Parkcare Homes (No.2) Limited

Westbury Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Westbury Lodge is a small home providing accommodation which includes personal care for up to nine people. At the time of our visit, eight people were using the service. The service supports people with a range of needs including learning disabilities, mental health, physical disabilities and sensory impairment. The provider Parkcare homes (No.2) Limited is part of the wider Priory group.

The inspection took place on 8 and 10 March 2016. This was an unannounced inspection. The home was last inspected on 29 January 2015 and received a rating of good. This inspection took place in response to on-going safeguarding investigations and information of concern received.

The registered manager had left the service four days prior to our inspection, which meant there was no registered manager in post at the time of our inspection. 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.

The home was being overseen by an 'acting manager' in this interim period whilst a new manager was being recruited. The regional manager was making weekly visits to the service to provide support during this time and another registered manager from a home within the same company was providing mentor support to the acting manager. The acting manager was accessible and approachable throughout our inspection.

People were not being protected against risks and action had not been taken to protect people from the risk of harm. People who had the most difficulty moving independently and were at risk of potential falls were accommodated on the upper floors of the building and had experienced several falls resulting in injuries. The building was not suitable to safely accommodate people with mobility needs other than on the ground floor. There were not effective methods in place for people to be able to call staff for assistance.

The home's medicine management systems required improvement in order to fully protect people. This was currently under investigation from the local safeguarding team, and being supervised by the regional manager and internal quality team.

Staff understood their responsibilities in protecting people and reporting any instances of abuse and had confidence to recognise potential signs in people that were unable to verbalise concerns.

Staff had not been supported to maintain skills relevant to their role. Staff did not receive regular or effective supervisions to discuss their development.

People were not afforded choices during the lunch meal. One person did not receive a substitute when they were unable to eat the pudding provided.

Staff were knowledgeable about the people they supported and demonstrated kindness and genuine care in their interactions with people. Staff encouraged people to maintain their independence.

We saw one example of undignified care. All other observations showed staff upholding people's privacy and treating people with respect.

Care plans were in an accessible format and contained information about the person's background, and preferences. However the recording of information was not always consistent and people's needs were not always reviewed and plans updated to reflect their current status.

Relatives told us they were kept informed about events affecting their loved ones. They were given the opportunity to provide feedback on the service, and people in the home had attended 'Your voice' meetings so they could discuss matters relating to the home.

The home had not been well led and staff lacked clear direction and leadership. The culture had not been positive and the acting manager and regional manager were putting things in place to address this.

Quality audits had not been consistently undertaken and some recordings were not an accurate reflection of events in the home. One audit relating to medicines had been falsely signed. We saw events that are notifiable to CQC, concerning injuries to people had not always been reported.

An action plan had been put in place identifying areas of improvement to be made within the home.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

People were not protected against risks and action had not been taken to prevent harm.

Medicines had not been safely managed in the home.

Staff were confident in recognising signs of abuse if a person was unable to verbally communicate this.

Staffing levels were sufficient but there was inconsistency in staff giving their notice. Staff lacked direction and had to fulfil multiple roles compromising their time for people.

Is the service effective?

Inadequate

This service was not effective

Staff had not been supported to maintain skills and knowledge relevant to their role.

Staff were not supported with consistent and effective supervisions.

The service had not applied for appropriate authorisation to restrict a person from accessing the community freely.

People were not offered choice during lunch of food or drinks. One person on a soft diet was not offered a substitute when the pudding was unsuitable for their consumption.

People's bedrooms were personalised and decorated with the individuals choice of colour and furnishings.

Is the service caring?

Requires Improvement

The service was not always caring.

There was one episode of undignified treatment towards a person but all other interactions observed were respectful.

People were treated with kindness by caring staff who knew people well.

Where people had specific communication needs, staff would ensure they communicated appropriately for that individual to understand them and gave people time to respond.

People were encouraged by staff to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were personalised and summary profiles were in place showing important information about the person and their preferences.

People's needs were not reviewed consistently and information was not always updated or actioned in response to these needs.

The activities that people had recorded on their planner were not being followed. Some of the activities listed were not appropriate.

Relatives were kept informed of events affecting their loved ones and were given the opportunity to provide feedback on the service.

Is the service well-led?

Requires Improvement

The service was not well led.

Staff had not been receiving effective leadership, direction or support.

There had not been a positive culture within the home which had compromised the core values and ethos.

Notifications that were reportable to CQC had not always been submitted.

The service had not been consistently monitored to ensure quality and maintain sufficient standards of living for people.

An action plan had been put in place to identify shortfalls and improve areas of concern.

Westbury 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.

This inspection took place on 8 and 10 March 2016 and was unannounced. The inspection team consisted of one inspector and a specialist nurse. We took a specialist nurse on this inspection to assess whether the provider had taken action to address previous concerns in relation to medicine management within the home. The home was last inspected on 29 January 2015 and received a rating of good. This inspection was planned and conducted in response to safeguarding concerns and information received.

