July 2016 when we found the provider was failing to provide safe care and treatment by the proper and safe management of medicines. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Therefore, we issued a warning notice for the unsafe management of medicines. We subsequently conducted two focussed inspections on 7 November 2016 and 11 January 2017 in order to monitor if improvements had been made around the management of medicines. The warning notice in relation to medicines was found to have been met at the inspection conducted on 11 January 2017.

During the inspection on 4 July 2016 and 6 July 2016 we also found the quality monitoring systems were not fully effective in identifying risks. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Therefore, we issued a warning notice for ineffective governance. We subsequently conducted two focussed inspections on 7 November 2016 and 11 January 2017 in order to monitor if improvements had been made around the monitoring of risk. The warning notice in relation to governance was found to be met at the inspection conducted on 11 January 2017.

During the inspection on 4 July 2016 and 6 July 2016 we also found a breach of the regulations in relation to person centred care. At that time people who lived at Westmorland Court were not consistently receiving care or treatment, which had been planned and personalised specifically for their individual needs.

Therefore, a requirement notice was issued for regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we looked at how the service provided person centred care. Records showed that people's needs had been properly assessed and the plans of care we saw were well written, person centred documents. The service demonstrated appropriate systems to assess health care risks for people who lived at Westmorland Court and robust systems were in place for the formulation of individuals care plans. Therefore, the previous breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was met on this occasion. However, person centred care and infection control practices could have been further promoted by people being supplied with individual hoist slings, where needed. Also the plans of care did not always accurately reflect the current situation and occasionally they were not being followed in day to day practice. We made recommendations around these areas.

We found those who lived at the home were not protected by the recruitment practices in place, as these were not robust and insufficient checks had been carried out for prospective employees, to ensure they were fit to work with vulnerable people. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found concerns around the safety of some areas of the home. The management of risks within the environment was insufficient and therefore people were potentially at risk of harm. The kitchen was found to be unhygienic and in need of a deep clean. The management of medicines could have been better, so that people who lived at the home were protected against poor medicine practices. These findings constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not always demonstrate appropriate use of the Mental Capacity Act and how individuals were supported in making decisions about their care. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found staff from the home and community professionals, who did not have legal authority to do so, had in one case signed consent to allow covert medication to be administered to one person who lived at Westmorland Court. Therefore, the provider had failed to act in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that a system had been implemented for assessing and monitoring the quality of service provided. However, this was ineffective, as concerns identified during our inspection had not been recognised by the internal auditing system. The minutes of one staff meeting chaired by the provider demonstrated a lack of confidentiality and the recruitment process for the appointment of the new manager was insufficient. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment in which people lived was clean and tidy throughout, although there was an unpleasant odour in one part of the home. We made a recommendation about this.

We had been notified of any significant events, such as deaths, safeguarding referrals and serious incidents, in accordance with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, there was no evidence available to show that lessons had been learned when things went wrong. We made a recommendation about this.

The staff team had received training in safeguarding adults and whistle-blowing procedures. Staff members we spoke with were confident in making safeguarding referrals, should the need arise. The manager told us that she was in the process of implementing annual appraisals for staff. Staff personnel records did not demonstrate that regular individualised supervision had been continued and knowledge checks were not being conducted. We made a recommendation about this.

Complaints were being well managed and people who lived at Westmorland Court were being protected from discrimination. They told us staff were responsive to their needs, although some felt communication was difficult with some staff members. Staff members were seen to be kind and caring. However, on occasions we noted they did not communicate with those they were supporting. We made a recommendation about this.

Records showed that a wide range of community professionals were involved in the care and treatment of those who lived at Westmorland Court. Records showed that surveys had been conducted for those who lived at the home, but staff members and stakeholders in the community had not been asked for their views about how the home was performing. We made a recommendation about this.

A company representative visited the home regularly. However, there was no evidence to show that during these visits discussions were held with people who lived at the home, in order to obtain their feedback or a tour of the premises was conducted in order to make a full assessment of the premises. We made a recommendation about this.

There were sufficient staff on duty on the day of our inspection and we saw staff were always present in the communal areas of the home. We found that disciplinary procedures were followed in response to incidents of misconduct or bad practice.

At this inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to; need for consent; safe care and treatment; safeguarding service users from abuse and improper treatment; fit and proper persons employed and good governance.

The overall rating for this service is 'Requires improvement'. The key question of 'Safe' is rated as 'Inadequate'.

If not enough improvement is made when we next inspect the service, so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service.

Full information about CQC's regulatory response to the more serious concerns found during this inspection is added to the end of this report.

You can see what action we told the provider to take at the back of the full version of the report.

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

This service was not safe.

There were serious concerns about the safety of the environment and the management of medicines was insufficient. This placed people at risk of harm.

The Personal Emergency Evacuation Plans (PEEPs) needed to be reviewed in line with current good practice guidelines.

Recruitment practices adopted by the home were poor and therefore the provider had not ensured that new employees were fit to work with vulnerable adults.

Staffing levels were satisfactory and staff had received training in safeguarding adults.

Is the service effective?

Requires Improvement

This service was not effective.

The provider had not always ensured that lawful authority had been granted in order to deprive someone of their liberty and formal consent had not been obtained from the relevant people.

Advice from community professionals had been sought and people's needs had been properly assessed.

Staff training was provided. However, induction programmes were not available on records we saw and individual supervision sessions were overdue. Annual appraisals were in the process of being introduced.

Is the service caring?

