HC-One Limited

# Westleigh Lodge

**Inspection report**

Nel Pan Lane, Leigh, Wigan, Greater Manchester.
WN7 5JT
Tel: 01942 262521
Website: www.hc-one.co.uk/homes/westleigh-lodge/

Date of inspection visit: 19th January 2015
Date of publication: 22/05/2015

## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Requires improvement** |
| Is the service safe? | **Requires improvement** |
| Is the service effective? | **Requires improvement** |
| Is the service caring? | **Requires improvement** |
| Is the service responsive? | **Requires improvement** |
| Is the service well-led? | **Requires improvement** |

## Overall summary

We carried out an unannounced inspection of Westleigh Lodge on 19 and 20 January 2015.

Westleigh Lodge is situated in Leigh, Greater Manchester. The home is registered to provide accommodation and support for up to 48 people who require nursing or personal care, including people with dementia nursing care needs. Accommodation is set over two floors, with lift access available between the different levels. At the time of our visit there were 43 people living at Westleigh Lodge.

At the time of our visit there was no registered manager in post. 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. We were told the registered manager had left three days prior to our visit.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to medicines, requirements

# Summary of findings

relating to workers, supporting workers and assessing and monitoring the quality of service provision. You can see what action we told the provider to take at the back of the full version of the report.

We found administration of medicines was not always safe and people did not always receive their medicines as directed. People's photos were not always present in the medication file. This meant there was a risk people would not receive the right medicine or would not receive medicine as prescribed . The provider started to take action to address this during our visit. We found a discarded tablet on the arm of a chair, and one person was given medicine that should have been discontinued. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One staff file we looked at did not contain documents that are required such as an application form or minutes from an interview. This was contrary to the home's recruitment policy and meant the home was not able to demonstrate robust procedures were in place to ensure only people suitable to work with vulnerable adults were employed This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were enough staff to meet people's needs on the day of the inspection. However, some relatives felt there had not always been enough staff to provide the support required in the evening. We saw the service had increased staffing to include an extra staff member on a 'twilight' shift in response to changes in people's needs.

Activity sessions were arranged for people and we were told that events were held to mark different occasions. For example, a tea dance and other activities had been held to mark remembrance day. We observed a cake baking activity session with a small group taking place. This had been thoughtfully planned by the activity co-ordinator to support people's friendships.

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to make choices where possible and where this was not possible there was evidence that proper procedures had been followed to assess capacity and make decisions in a person's best interests.

Most of the people and relatives told us the staff were kind and caring and spoke to them with respect. We observed many positive and friendly interactions between staff and people living at Westleigh Lodge. However, on two occasions we observed staff supporting people with moving and handling, whilst at times providing little interaction or reassurance.

Some systems used to monitor training and delivery of supervision to staff had not been updated. This meant the manager would not be able to monitor that staff received the support and training required to provide safe, effective care. Staff records we reviewed indicated there were gaps in training including training in safeguarding, health and safety and training for staff to take blood samples. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that documents in relation to people's end of life wishes were present in some people's files and staff were aware what these meant in relation to people's care. However, to ensure best practice in this area improvements were required in identifying when end of life care planning should be started in order to ensure good quality end of life care.

The registered manager had recently left and all but one relative we spoke with was unaware of this. People told us they felt able to approach management to raise concerns or complaints, however, not everyone felt confident their complaint would be acted upon.

Audits were undertaken by the service; however we found actions identified were not always followed up. Audits had also failed to identify that care plans were not being reviewed and updated as frequently as was necessary and had not previously identified the problems we found in relation to medicines. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

**Requires improvement**

Not all aspects of the service were safe.

Medicines were not always given as directed and records relating to medicines were sometimes incomplete, inaccurate or missing. This meant there was a risk people did not receive their medicines as prescribed and when required.

Documents were not in place for one staff member to demonstrate proper recruitment procedures had been followed to check their suitability to work with vulnerable adults.

Staff knew how to recognise signs of abuse and how to report any concerns. People told us they felt safe, however some relatives had concerns about other people living at Westleigh Lodge entering their family members' rooms.

**Is the service effective?**

**Requires improvement**

Not all aspects of the service were effective.