Before the inspection we checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with three people living at the home and three relatives, five staff members, the acting manager and the regional manager. The registered manager had ceased to work at the service four days prior to our inspection, and an acting manager was responsible for the day to day running of the service whilst a new manager was being recruited. We reviewed records relating to people's care and other records relating to the management of the home. These included the care records for five people, medicine administration records (MAR), five staff files, the provider's policies and a selection of the services other records relating to the management of the home.

We observed care and support in the communal lounge and dining area during the day and spoke with people in their bedroom. We spent time observing people's experiences at lunch time and observed the administering of medicines.

Inadequate

Is the service safe?

Our findings

People were not being protected against risks and action had not been taken to prevent the potential of harm. The building did not safely accommodate people who had difficulty moving independently other than the two rooms on the ground floor. The remaining six rooms were all located on the upper floors. The home did not have a lift in place or a stair chairlift. The rooms did not have call bells in place for people to call for help and alert staff if they needed to. We asked staff how people called for help and were told they have to shout. However not everybody had the capacity to be able to call for help. People with the highest mobility risks were accommodated at the top of the building and had experienced several falls resulting in injuries, three of which had taken place on the stairs.

We saw for one person who had experienced six falls since August 2015 a floor sensor mat had been put in place to alert staff when this person was mobile so they could check on them and offer assistance and a further sensor mat had been placed on their chair. This person however was still experiencing falls; the most recent was notified to CQC early May 2016. Injuries had been sustained from some of these falls in which medical assistance had on some occasions been sought. We saw another person who resided upstairs had fallen twice within two weeks and a third person also living upstairs had experienced three falls within six days during February 2016. This person had not received medical attention for this fall until six days later and is part of an on-going safeguarding investigation. We spoke with staff about why this had been allowed to happen and they were unable to provide a definitive answer. The registered manager had left the service prior to our inspection so we could not obtain the reasons why this had not been managed appropriately for this person. This meant people were not being kept safe by the service.

At the time of our inspection an on-going safeguarding investigation was taking place. There had been a communication breakdown in the home between staff and the registered manager which had compromised the safety of people living at Westbury Lodge. Actions to seek appropriate medical advice had not been conducted in a timely manner. Risk assessments were in place for people but were not always updated to reflect the changing needs of a person after incidents had occurred which meant they were at risk of not being supported appropriately. The acting manager and the regional manager explained their whole safeguarding procedure had been reviewed and staff had been made aware of their responsibilities in reporting and recording any concerns. We saw a safeguarding folder had been put in place which had been read and signed by staff to say they understood the process. Safeguarding processes had been identified on the regional manager's action plan to be fully discussed with staff and questionnaires were in place for staff to ensure the understanding was embedded in staff knowledge.

We spoke with staff about protecting people from abuse and staff were confident in recognising signs and reporting concerns. Comments included "I would report any abuse, I would whistle blow, and go to my senior, if the senior is not dealing with it, I would go higher", "If someone can't communicate abuse, I would look for bruises that are unrelated to a fall, their personal appearance and behaviour", "There's room for improvement here but people are safe" and "I would look into it if a person told me anything, then report it to the team leader or higher, or external to safeguarding and CQC". One relative said "I have no concerns for overall wellbeing; nothing has made me uncomfortable when I have been there". One person told us "I feel

safe, I can talk to staff".

One person spent a lot of time in their room and staff said this person did not go out as often as they would like. We spoke with this person who told us they try not to drink too much as worried they would need the toilet, and have to wait for staff to come and check on them to assist, as there was no means to call for help. Staff told us that they assisted one person downstairs each day and they then had to stay downstairs until evening as they are not able to use the stairs because of previous falls on the stairs. This meant this person was being prevented from accessing their bedroom freely should they wish to spend time away from other people. We raised this with the acting manager who clarified that this had been put in place by the previous manager and is no longer reflective of what the home is doing. We asked the acting manager to ensure that staff were all aware of how they should be caring for this person and to reflect this in the person's care plan as there was some confusion among staff.

We spoke with relatives about the safety of people and comments included "I worry about the stairs, they are all getting older and they are not the most suitable of stairs" and "My relative is moderately safe, had a couple of falls recently". One staff member said "We need to be more proactive, we have been naïve". The acting manager told us on the second day of inspection that they had requested a quote for a chair stair lift, however due to the layout of the stairs a chair lift could only be fitted to cover part of the stairs to the first landing. The acting manager said "I know there is a lot we need to do".