Requires Improvement

This service not consistently caring.

The care plans we saw incorporated the importance of privacy, dignity and independence, particularly during the provision of personal care.

We saw some staff interacting with people in a kind and caring

manner and choices were offered regularly. However, some staff did not communicate with people whilst supporting them.

Is the service responsive?

Requires Improvement

This service was not consistently responsive.

Assessments of people's needs had been conducted before people moved into the home and plans of care were person centred. However, assessed needs were not always reflected and guidance was not always followed in day to day practice.

Complaints were being well managed and people were being protected from discrimination.

There was little evidence available to demonstrate that activities were being provided at the time of our inspection.

Is the service well-led?

Requires Improvement

This service was not consistently well-led.

Staff members we spoke with spoke highly of the current manager. The manager had notified us of any significant events, such as deaths, safeguarding referrals and serious injuries.

Feedback from those who lived at the home was actively sought through surveys. However, staff members and community professionals had not been asked for their views about how the home was performing.

A range of audits had been introduced. However, these were not always effective in identifying any shortfalls within the home.

Westmorland Court Nursing and Residential 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 18 January 2018 by two Adult Social Care inspectors from the Care Quality Commission (CQC). The inspection team also consisted of a specialist mental health nurse advisor, a specialist advisor in medicines management and an expert by experience. An expert by experience is a person who has experience of the type of service being inspected. Our expert by experience on this occasion had been involved in supporting an elderly family member who was living with dementia and who was accessing regulated services.

At the time of this inspection there were 30 people who lived at Westmorland Court. We were able to speak with twelve of them and four family members. We also spoke with six members of staff and the manager of the home.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we 'pathway tracked' the care of six people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. Other records we saw included a variety of policies and procedures, medication records, quality monitoring systems and the personnel records of six staff members.

The Provider sent us their Provider Information Return (PIR) five months previously, as we had planned to visit the home towards the end of 2017, but had to postpone due to inclement weather conditions. Therefore, some of the information provided on the PIR was out of date. A PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements

they plan to make.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection, such as serious incidents, injuries and deaths. We were in regular discussion with local commissioners and community professionals about the service provided at Westmorland Court. We asked nine community professionals for their feedback and we received three responses.

Westmorland Court is currently involved in the Quality Improvement Planning [QIP] process, which provides the home with additional support from the clinical commissioning group and the local authority. This is to help them make improvements where needed and to reach a satisfactory standard of service. Progress continues to be made, in accordance with their action plan.

We used a planning tool to collate all this evidence and information prior to visiting the home.

Inadequate

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe living at Westmorland Court. People said they were pleased with their accommodation and expressed satisfaction about the environment.

During the course of our inspection, we looked at the personnel records of six people who worked at the home. We found the appointment of staff was not in accordance with the policies and procedures available at Westmorland Court and gaps in documentation were evident. Therefore, people who lived at the home were not protected by the recruitment practices adopted by Westmorland Court.

A staff selection and recruitment policy was in place at Westmorland Court. This stated, 'The policy defines the arrangements in place at the home for the effective selection, screening and recruitment of staff, to ensure that job positions are filled by the most suitably qualified and experienced applicants with due regards to Equal Opportunities and fair employment legislation'.

We noted a high percentage of staff had been recruited from overseas. We discussed recruitment procedures with the manager at the time of our inspection. She told us local applicants would be interviewed face to face at Westmorland Court, but those from overseas were appointed through a recruitment agency and video online interviews were conducted by the management of the home. However, there was no documented evidence on any of the personnel files we looked at that confirmed people were suitable for the role they were applying for.

There were completed application forms, with health questionnaires on only three of the personnel records we saw. Curriculum Vitae were available on another two. However, one application form we saw contained personal details only and no information was available about the person's employment history. This individual had been appointed from overseas without any further checks in relation to their skills, knowledge or relevant experience.

There was evidence of police checks for each person employed and at least two written references were present on five of the files we looked at. The sixth file only had one reference present. This was despite the home's polices stating that two written references were required from previous employers. Two of the references for one employee were letters of recommendation, which were not on letter headed paper and were either generically addressed, 'To whom it may concern' or a salutation was not included at all. This indicated the home had accepted references supplied by the applicant themselves. There was no evidence available to demonstrate verification checks had been conducted to ensure these references were authentic.

Therefore, this was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records we looked at showed that not all the hoist slings had been checked to ensure they were fit for purpose. Therefore, not all equipment had been appropriately serviced to ensure it was safe for use and

protected people from harm.

During our tour of the premises we had serious concerns about several areas of the home, which created potential risks for those who lived at Westmorland Court. Stair gates were in place at the top and bottom of each of the four stairwells. There were no risk assessments in place for the safety of the stair gates, which could be opened easily from either side. Therefore, people were at risk of falling down the stairs, or as the gates were approximately waist height people could easily fall over the top, should they try to reach the gate latch from the outer side. The manager told us those who were living with dementia were generally accommodated on the ground floor. However, it was still possible that these people could access the stairwells and therefore be at risk of harm.

We noted that window restrictors were in place. However some of these did not conform to environmental safety standards, as some windows opened more than the recommended distance of 100mm. Therefore, there was an increased risk of people falling from these windows. There were no risk assessments in place in relation to window restrictors and the monthly internal record checks indicated that all windows were satisfactory for the previous six months, which was inaccurate information and therefore these checks were not accurate.