Training was not up to date for all staff including training in safeguarding, health and safety and the Mental Capacity Act. Systems for monitoring the training and supervision provided to staff were not always up to date.

At the time of our inspection, few staff had the training required to be able to take blood samples.

People were supported to make decisions where possible. When this was not possible we saw best interest decisions had been made that involved families and professionals where appropriate.

**Is the service caring?**

**Requires improvement**

Not all aspects of the service were caring.

The documents we saw relating to end of life treatment decisions had been properly completed with the involvement of appropriate people. However, end of life care planning was not always carried as far in advance as would be expected to ensure good quality end of life care could be delivered.

People told us that staff were kind and caring. Most of the interactions we observed were friendly and respectful; however on two occasions staff did not clearly explain what they were doing when supporting people with moving and handling.

We saw the maintenance worker had received an award for building a positive relationship with a person with dementia who helped them around the home. This was a good example of person-centred care having been delivered.

**Is the service responsive?**

**Requires improvement**

Not all aspects of the service were responsive.

# Summary of findings

People felt able to raise complaints if required and we saw two formal complaints that had been thoroughly investigated. However, one relative said the manager had listened but not done much in response to a complaint. Another relative told us nothing ever happened as a result of feedback given in relatives meetings.

Whilst some care plans were completed in a detailed and person-centred way this was not consistent. Some of the care plans we viewed were incomplete.

We were told community groups visited the home including the salvation army and a local school.

**Is the service well-led?**

**Requires improvement**

The service was not consistently well-led.

There was no registered manager in post. The former registered manager had left three days before our visit. Staff and relatives of people living at Westleigh Lodge felt there was a high turnover of managers. Our records indicated there had been three registered managers in the previous three years.

Audits had been carried out, however these had not been sufficiently robust to pick up the issues we found in relation to medicines and infection control.

Identified actions from audits had not always been followed up.

Staff said they enjoyed working at the home. Staff survey results also showed staff were positive about the service delivered at Westleigh Lodge.

# Westleigh Lodge

**Detailed findings**

## Background to this inspection

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

The inspection took place on 19 January 2015 and 20 January 2015. The visit was unannounced. We carried out the inspection sooner than initially intended as we had received information of concern relating to the provision of end of life care and infection control procedures.

The last inspection of Westleigh Lodge took place on 20 October 2014 when we found the service to be compliant in all areas inspected.

On the first day of the inspection there were two adult social care inspectors, an expert by experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had experience visiting and providing support to people who had lived in care homes, including people living with dementia. The specialist advisor was a registered nurse specialising in end of life care, dementia and mental capacity.

Before the inspection took place we reviewed information we hold about the service. This included any concerns or other information about the service shared by people contacting CQC. We also reviewed notifications that the service is required to send us about accidents, safeguarding and other important events. We reviewed the provider information return (PIR) sent to us by the service. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make

We contacted and received feedback from the quality assurance team at Wigan Council and used this information to help plan our inspection.

During the inspection we spoke with six people living at Westleigh Lodge and ten relatives visiting that day. We spoke with fifteen staff including the deputy manager, five care staff, three nursing staff, two domestic staff, the activity co-ordinator and a catering assistant. We also spoke to the assistant operations director and a relief manager who visited during our inspection.

As some of the people living at Westleigh Lodge were not able to tell us about their experiences of living there 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.

We reviewed eleven people's care files, seven medication administration records (MARs) and other paperwork related to the running of a care home. This included seven staff personnel files, policies, minutes of meetings, records of complaints and the service's training matrix. Following the inspection the provider sent us further information as requested.

Requires improvement

# Is the service safe?

## Our findings

We found that medicines were not always managed, administered and recorded in a safe way. On one medication administration record (MAR) we saw that it was clearly marked to discontinue one of the medicines while a course of antibiotics was administered. Records indicated that the medicine that should have been discontinued had been administered daily for a period of six days. We alerted staff to the error and requested that this was followed up with a GP. The staff confirmed when they had done this and told us the GP had advised there should not be any ill effects, but to monitor the individual. This incident was also reported to the local authority safeguarding team.