We spoke with the regional manager about our concerns for people's safety and were told that everyone living in the home was going to have a placement review with the view of facilitating people with the highest mobility risk onto the ground floor. The regional manager agreed that Westbury was not a suitable environment above ground level for people with mobility needs and that this was currently being discussed with the company operations manager. In the meantime for one person who had recently fallen, a call monitor had now been put in place as this person had the capacity to be able to use it and alert staff they needed help. For another person that did not have the capacity to do this the home was considering a door sensor to be put in place.

Fire alarm testing was done weekly, and we saw personal evacuation plans (PEEPS) in place for people in case of an emergency. The PEEPS had last been reviewed in January 2016. The deputy discussed the home's contingency plan and told us how emergency bags had already been put in place at the evacuation location so people would have access to the essentials they may need.

This was a breach of Regulation 12 (2) (b) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples' medicines had not been managed and administered safely. This was currently under investigation from the local safeguarding team, and being supervised by the regional manager and internal quality team. Due to concerns raised a specialist nurse was part of this inspection who looked specifically at medicine management within the home. Although some concerns had been identified and addressed we still found areas needing improvement in the safe management of medicines.

Each person was prescribed their medicines and these were dispensed primarily in bubble packs where possible, clearly labelled with each person's name and relevant instructions. "As required" or liquid medications were stored in secure cupboard and kept in separate labelled plastic boxes. The medicine stock was checked daily by a member of staff who had completed the first level of medicines training, known as the 'checker'. During our observations we saw staff administering and signing for medicines appropriately.

In the medicine room there was no fridge available to keep medicines that needed to be stored at fridge temperature. We asked staff where such medicines would be kept and they told us they could use the fridge in the kitchen if necessary and keep them in a locked box inside it. People living in the home had access to this fridge which would not be a safe method of storage. We looked at the provider's policy on safe storage of medicines which stated a medicines fridge should be in place 'exclusively for medicines'. This was not being followed. At the time of our visit the home did not have any medicines in use that needed to be kept in a fridge.

One person in the home received their medicines covertly. This meant the person's medicines were given in a disguised format either in a drink or food. The person was unable to give informed consent to receiving their medicines, and it was recorded that it was in the person's best interests to receive the medicines they had been prescribed. A mental capacity assessment was in place and a best interests form had been completed by the previous registered manager and consultant psychiatrist in 2014. However there was no information accompanying the medicine administration record (MAR) to indicate if the medicines had been administered covertly, or how this was undertaken. This meant staff administering medicines had no clear guidance to follow to support this person receiving their medicines in this way. The acting manager informed us this would be reviewed which previously it had not been.

One box of medicines prescribed for a person had a different name recorded than what was on the MAR. Staff explained the medicine label was the person's real name but they preferred to be called another name and this was the name recorded on the MAR's. We explained to the acting manager that both names need to be included on the MAR's as this creates room for error if an agency worker or member of staff who was unfamiliar with this was responsible for administering medicines.

During observation of a medicine round a staff member explained one person had difficulty swallowing capsules so the person would crunch it up first in their mouth. Staff we spoke with were unaware of the importance of taking the medicine in the prescribed format and no checks had been made with the GP or pharmacy to see if this medicine was as effective if not swallowed whole. This difficulty in taking the tablet had not been flagged up to senior management, or picked up through quality monitoring of the service in order to review if the person can be supported with a more effective method of receiving this medicine. One staff member also reported that some staff would push the capsule to the 'pouch at the back of the person's throat' in order for it to be swallowed whole. This was not a safe practice; however we did not see any staff administering medicine in this way during our inspection. We raised these concerns with the acting manager who is going to address this with the GP.

There was no evidence in place to show that staff had received competency checks once signed off as competent to administer medicines. The acting manager told us some files that were kept by the previous manager were not available for her to access and these documents may be contained in those files. The pharmacy had been contacted and a complete retraining of all staff for safe medicines management and administration had been requested, with the view to all staff being competent by the end of April this year.

The protocols for some medicines that were prescribed 'as required' (PRN) and prescribed creams were not effective in providing guidance for staff to safely administer these medicines. There were no protocols in place for prescribed creams to explain why the cream was needed or where the cream should be applied. One person's PRN medicine was prescribed but there was no protocol to explain why it had been prescribed and when it was appropriate to administer it. We saw that the person had received it and staff had signed to say they had but there was nothing to indicate why it had been necessary to give this to the person. Staff were supporting people who at times could become anxious and exhibit behaviours which may challenge others. We saw people had clear emotional support plans in place, which described the individual

behaviours that may be shown, potential triggers and effective strategies to support each person. However the protocol in place indicated that the PRN medicine available should be given as a first response when these behaviours are presented. This meant people's behaviour was at risk of being controlled by medicines rather than seeking more appropriate ways to manage and support the person's behaviour. We spoke with the acting manager who agreed care plans need to link up with the protocols to guide staff in supporting people to manage their behaviour in other ways before medicine is administered.