There was a plug socket to be evident in one of the lounge floors. We were told this had been installed for use with screen projectors, although was never used. The socket protruded slightly from ground level and therefore created a potential tripping hazard. A store room door had a notice instructing staff, 'When not in use keep locked shut'. This door had been left unlocked and the key was in the door. Staff were not in the vicinity and therefore people were at risk of harm. The bed rail protectors for one bed did not fit properly, as they were not long enough to cover the bedrails. Therefore, this individual was at risk of harm, due to possible entrapment. We noted the door of one staff member's private accommodation, who lived on the premises displayed a sign saying, 'Fire door'. However, two hooks were evident over the top of the door from the clothes rack on the internal facing. This created a potential fire risk, as the seals around the door were not intact.

A fire risk assessment had been conducted by an independent company in 2016. This identified some areas which were classified as being at high risk. It was considered that the fire safety management levels at Westmorland Court were not adequate and that the risk to life from fire would be moderate. We asked the manager of the home for an action plan and updated fire risk assessment. She told us that a fire risk assessment had not been conducted since 2016 and the action plan we saw showed some areas needing attention had not been addressed.

We looked at the Personal Emergency Evacuation Plans [PEEPs], which had been implemented. Although an evacuation procedure was recorded, this was not in accordance with horizontal evacuation guidance. Therefore, plans to evacuate people in the safest and most appropriate way were not evident. As a result of our findings we referred our concerns to the relevant authorities. The fire officer conducted a full fire safety audit of the premises following our request. He found some areas of concern and as a result the original enforcement notice was extended by three months, in order to allow appropriate action to be taken.

We spoke with the chef who was not aware of the last food hygiene rating by the Environmental Health Officer. The manager told us this resulted in level 5, which corresponded with 'very good', the highest level achievable.

During our tour of the premises we visited the kitchen, which we found to be very unhygienic. There was dirt and grime under the kitchen units, on the skirting boards and on the fridge door. The sealant behind the sink

units had was stained and broken and therefore was an area, in which bacteria could multiply. The flooring in the kitchen had split in parts and the walls were noted to be dirty. We also saw that the inside of all the drinking cups used by people who used the service were stained. There were no disposable aprons available outside the kitchen door for people to use on entry to the catering facilities. We raised our areas of concern in relation to the cleanliness of the catering facilities with the manager and advised a deep clean was urgently needed. The manager confirmed new flooring had been laid in part of the kitchen and told us that floor covering for the remainder was on order, as were new drinking cups. We also saw that the COSHH (Control of Substances Hazardous to Health) risk assessment was out of date and therefore was no longer effective. Our findings demonstrated poor infection control practices in this area of the home and therefore this presented a potential risk of food contamination. We subsequently requested a visit by the Environmental Health Officer.

We observed a medicine round, which was being performed by a senior care worker. We were told this staff member was under supervision, but at the time we were observing this medicine round there was no supervision taking place. We witnessed this member of staff adding thickener to the contents of a capsule mixed with water. However, there was no reference to swallowing difficulties for this individual and no instructions about the addition of thickeners.

We checked the medicines room on the ground floor and found a large amount of thickener for one person stored on top of the medicines cabinet. This was dated from 1 July 2017 to 8 January 2018, which indicated this product had either been over-ordered, or the person had not been receiving it as prescribed.

We looked at how Controlled Drugs (CD's) were being managed and found some improvements could be made. The CD register was difficult to follow as records did not include information relating to the quantity and route of administration. The recordings in the Controlled Drug register were also not always legally correct, as service users' names were recorded in the column headed 'Name and address of supplier',

The maximum and minimum fridge temperatures were not being recorded accurately and therefore the shelf life of medicines needing refrigeration could be reduced and possibly render them ineffective. We reported this to the clinical lead at the time of our inspection and told her this needed to be rectified without delay, as did the viability of all medicine stock in the fridge. We noted excessive stocks of some medicines being stored in the drugs fridge.

We reviewed the Medication Administration Records (MAR) charts. We found the front sheets for each person varied in quality. Some contained good details about the individual, whilst others provided limited information and some were without photographs for identification purposes. Although allergies were recorded, these were not specific. For example, one MAR chart recorded an allergy to 'Opiates' and not the type of medicine. □

We found in some cases records in relation to variable doses, pain relief and topical medicines to be personalised. However, one individual had a topical cream record sheet, but no creams were prescribed and another person was prescribed analgesic capsules, but this medicine was being given in the form of a liquid. This discrepancy should have been realised at the start of the new MAR chart, but it had been over-written with the words '50ml carried forward.'

We noted that PRN protocols were not always in place for individuals prescribed 'as and when required' medications and there was insufficient detail recorded for the safe administration of some PRN medicines.

Records for covert (disguised in food) medicines needed to be more detailed, by providing staff with clear

guidance about how these should be best administered. Body maps were in place for the application of transdermal patches. However, these records were not always consistent. We noted that on one occasions two prescribed medicines had been missed for three days, due to lack of availability within the home.

Records showed that monthly medication audits had been conducted and that any shortfalls identified were documented on an action plan. However, there was no recorded evidence to demonstrate that actions needed had been followed up and audits conducted had not always recognised the shortfalls in the management of medicines, we identified during our inspection and therefore the medicine audits were not always effective.

Our findings above constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered nurse, who was undertaking the medicine round for the nursing clients at lunch time, was from an agency, but they had worked at the home previously on several occasions. We saw the nurse appropriately manage some medicines for destruction, which was considered to be good practice.