When reviewing the medication file we saw that two people did not have photos with their medication records and the photo of another person was not a current likeness. This meant there was a risk of medicine being administered to the wrong person if new or temporary staff were required to administer medicine. We saw the provider was in the process of taking action to address this issue on the second day of our visit.

Stock control of medicines was poor. For example, we found there was a gap of three days on one MAR chart that showed a person taking a course of antibiotics had not had their medicine. This was because a partial prescription had been received and additional medication had not been requested by the service in time. This meant this person did not receive their medicine as prescribed. We also found that the balance of stock of one medicine recorded on the MAR did not match with the number that should have been left given the stock received and number of tablets administered. When observing the medicines round we saw the nurse was not able to find one person's 'when required' pain relief medicine. They told us they had administered the last dose in the morning and needed to reorder it. The nurse said that as the medicine was also a 'homely remedy' they could still administer this if it was required. A homely remedy is a medicine that can be given without prescription that the home kept stocks of.

During our tour of the building we saw a tablet had been left on the arm of a chair. We spoke to the staff member who had administered the medicine who told us they had supervised the person who had taken the medicine and believed they had swallowed it. We saw the care plan indicated this was a known risk and stated "Staff to monitor that X has swallowed medicines". However, there was no indication how long this person should be observed for. This meant the risk was not being managed effectively and meant this person had not received their medicine as was believed. It also meant other people at Westleigh Lodge had access to the medicine. We found the provider had failed to protect people from the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff personnel files to check that procedures were in place to ensure only suitable and appropriately qualified staff had been recruited. In one file we could not find copies of required documents including an application form, details of an interview or references. We queried this and were told this staff member had been recruited with the help of an agency and that documents would likely be at head office. We asked for copies of these documents to be sent to us within a week of the inspection. The service was unable to do this as they said the required documents were with the recruitment agency.

When we later received the requested documents, the date on the application form showed it had been completed after the staff member had commenced work and was for a new role they had applied for in the home. The provider was not able to locate the original application but said it would have been completed as part of the staff member's induction. Sections of the application form provided, including dates of previous employment, reference details and reasons for leaving former employment were blank. One of the two references sent to us was also not dated so it was not possible to determine when this had been obtained, and therefore whether it was up to date. This was contrary to the home's recruitment policy which stated that all interview notes, completed forms, employment history and eligibility documents should be kept securely in the service.

We found effective recruitment procedures had not been followed to ensure people employed were of good character and had the qualifications and skills necessary for the work to be performed. This was a breach of

Requires improvement

# Is the service safe?

Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of regulation 19(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people we spoke to told us they felt safe living at Westleigh Lodge. One person said "It's nice and warm and safe here". Four of the five relatives we spoke to felt their family member was safe, however three relatives added that they felt there were not always enough staff on in the evenings and at night to meet high levels of care and support needs. One relative told us their family member was sometimes not supported to use the toilet. They said this was because they were one of the last people to receive support to the toilet, and staff could be called away to do other tasks before they had got round to supporting them.

At the time of our inspection we saw there were enough staff to meet peoples' needs. We talked to the deputy manager about staffing and they told us an extra member of staff working a 'twilight shift' had been introduced in response to a change in dependency. Staff told us this extra staff member had been useful and they now felt there were enough staff. We looked at rotas and confirmed that this was in place.

We noticed that gates had been put on the doors of some people's rooms who were cared for in bed. We were told this had been arranged due to relatives' concerns about others entering their family member's room. On one occasion we saw a person trying to access another person's room for approximately four minutes before we were able to alert staff to this. This suggested staff were not always allocated effectively where they could provide people with the support they required.

The staff we spoke to were able to explain how they could recognise signs of potential abuse or neglect, such as through a change in someone's behaviour. They were also aware of procedures for reporting any concerns. One relative we spoke to told us about a safeguarding incident that had taken place involving their relative. We followed this up and found that the issue had been raised correctly with the local authority safeguarding team. Discussion with the deputy manager showed that the service had responded appropriately and put measures in place to reduce the risk of a repeat incident.