The senior care worker we observed giving out medicines was not rushing and was double checking the MAR charts for accuracy. Good techniques were being undertaken. Hand written entries on the MAR charts were, in general being signed, witnessed and countersigned. This helped to reduce the possibility of transcription errors.

A review of the previous months' MAR charts showed fairly consistent signatures being recorded for medication administration, with no omissions being evident. Pain relief records showed entries for the last few days, but detail of the medication was not recorded at the top of each page. However, we noted that one individual had been given pain killers prior to and after a change of wound dressing, which demonstrated good responsive care. Recognised codes were used for medicines omitted and when PRN medicines were given, then this was appropriately recorded.

We checked the treatment room on the first floor and found there was reasonable storage of dressings, which were in date. However, a large number of one litre sharps bins were located around this room, which were surplus to requirements.

The temperature from the front of the drugs fridge was being recorded twice a day and all recordings were seen to be fairly constant. It would be beneficial if guidance was sought from the supplying pharmacy in relation to medicines, which need refrigeration, as some items in the drugs fridge could be stored at room temperature.

We found that appropriate signage was available to help people find facilities within the home. Communal areas, such as lounges and dining areas displayed a good standard of cleanliness and were appropriately maintained. The ground floor was hygienic and pleasant smelling, but we noted there to be an unpleasant odour on the first floor during this inspection. It is recommended that this be investigated and action taken to address the malodour in this area.

Records showed that regular internal checks had been conducted, which included the nurse call system, water temperatures, shower heads, wheelchairs, walking aids, hoists, bed rails, pressure relieving equipment and radiators, with remedial action taken, as required. This helped to ensure these were safe for use. We were told that not everyone who used the hoist had their own slings. However, the member of staff we spoke with about this was aware of the need to make sure the right size of sling was used for each person in order

to promote comfort and safety. It is recommended that everyone who uses the hoist is supplied with their own slings, so that infection control is promoted.

A business contingency plan was in place at the home, which covered emergency contact details and action staff needed to take in the event of an environmental emergency, should the need arise.

Records showed that some systems and equipment within the home had been serviced in accordance with manufacturers' recommendations. A policy was in place outlining action staff needed to take in the event of a fire and a portable slide was available, should evacuation be necessary. Records showed that internal checks were regularly conducted for systems and equipment in relation to fire safety.

During our tour of the premises we noted in general the environment in which people lived was clean and hygienic, with liquid soap and paper towels being available at hand washing stations. Advice notices were also displayed in relation to effective hand-washing procedures. Daily cleaning schedules were kept within each bedroom, which helped to ensure these areas of the home were cleaned, as planned. We observed the carpet in one area of the home being cleaned with specialised equipment. Staff were seen to be using Personal Protective Equipment (PPE) throughout the day and special bags were being used for soiled linen. The laundry department was clean and hygienic and was being managed well. These findings helped to reduce the possibility of cross infection. One member of staff commented, "I think the environment is very clean."

We looked at how the service identified and reduced potential health and social care risks for people who lived at the home. We found that appropriate risk assessments had been completed, which effectively identified people's needs. These had been reviewed on a regular basis to highlight the changing needs of those who used the service. For example, records showed one person to be at increased risk of skin break down. We found that a specific risk assessment had been completed, which highlighted their needs and which was reflected within their care plan. Another person was at increased risk of malnutrition. We found that the service had identified this risk and demonstrated regular review on a monthly basis to monitor this person's condition. One community professional wrote on their feedback, 'I rely on them (the home) referring patients to my service. In the most part, the referrals I get are appropriate and needing specialist skin advice. The staff follow advice given and report back if issues have arisen. No real concerns over this nursing home.' Records showed that 15 people who lived at the home had been provided with pressure relieving mattresses.

We looked at one person's care records who required support with their mobility. We found that effective systems had been used to identify potential risk and this had been incorporated into the person's care plan. The service had also used effective systems to identify and reduce the potential risk for another person who was at high risk of falls.

We looked at another person's care records, which indicated they were at risk of choking. We found a risk assessment had been undertaken, which identified the severity of the choking risk. Another person's care records showed they could become upset and distressed at times. This specific risk had been appropriately assessed and strategies implemented, should this occur.

First aid kits were available in the home and records showed that staff received first aid training. This helped to ensure staff were able to respond to accidents within the home. We found that accidents and incidents had been documented and these records were retained in line with data protection guidelines. However, there was no evidence available to demonstrate that lessons had been learned when things went wrong. It is recommended that systems be implemented to show how lessons have been learned following significant

events within the home.

There were adequate numbers of staff on duty on the days of our inspection and we saw staff members were present within the communal areas of the home. One staff member told us, "We have a good number of staff on duty and sickness is always covered where possible." We observed people being offered choices during our inspection. For example, people were asked where they would like to sit or what they wanted to eat and drink and if they would like to go to their room. This helped to promote individual human rights.

A policy was in place at the home in relation to safeguarding adults and easy step by step guidance was displayed in the form of a flow chart. This helped to ensure that everyone was aware of action they needed to take should they suspect abuse was taking place. Staff members we spoke with told us they had undergone training in relation to safeguarding adults and records we saw confirmed this information to be accurate. They were also fully aware of the whistleblowing policies and were confident in reporting any concerns in the most appropriate way.

We were told by the manager of the home that 60 staff members had left employment between October 2016 and October 2017. We asked for a list of these ex-staff members with reasons for leaving. This was provided. Reasons for leaving employment varied. However, this high turnover of staff could have had a detrimental effect on those who lived at the home, as it did not promote continuity of care and did not allow for a stable staff team to be embedded within the home. We were told this excessive turnover had since settled and a consistent staff team was being developed.

During the course of our inspection we established that seven members of staff lived on upper floors of the premises. One of the floors was also occupied by some people who lived at Westmorland Court. There was no separate entrance to access this private accommodation and therefore it was necessary for staff who lived in to gain access by entering the main part of the home. However, there was secure access to the home by a key pad, intercom system and external camera. There was a notice on the door leading to staff private accommodation. This read, 'Please be respectful during the night. Staff are trying to sleep.' This did not promote the fact that Westmorland Court is the home of the people who live there, as well as the staff who have accommodation there.

The manager told us that all staff who lived on the premises had signed tenancy agreements. However, there were no risk assessments in place to ensure those who lived at the home were protected against the general day to day private activities of staff members, who were accommodated on the premises. We discussed this with the manager of the home at the time of our inspection, who promptly implemented risk assessments for each staff member living on the premises and made a full review of the tenancy agreements.

Records showed probationary periods lasted for a period of three months, which included an initial two week shadowing experience, but these sessions could be extended if required. Disciplinary procedures were followed in day to day practice for acts of misconduct. This helped to ensure appropriate action was taken following poor practices or unacceptable behaviour and that lessons were learned when things went wrong.

Requires Improvement

Is the service effective?

Our findings

Comments from people who lived at the home included: "There is no-where like home, but this is not bad. They do look after me properly"; "The food is ok, but some choice would be nice. I don't get involved in any activities"; "This doesn't feel like home. It's not homely. I enjoy television, but I need an appointment to check my eyes. I enjoy reading, but I don't do it anymore"; "The staff try to get me out of my room, but I don't like it."; "The food varies but there is no choice. There is no menu. I just hope that when it arrives it will be to my liking"; "The staff do help me a lot. I can't really move without them. I do use a frame, but again with help" and "The girls wash and dress me every day. They are kind. I do spend my time here [in the lounge]. I have my meals in here as well. The food is good and if I don't like it you can have soup and bread instead."

One family member told us, "The food appears fine. Sometimes [name] complains that the food is cold, but he eats it"; "It was very difficult when Mum first came. I felt my standards were too high and my expectations were too great. Her care can be a bit hit and miss. I will come and she is only half dressed. [I found that this morning]. Mum can be difficult so I think she has stopped the staff from doing their jobs. Mum uses a commode at night and I like it to be moved out of her room during the day. This doesn't always happen. It is not hygienic. The staff problems seem to be settling down. There have been a lot of problems – not enough staff. The food is not to Mum's taste and there doesn't seem to be a choice. Today was beans and sausage. My mother would never eat that. It was in her room when I arrived. However, she did eat her pudding. I know Mum is difficult, but I worry she doesn't get enough nutrition."

One visiting health care professional wrote on their feedback, 'At one point the home employed a nutritional support assistant. This person was very proactive in their role. However, the post was not continued, so the nurses and carers now have had to take on these aspects of care. This person also told us they had spoken with the Chef on occasions, who seemed to have reasonable knowledge of food fortification and good nutritional practices.'

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.

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

We checked whether the service was working within the principles of the MCA.

We found that policies and procedures were in place in relation to MCA and DoLS. We looked at how the service assessed a person's mental capacity and how decisions about their care and support were being made. We found that where necessary applications for DoLS authorisations had been made and the service

had appropriate systems in place to assess a person's mental capacity. However, we found these were not always used. For example, we looked at one person's care records who received their prescribed medication covertly, as they were unable to understand why medication was necessary. We found that the service had not appropriately assessed this person's capacity in relation to the administration of their medicines and evidence of a best interest decision was not found within their care records.

A mental capacity assessment had not been conducted for one person who was using bed rails, whilst they were in bed. They were unable to appropriately consent to the use of bed rails and their ability to understand why bed rails were necessary had not been established. Therefore, the home was not working within the principles of the MCA, by ensuring this person was not being unlawfully deprived of their liberty and by ensuring decisions were made in their best interests.

We also found that one person required a door sensor, which alerted staff when they were leaving their bedroom. An assessment of this individual's capacity had not been undertaken, in order to ensure their liberty was not being unlawfully restricted.

We looked at a third person's care records who was unable to take part in decision making about their care needs. We found the home had undertaken an assessment of their capacity; however this capacity assessment was not specific to individual decisions being made on their behalf.

Therefore, this was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care files of six people who lived at Westmorland Court. We found that consent to care and treatment was not always evident. However, the care records of one person demonstrated they had consented to the use of bed rails at the time of admission to the home, but their condition had since deteriorated. Therefore, the ability for them to now understand the initial agreement about the use of bed rails was uncertain. There was no evidence of regular reviews of their capacity or subsequent best interest decisions being made within their care records.

The records of another person who required covert medicines showed that a GP, a pharmacist and two senior staff from Westmorland Court had signed a consent form. This is not legally accepted, as consent forms must only be signed by those who have legal authority to give consent on behalf of someone who lacks capacity to make specific decisions. A best interest decision meeting should have been recorded, in order to ensure the decision made was in the best interest of the person who lived at the home.

Therefore, this was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we looked at the personnel records of six staff members. The manager told us that new staff were issued with personal induction workbooks, which helped them to gain knowledge and to be aware of what was expected of them whilst they worked at Westmorland Court. However, there was no record to support this information.