In the month before our inspection, Westleigh Lodge had had an outbreak of a sickness bug, and we had received information from relatives of people living at Westleigh Lodge that good infection control procedures were not being followed. On the first day of our inspection we saw a dirty commode and items including hoist slings, personal clothing and a towel in the communal bathroom. These items were removed promptly when pointed out. We spoke with a domestic who was aware of good practice in relation to infection control and was aware of proper procedures for cleaning up spills including bodily fluids. However they told us other staff members did not always tidy up or clear spills. This would increase the risk of spread of infection.

We saw that there was adequate personal protective equipment (PPE) such as gloves and aprons available for use and hand gel dispensers were stocked. The deputy manager was aware of the role of the infection prevention and control (IPC) lead in the service and who they could go to for further advice if required. We saw that infection control audits had been undertaken regularly and had not identified any major concerns or areas for improvement.

Requires improvement

# Is the service effective?

## Our findings

The assistant operations director told us that training in end of life care had been undertaken by some staff. However, they said that following investigation by the service into complaints received about the quality of end of life care and competency of staff to deliver effective end of life care, a need for further training in this area had been identified. The service did not have a summary of end of life care training undertaken available for us to review as it had not been entered onto their monitoring system.

Staff told us they received supervisions, however we found copies of supervision records had been archived. We were unable to tell when staff last received supervisions from the records as we were told the supervision matrix was not up to date. This meant effective systems were not in place for the manager of the service to monitor that staff were receiving the support and training they required to deliver good quality care.

We looked at records to see if staff had received the training required for them to carry out their role safely and effectively. The training matrix indicated gaps where refresher training was required for a number of staff. In particular, refresher training was required by more than quarter of the 72 staff for emergency procedures, food safety in care and health and safety. Safeguarding training was overdue for 19 staff and Mental Capacity Act and DoLS training was overdue for 16 staff.

We were told two staff were trained and able to take blood samples. If one of these staff members was not available this meant people had to be taken to a clinic outside the home to have a blood sample taken or another health professional would be asked to visit. A complaint we reviewed indicated this meant there had been instances when samples had not been obtained promptly. We viewed minutes from a meeting with relatives approximately three months before our inspection took place where a need for this training had been identified. We discussed this with the assistant operations director who told us following receipt of the complaint, enquiries had been made to arrange this training although a date had not yet been agreed. We saw emails that confirmed this was the case. However, these were dated around two months after the issue had been raised at the relatives' meeting.

We found the provider did not have suitable arrangements in place to ensure staff had received appropriate training and support to enable them to deliver care to people safely and to an appropriate standard. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to a breach of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to staff about the training they had received to use syringe drivers. Syringe drivers are a way of delivering medicine and are often used in end of life care as a way to manage pain. We saw copies of emails that showed thirteen staff had been booked onto syringe driver training that had taken place a short time before our visit. This training had been arranged as a result of an investigation into a complaint that had identified a need in this area. We spoke with a nurse who confirmed they had completed this training recently and had been building confidence in the technique.

We saw documentation in people's care files that showed referrals were made to specialists including speech and language therapists, GPs and other health professionals regularly and in response to changing health needs. We saw assessments of weight and nutritional risk had been completed in the care files we looked at. Most of these had been regularly reviewed, however, in one file a nutritional risk assessment that should have been reviewed monthly had not been reviewed for over three months. This meant there was a risk that any change in relation to nutritional risk would not be noticed and therefore appropriate actions not put in place.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We saw that the service was making DoLS applications to the local authority where it had been identified that restrictions were required to ensure people received the care they required. We spoke to staff about DoLS and found they were aware of which people living at Westleigh Lodge

Requires improvement

# Is the service effective?

had an authorised DoLS and what this meant in respect of their care and support. Staff were able to explain how they supported people to make choices, for example by giving people a visual choice of two meals.

We saw evidence of capacity assessments and best interests decisions having been carried out in relation to the care people received. The process had involved other professionals and family and was clearly documented. We saw a 'consent to photography' form in one person's care file had been signed by another person. It was not clear who this person was, how they were related or whether they had any legal power such as a lasting power of attorney to be able to provide consent on behalf of that individual.