Comments received from staff members we spoke with included; "I have received training in many things and the manager encourages extra learning if I want it"; "I feel that there are a lot of staff"; "My induction could have been longer" and "I think most of the staff are happy in their job, but others just do their duties."

We looked at the arrangements in place to ensure staff had the required knowledge and skills to care for

people safely. We saw some written feedback from one group practice which stated, 'There was a previous concern, when the nursing staff were not qualified to administer medications via syringe driver for a palliative patient. Previous reassurance that a nurse would be able to set up and supervise a syringe driver was given. The practice wrote to Westmorland Court to document this concern and we were reassured that the training problem in the care home was being addressed. Unfortunately, we had to subsequently raise the issue when another patient was likely to benefit from the same treatment and it appeared that the training issue had not been resolved and no-one in the nursing home could set up this treatment. We have subsequently been reassured that this matter has now been resolved.'

During our inspection we looked at the training matrix, which showed that three members of staff had since completed syringe driver training, so that anyone who required such treatment was able to receive it at the home.

We found a staff training matrix to be in place and individual training records were available for each member of staff, which documented completed learning modules, such as assessing needs, safeguarding, infection control, medicines management and fire evacuation. Additional sessions, such as venepuncture, syringe drivers and catheterisation were also available for qualified nursing staff. Staff we spoke with gave us some examples of training they had completed, which corresponded with the records we saw. One member of staff commented, "All of us here enjoy our jobs and are happy. We receive regular online training." Although some observation assessments had been conducted, knowledge checks had not been undertaken following specific training modules. It is recommended that knowledge checks be introduced. This would help to ensure staff members had understood information provided during learning modules.

Records showed that regular group supervision sessions were held for the staff team. These were sometimes conducted during handover periods at the time of shift changes. However, group sessions did not always allow workers to discuss their progress, training needs or any concerns they may have in private, should they wish to do so. We saw that individual supervision sessions and recorded observations had previously been conducted, but there was little evidence of this during the six months prior to our inspection. It is recommended individual supervision sessions and observation checks are reintroduced for all employees, so they are supported to develop their abilities and increase their knowledge and skills.

Systems were in place to enable the service to move forward with the use of technology, in areas such as staff training and care planning. The manager of the home told us that she was in the process of introducing annual appraisals for all staff members. This would help to ensure that staff were being monitored and supported with their personal development and additional training needs.

We looked at the management of meals, which were served in two dining rooms and we observed how people were supported at meal times. The menus we saw were on a four weekly rotational basis. Breakfast offered a range of options each day, including a full English breakfast, for those who wanted it. The menu for dinner and the tea time meal showed one option only. We observed a variety of snacks and beverages, both hot and cold, being offered mid-morning and mid-afternoon. The menu showed that hot beverages, biscuits and sandwiches were available at supper time. We saw a record of the meals served, but this only recorded one option at dinner and teatime. However, we saw that people were offered a choice of food and drinks throughout the meal service and alternatives were available at people's request.

During our tour of the home we found bedrooms to be pleasantly decorated and individualised with personal belongings. The dining rooms were nicely set out and a calm ambiance throughout the meal service was evident. Food hygiene standards were maintained whilst food was being served and we observed staff wearing Personal Protective Equipment (PPE).

Records showed that a wide range of community professionals were involved in the care and treatment of those who lived at Westmorland Court, such as GP's, mental health teams, chiropodists, dieticians and Speech and Language Therapists (SALT). The chef we spoke with was well aware of people's individual dietary needs and food preferences, which were clearly displayed in the kitchen for easy reference. Records we saw showed that regular checks of food and catering equipment were conducted.

Requires Improvement

Is the service caring?

Our findings

Comments we received from those who lived at Westmorland Court included; "I am looked after by lovely nurses. They do care for me. Sometimes I get lonely, but they are busy"; "I don't watch much TV but I enjoy reading. That's about all I do"; "All my care is done by the nurses. They wash me and everything. I do like it here" and "The staff care for me. I have a wash every morning and a bath at least once each week. A boy sometimes cares for me."

Those we spoke with described the staff as kind, caring and lovely. Family members we spoke with felt involved with the care and support of their loved ones. However, a few people said they found communication with some staff difficult because of a language barrier.

Written feedback from one group practice stated, 'The care people receive from the nursing staff seems appropriate and the staff are always helpful. However, there are some communication issues. On occasions it has been necessary to make telephone contact with Westmorland Court to discuss a clinical issue, such as medication. Voicemail messages have been left, asking for a return call. On some occasions there has not been any response to the messages left. Therefore, this is an area which could compromise good care.'

We looked at how staff supported and engaged with those who lived at the home. We found that people were supported on an individual basis and dignity standards were being maintained. Staff adopted a kind and caring approach towards those who were using the service.

We saw staff treating individuals with respect and dignity throughout the inspection process, being attentive to their individual needs and supporting independence, where possible. However, we noted two members of staff had some difficulty in communicating in the English language, as this was not their native tongue. When we spoke with one of them, they replied, "I don't speak English." We were concerned about how these staff members communicated with those who lived at Westmorland Court and how they understood the training provided. We saw two staff members supporting people at lunch time. They did not communicate with those they were helping. This resulted in one individual becoming startled because communication had not been made prior to support being given. It is recommended that additional training be provided for staff around the importance of communicating with people whilst supporting them to meet their care needs.