We observed the mid-day meal and saw that people were offered a choice of what they wanted to eat. We received positive comments about the food including, "Food is very nice and there's enough" and "Food is okay. I choose what I want". When someone did not eat the meal provided we saw that they were offered an alternative. We spoke to a kitchen assistant who told us people's preferences and allergies were recorded when they moved in and they also received regular feedback on people's preferences via the care staff. The kitchen assistant said where people required special diets, such as diets for people with diabetes or vegetarians, ingredients to make these were ordered in. The kitchen assistant was aware of the food supply chain and told us all the food was fresh. We saw the home had received a bronze 'food for life' award, which the deputy manager said was in recognition of providing healthy, nutritious food.

We saw there were a number of adaptations to the environment to make it 'dementia friendly' such as memory boxes on some people's doors, pictorial signs, contrasting colours in the bathrooms and different coloured doors. These adaptations would support people living with dementia to retain independence in their home. It was noted that some of the pictorial signs were quite small however and might be hard to make out by people with impaired vision. We spoke to a nurse who told us they felt dementia care was one of the home's strengths, and they demonstrated good knowledge of best practice in dementia care.

Requires improvement

# Is the service caring?

## Our findings

The deputy manager told us wishes in relation to end of life care were discussed with people and their families during initial assessment before moving into Westleigh Lodge. They said this would include discussion as to whether further assessments in relation to mental capacity, health and best interests were required to decide whether a statement of intent or a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision were appropriate. Statements of intent and DNACPRs document how the person should be cared for and what medical intervention, if any; they should receive at the end of their life.

We saw that these documents were present in some people's care files and they had been completed correctly with the involvement of a GP and family where appropriate. We followed this up by asking a nurse if she was aware of people having made decisions regarding their end of life care. The nurse was aware of people having statements of intent and DNACPRs and what these meant in relation to the care those people should receive. We saw that some people had end of life care plans in place that detailed their wishes in relation to end of life care. However, we saw one end of life care plan had not been completed as far in advance as would be expected. Whilst there was no evidence of a negative impact on this person, it was discussed and acknowledged by the provider that best practice would be for end of life care planning to be started sooner to ensure good quality end of life care provision to people.

We received information before the inspection from a relative that pain scale assessments were not always accurately completed or used to determine when pain relief should be given. The pain scales we saw on the day of the inspection had been used to assess people's level of discomfort and were up to date. They also indicated that pain relief medicines had been administered in response to identified pain, such as pain occurring between doses of regular pain relief medicine.

Most of the people we spoke to living at Westleigh Lodge felt the staff were kind and caring. Comments received from relatives were generally positive and included, "Care is exceptional" and "All the staff are kind, they listen to us and they're approachable" and "I have no complaints whatsoever. All the staff are brilliant". One relative told us how staff spoke nicely and respectfully to their family member who could not communicate verbally. However, one relative felt that whilst most staff were kind and caring, others were not so good. One person living at Westleigh Lodge also said if the staff were rushed they could be in a bad mood

We observed interactions between staff and people at Westleigh Lodge to be friendly, respectful and unrushed. We saw people smiling and laughing with staff. Our discussions with staff and observations of them delivering care to people indicated they knew people well, including their likes and dislikes. On two occasions however, we observed staff talking to each other and providing only limited explanation of what they were doing when supporting people with moving and handling tasks such as using the hoist. This showed a lack of respect and meant the individuals being supported were not being involved in the care being provided to them.

We asked staff what they understood by the term 'person centred care'. One member of staff said "Everyone is an individual. Each resident has their personal needs". Another staff member told us it was about people making their own choices. The deputy manager told us there was a 'kindness in care award' that was given out quarterly to staff that had provided particularly good or person centred care. We saw the latest award had been given to two staff. One of these staff was the maintenance worker who had received the award for building a positive relationship and providing support to an individual living with dementia. This showed the home considered people's individual preferences and supported people to build relationships that supported their social needs and helped them remain engaged in occupation.

Requires improvement

# Is the service responsive?

## Our findings

All the relatives we with told us they would approach the registered manager or deputy manager if they needed to make a complaint and felt confident in doing so. Not everyone was confident their complaints would be acted upon however. One relative said "My complaints were addressed, the manager seemed approachable"; however another said "The manager listened but didn't really do anything".

We viewed minutes of meetings held with relatives, the most recent we saw being around three months prior to our visit. These were detailed and showed that people attending the meetings were able to raise any concerns or ideas they may have. People we spoke to told us they were aware there were meetings they could attend. However, one relative said they felt nothing changed as a result of them and commented 'It's a long time since we had one due to the changes in manager".

We saw there were two formal complaints in the complaints file, which were also logged on the on-line monitoring system. The complaints raised concerns relating to end of life care including competence of staff to deliver pain relief medication, failure to put in place appropriate end of life care planning, not following relatives' requests to contact a GP to look into arranging a statement of intent/DNACPR and sending a person to hospital when this was not in their best interests.

We saw that these complaints had been investigated, apologies issued where the home was at fault, and actions identified in order to prevent any similar incidents. We discussed the complaints with the assistant operations director who confirmed the actions taken such as arranging specific training for staff to ensure they were competent to deliver pain relief medicine using syringe drivers.

We saw that surveys were given to people living at Westleigh Lodge and their relatives to seek their feedback and views on what the service did well, and where it could improve. The scheme was run by an external research company. This meant feedback was independently analysed and was benchmarked against other homes participating in the scheme. This would help the service gain a better understanding of how it was performing in terms of the satisfaction of people living there and their relatives. The results were also published online, allowing people thinking of moving to Westleigh Lodge to see how satisfied people were with the service.

Following our visit we viewed the most recent report that was awaiting publication at the time of our inspection. This showed the service scored above average for the three main areas of satisfaction assessed.

We reviewed people's care plans and saw these were not consistently completed to a good standard. Whilst some of the care plans were person centred, regularly reviewed and fully completed, two of the care plans we looked at were not fully complete and lacked details such as life history and current capacity profiles. This meant there was a risk that staff would not have the information required to provide the correct or personalised care to these individuals.

One of the incomplete care plans was for a recent admission and a temporary care plan was in place. The nurse told us they felt the seven day target for completing a full care plan was not realistic given other direct care duties. We also found that there were sometimes duplicate care plans in people's care files and it was not always clear which one was current. The assistant operations director told us they were in the process of updating care plans to a standard format and this should be resolved soon.

Relatives we spoke to told us they were involved in care planning and that reviews were held every six months. We saw evidence of regular reviews having taken place in people's care files. However, not all care plans had been reviewed as often as required. We saw the care being provided to one person was not consistent with details in the care plan. The care plan stated staff spent 90 minutes in turn providing one to one support to take part in meaningful activities. When we spoke to staff they told us they spent 60 minutes each and told us this person spent a lot of time in bed rather than taking part in activities. This meant there was a risk of people receiving inconsistent support or support that might not meet their needs.

One relative we spoke to told us the service had taken actions in response to the risk of their family member falling in their room. They said that use of pressure mats had not met their family member's needs and so the service was trying alternative equipment. This showed the service was responsive to this person's needs.

Requires improvement

# Is the service responsive?

During the inspection we observed an activity session being run by the activity co-ordinator. The session involved a small group making a cake. We observed little involvement in the task from people in the session. Some people said they did not want to help when asked and showed little interest in the activity. However, the atmosphere was relaxed and social and with lots of interaction between people. We spoke to the activity co-ordinator about the session. They told us people had chosen to join that activity and said the group had been planned with friendships between individuals in mind. This showed thought had put into supporting people's social needs.

The activity co-ordinator showed us documentation used to assess people's interest and involvement in sessions and this was used to plan future activities. We were told one to one activities were arranged on an ad-hoc basis. One person in the session asked to go to the pub in the afternoon and they told us later that they had done this and enjoyed a drink.

There was involvement with community groups and the activity co-ordinator told us a local school visited as well as the salvation army band. They had also recently held remembrance day activities that included a singer and a tea dance. Outside the planned activities we saw interactions and activities were sometimes limited. For example we observed staff members in the lounges not speaking or interacting with people when there had been opportunity to do so.

We saw that one of the ground floor lounges had been turned into a 'pub'. We didn't see anyone using the room during our visit as the door was locked for safety reasons. However, we were told the room was frequently used for social events and by families when visiting. The nurse we spoke to said it had been a popular addition to the home since it was added just over a year ago.