We saw those who lived at Westmorland Court looked well-presented in appearance. We saw care workers knocking on people's bedroom doors before entering and supporting people in a warm, pleasant and caring manner. However, we noted a high percentage of male care staff worked at the home. We discussed this with the manager at the time of our inspection, in relation to the provision of care for female service users. The manager advised us that there would always be a female care worker in attendance during the provision of personal care for a female service user. She subsequently confirmed that the percentage of male to female care staff equated to 50/50 and that those who live at the home are asked their preferred gender of care worker. It is important people's privacy and dignity is respected by ensuring support is provided by their preferred gender of care worker.

The care files we saw recorded people's likes, dislikes and leisure interests, as well as their family history, education, employment and any significant events in their lives. This helped the staff team to develop a picture of the people who lived at Westmorland Court. The plans of care incorporated the need for privacy, dignity and independence, particularly during the provision of personal care.

We found staff had good knowledge of people's assessed needs. For example, we observed one person who experienced frequent periods of distress, but was supported to receive effective and person centred care from staff to reduce these episodes from occurring.

Information was displayed within the home about access to advocacy services. An advocate is an independent person who will support people to make decisions which are in their best interests. We were told that people would be assisted to use the services of an advocate, if they wished to do so, or if they lacked the capacity to make specific decisions and did not have anyone who could support them with the decision making process.

We were aware that Close Circuit Television (CCTV) cameras were used within the communal areas of the home. We were told this was for people's safety and evidence was available to show footage had previously been used towards disciplinary action. A privacy impact assessment had been conducted, in accordance with guidance received from the commissioner's office. Relatives had been informed by letter of the installation of CCTV and those who lived at the home had been given the opportunity to provide their feedback using a specific questionnaire. The Service Users' Guide, provided to all new residents informed its readers of CCTV usage and we observed a prominent notice displayed within the home telling people that CCTV cameras were in operation. Information was available, so that people were aware they could receive visitors in private, should they wish to do so.

Requires Improvement

Is the service responsive?

Our findings

One person we spoke with commented, "I am looked after well because I need a lot of help. There are no activities at the moment, but they are going to start. I like quizzes and watching western films. It's sometimes difficult to watch a film because others don't want to watch."

Another person we spoke with told us they didn't like it at Westmorland Court, but felt they had no choice. They commented, "The staff do their best, but I will be glad to get home. Sometimes it's difficult to communicate, because there are so many different languages."

A family member commented, "My relative had no choice, he was just brought here. I think he is looked after ok. He always seems to be cared for when I come."

At this inspection we pathway tracked the care and support of six people who lived at the home. Pathway tracking is a process we use to check if people are receiving the care and support they need.

We looked at how the service provided person centred care. The plans of care we saw were well written, person centred documents. Therefore, the previous breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was met on this occasion.

However, we found that relevant information was occasionally missed and actions recorded were not always followed in day to day practice. For example, we looked at one person's care plan in relation to their dietary needs. We found their individual needs and preferences were detailed and effectively incorporated into their care plan. Although this person was assessed as being at high risk of malnutrition, their care plan failed to provide information in relation to their weight management.

We looked at a person's wound care plan. We found that the plan of care identified the individual's increased risk and action had been implemented in order to minimise this risk. Records we saw showed that further support had been sought from external professionals, so that the person's skin integrity was maintained. However, we found that actions within their care plan in relation to wound care were not always followed in day to day practice. We looked at another person's care plan which had not been updated to reflect the present situation, as this showed the individual required wound care management when they did not have a wound at the time of our inspection.

Another person's care plan showed they were unable to mobilise without support. We found the service had implemented specific strategies within their care plan to support this individual with their mobility safely. However, the record did not incorporate specific equipment to use during mobility interventions. It is recommended that plans of care be updated to reflect current needs and that guidance is followed in day to day practice.

The six care files we looked at highlighted a wide range of assessed needs, which were specific to individual people who lived at Westmorland Court. These covered areas such as, medication management, falls,

anxiety and mental health, breathing and sleeping. We found extensive person centred care plans and detailed risk assessments in place in relation to these areas of need. These outlined specific requirements and action staff needed to take to ensure care and support was delivered in the most appropriate way. We found that the service had effectively identified signs and symptoms to be aware of when people were becoming unwell and highlighted direct action to take should concerns arise.

We found that individuals care plans had been reviewed on a regular basis to accommodate peoples' changing needs and these contained individual and person centred information to ensure people's needs were being met. We looked at one person's care plan regarding their nutrition. We found the service had identified and documented the person's specific likes and dislikes to ensure a healthy dietary intake was maintained and to ensure the risk of weight loss was reduced.

We looked at another person's care plan who could become distressed whilst being supported. We found appropriate steps had been taken to reduce distress and these were included in the person's plan of care to reduce the likelihood of these episodes occurring.

Care records we saw showed that people who used the service and their loved ones had been consulted about end of life care. Where a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order was in place, due to a progressive, debilitating or life threatening condition, then this had been discussed and agreed by the individual themselves, where possible, their next of kin and their GP.

A separate file was retained for each person, which contained relevant information, should hospital admission be necessary. The hospital passports were in picture format and covered areas such as, 'Things you must know to keep me safe', 'Things that are important to me' and 'My likes and dislikes'. Information recorded included, allergies, GP contact details, communication abilities, medical history, dietary needs, emotional needs and risks of falling. For those who lived with a dementia related condition, these files were marked with a butterfly emblem, so that emergency services were aware of their individual cognitive needs.