Requires improvement

# Is the service well-led?

## Our findings

There was no registered manager in post at Westleigh Lodge. The registered manager had left three days prior to our visit. 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.

We were informed that the registered manager had left having given around three weeks' notice, and without having worked the full required notice period. We found that only one of the relatives we spoke with was aware of their departure. Two staff we spoke with said they had been unaware the registered manager was leaving until the week before. One staff member said "Communication has not been very good, we don't have a lot of support".

Relatives said they felt there was a high turnover of registered managers in the home. Our records indicated there had been three different registered managers in the previous three years. One relative commented "I was shocked that the manager had left. I'd just got to talking to her" and another said "There have been quite a few managers". Staff also told us they felt the service lacked stable management. One staff member commented "We are getting used to not having a registered manager. It all drops to the deputy manager".

We discussed interim management arrangements until a new registered manager could be recruited and were told the deputy manager would be supported by the relief manager and the assistant operations director. The deputy manager said they were happy with this arrangement and with the support they would receive.

During our inspection the service found it hard to locate the documents we wanted to look at, or to tell us whether the document we had was the most recent version. We found many of the files were empty and the documents had been placed in archive envelopes that were not always in order. We were told this had been done by the registered manager before they left, but staff were unsure why this had been done.

We saw that regular audits were undertaken to monitor the quality of service provision. These included audits of medicines, infection control and care plans. These audits had not picked up the issues we had identified in respect of medicines or identified any concerns relating to infection prevention and control prior to an outbreak. This suggested that they were not sufficiently robust or in depth. We also saw that identified actions from audits were not always followed up. We noted that an audit carried out by the provider in October 2014 had identified a need for safeguarding training. We also identified a gap in safeguarding training around three months after the date of this audit indicating actions had not been taken to address this requirement.

Audits of care plans had not picked up that care plans were not all being reviewed as required or where issues had been identified, they had not resulted in actions being taken to improve care plans as required. Three of the care plans we looked at had sections that had not been reviewed within the indicated time-scales, or did not contain any evidence of review. We saw that a wound care plan in one person's file had not been reviewed since it was started around two months earlier. The care plan indicated that the review was over one month overdue. A document titled 'wound care checks weekly by home manager' was also blank. This meant the service had not effectively monitored changes to that person's care needs and there was a risk that staff would not know how to support this person correctly in relation to wound care.

Another care plan for medicines indicated it should be reviewed monthly, then "or as required" had been added underneath. The last review date was around six months prior to our inspection and it was not possible to tell when the last review had taken place. This meant there was a risk the care plan was not being reviewed as frequently as required to ensure that person was receiving the care they currently needed. One care plan audit we saw stated 'grade inadequate review in seven days'. However, there was no evidence of any review having been undertaken.

We found the provider had not put systems in place to enable the effective assessment and monitoring of service provision in order to protect people from the risks of unsafe care or treatment. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to a breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

# Is the service well-led?

Staff told us they attended staff meetings although they had not attended one for some time. The most recent minutes we saw were from a senior carers meeting held around 2 months prior to the inspection. This meeting covered topics such as induction of bank staff, monitoring fluid intake and supervisions. These meetings would allow the registered or deputy manager to communicate their expectations as well as provide a forum where staff could discuss any concerns. Previous copies of the minutes showed these meetings had taken place every two to three months.

Staff told us they liked working at the home and felt able to approach management to raise any concerns they might have. One member of staff said "I love working here. It's really homely". Another member of staff talked to us about how they felt a moving and handling assessment had not been effective in meeting someone's mobility support needs. They said they would raise this with the deputy manager and moving and handling assessor. We reviewed results of an annual staff survey and this also showed that staff were generally positive about working at the home and believed it provided a good service to people living there.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Care and treatment was not provided in a safe way. Medicines were not recorded, or administered in a safe way and there were not always sufficient stocks of medicines. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>Effective procedures were not in place to ensure only people of good character were employed by the service. Information required in relation to people employed to carry on a regulated activity was not available. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Arrangements were not in place to ensure people employed by the service had received appropriate training and supervision to enable them to carry out the duties they were employed to perform. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Effective systems were not in place to monitor and assess the quality and safety of services provided. |