At this inspection we found complaints were being well managed. A policy was clearly displayed within the home, which outlined the procedure people needed to follow, should they wish to make a complaint. Systems were in place for recording any complaints received. These showed complainants were kept informed of the progress, outcome and action taken following any investigations conducted. People we spoke with told us they would know how to make a complaint and would not be afraid to do so.

There was a lot of easily accessible general information displayed in the entrance hall of Westmorland Court, which included photographs of a variety of events that had taken place, such as a summer barbeque, scarecrow competition, music activities and a dignity challenge. However, at the time of our inspection we did not observe people being supported to pursue any activities of their choice or leisure interests specific to their preferences.

Requires Improvement

Is the service well-led?

Our findings

At this inspection there was no registered manager in post at Westmorland Court. The deputy manager, who until recently had been the office manager for the past four years was in charge of the day to day operation of the home. She was in the process of applying to the Care Quality Commission to be the registered manager of Westmorland Court. However, the provider had not conducted any additional recruitment practices in accordance with her change of career within the home. She told us that the provider had interviewed her by telephone, but there was no evidence of this. It was evident that the current manager had not completed a new application form and relevant checks had not been obtained, in accordance with her new role at Westmorland Court.

Staff members we spoke with told us; "The manager is a good listener and will always discuss things with us"; "The manager is very supportive"; "Everyone gets on well with the manager and she always shares information"; "The manager is helpful and understanding"; "I feel supported in my work" and "I feel the team are valued and supported by the management."

Records showed that regular meetings had been held for different groups of the staff team. This enabled those who worked at the home to raise any concerns or to discuss areas of good practice, as well as topics of interest. However, we found that confidential information not related to anyone living at the home or their family members, which should have not been discussed openly, had been passed on by the provider inappropriately at one general staff meeting.

At this inspection we found a range of daily, weekly and monthly audits had been introduced, such as catering facilities, cleanliness of the environment, safeguarding, moving and handling, staff allocation, meals and nutrition, medicines management, laundry facilities, daily care charts and privacy and dignity. However, the auditing system was not always effective, as it did not identify many of the improvements needed, as recognised during our inspection and there was no system in place for monitoring accidents and incidents.

The above findings constitute a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager of the home told us that a company representative visited each week and we saw records of these visits, the most recent being a week prior to our inspection. However, although these highlight discussions with the manager, there was no record to show a tour of the building had been conducted, or whether a random selection of records had been examined or discussions with those who lived at the home had taken place. It is recommended that management visits incorporate a wider range of areas in order to monitor the service more closely.

We saw that surveys for those who lived Westmorland Court and their families had been conducted during 2017. Positive feedback was provided on those returned and a large number of thank you messages had also been received by the home. This helped the management team to seek people's views about various

aspects of life at Westmorland Court. However, surveys had not been conducted for those who worked at the home or community professionals who visited Westmorland Court. Therefore, it is recommended that feedback about the quality of service provided be obtained from a wider range of people with an interest in the home.

Meetings for those who lived at the home and their families were held periodically. This allowed any important information to be passed on to interested parties and also enabled people the opportunity to discuss various topics in an open forum, should they wish to do so.

On our arrival at Westmorland Court, we noted that the last inspection rating of 'Requires Improvement' was clearly displayed in the reception area of the home. This information had also been posted on the home's website, so that people had access to information about the quality of the service.

A new clinical lead had recently commenced employment at the home and a new activity coordinator had been recruited. These appointments should help to improve the quality of service provided.

We had been notified of any significant events, such as deaths, safeguarding referrals and serious incidents, in accordance with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had notified the Care Quality Commission of any significant events, such as deaths, safeguarding referrals and serious injuries. A system was in place for recording safeguarding incidents and evidence was available to demonstrate these had been reported through the appropriate channels. However, there was no evidence to show that some incidents had been fully investigated and outcomes determined. There were no details to show what actions had been taken in relation to lessons learned following safeguarding incidents. We discussed this with the manager of the home, who agreed that some improvements were needed around the recording of investigations.

We read the home's service users' guide, which had been updated to reflect the current status of Westmorland Court, as there had been some recent changes in the management structure of the service. This document included areas, such as the philosophy of care, the facilities and services available and important policies and procedures, such as the complaints procedure.

We saw there were a wide range of written policies and procedures within the home such as, health and safety, safeguarding adults, privacy and dignity, infection control, fire awareness, confidentiality and data protection. This helped the provider to ensure the staff team were kept up to date with current legislation and good practice guidelines.

Westmorland Court was in the Quality Improvement Programme (QIP). This meant they were being supported by outside agencies such as, the local authority and safeguarding team to make improvements needed.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that consent to care and treatment had always been sought from people who had the legal authority to make decisions on behalf of those who lacked capacity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The home was not working within the principles of the MCA, by ensuring this people were not being unlawfully deprived of their liberty and by ensuring decisions were made in their best interests.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always ensured that environmental assessments had been conducted in order to mitigate potential risks to the health, safety and welfare of those who lived at the home. People did not always receive their medicines as prescribed and were therefore at risk of health problems. The overall management of medicines could have been better. The kitchen was in need of a deep clean and therefore infection control and food hygiene standards were not being promoted.

The enforcement action we took:

Warning Notice

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 The provider had not ensured that effective systems had been established in order to assess and monitor the quality of service provided.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that new employees had been appropriately recruited.

The enforcement action we took:

Warning notice