This was a breach of Regulation 12 (2) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told that staffing levels had stabilised and no agency staff were being used at the time of our inspection. There were four care staff supporting eight people and new staff were in the process of being recruited. Staffing had been a concern recently with some staff members giving their notice and then choosing to retract it providing inconsistency within the service and staff team. The acting manager told us this had been addressed. Relative's told us "There are concerns for the turnover of staff and the continuity of care", "I think they have struggled, but there's always been sufficient staff" and "There are enough staff from what I can see". We have received information post our inspection visit that further staff members have given notice to leave Westbury Lodge.

There was a lack of clear direction on each shift and the multiple roles that staff had responsibility for which took them away from spending time with people. Staff took responsibility for cooking, cleaning, providing activities, and administering medicines which took time away from their main role of providing care and support to people. One staff member told us "We have a lot to do". Another staff said "We do everything". We spoke with the acting manager about this who was in the process of addressing the shift direction and told us "We need more structure to identify staff roles of who is doing what". On our second day of inspection the acting manager explained the staff had been divided to support two people each to provide a greater level of support especially to those people who were less mobile. The regional manager confirmed this had been identified as needing improvement and one staff member would be working for a few hours in the morning's specifically just to clean people's bedrooms, bathrooms and communal areas.

Two people were being interviewed to take the role of seniors to lead the shifts and they would be responsible for completing the medicine rounds. One staff was to be allocated each day to do the cooking and this would be done with anyone living in the home that wanted to participate. This meant the core staff team would not be dividing their time between supporting people and the other roles within the home.

Inadequate

Is the service effective?

Our findings

People were being supported by staff who had did not have the opportunity to maintain their skills and knowledge. During our inspection we spoke with staff and found areas of knowledge around medicines concerned with administration and policy, and understanding around mental capacity was lacking. Senior staff comments included "Staff need to be skilled up, we need to go back to basics" and "We need to reskill staff to do things so we all know, we have been deskilled".

We looked at staff files which showed incomplete induction sign off sheets to monitor staff competency. For one recently employed member of staff there was no induction folder in place or details showing the support and monitoring checks completed. The acting manager confirmed that this had not been documented but it had been put on the agenda to address. We spoke with staff about their induction who said "It was a poor induction, my training is not up to date", "My induction was ok, it was all on the computer, there was no face to face training" and "My induction was only e-learning training".

The acting manager informed us that every employee will be receiving a new induction irrespective of how long they have been employed. We looked at the new induction plan to be put in place which demonstrated a comprehensive and supportive process for new employees to complete. The action plan devised by the regional manager stated it would be reviewing all the staff files.

We looked at the training records for staff and saw the majority of training completed had been done as e-learning (learning conducted via electronic media) not face to face. Staff had received training relevant to their role but there were areas where training had expired and was not yet arranged to be renewed. This was in areas such as mental capacity, deprivation of liberty and safeguards and medicines. This meant staff had not always been given the opportunity to maintain their skills and knowledge central to their role. All staff responsible for administering medicines were to receive face to face training and complete a competency based assessment. During our visit we witnessed medicine training for staff being arranged for the following week after our inspection. The action plan put in place by the regional manager detailed that specialist training was to be booked for staff on subjects such as diabetes, positive behavioural support, mental health and first aid.

Staff told us they had not felt supported working at the home. They had not been receiving regular or appropriate supervisions. A supervision is a one to one meeting with a line manager in which staff can discuss any training needs or concerns they had. Staff told us "I had a supervision three weeks ago, the manager wrote up a page and I just had to sign it, I had no input", "I had a supervision a long time ago, it was a meeting where the manager wrote it and we signed it" and "Supervision is a form to sign, I had one and didn't realise it was a supervision".

We looked at some supervision's that had been documented and saw a discussion over an incident had been recorded as that person having had their supervision. Another member of staff had received a supervision where the only item discussed related to supporting a person to throw away their clothes. We raised this with the acting manager who agreed this should not have been documented as a staff

supervision and confirmed that supervisions had not been completed regularly or conducted appropriately with staff signing a pre-written document. The action plan had recorded staff were to receive supervisions and these needed to be regularly scheduled.

This was a breach of Regulation 18 (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

We saw one person who was no longer lawfully restricted had a DoLS in place. The DoLS had expired and had not been reapplied for prior to the expiry date as required. Another person was not allowed to access the community without staff supervision. This person did not have a DoLS in place to support this decision and lacked the capacity to understand and make a decision on their own safety whilst accessing the community. A mental capacity assessment had not been carried out and there was no evidence that a best interest's decision had been discussed or made. The acting manager said no DoLS or assessments had been considered for this person. The action plan in place had acknowledged that DoLS applications needed to be completed and mental capacity assessments where there was an apparent need.

There was evidence of a completed capacity assessment for one person, with a separate capacity assessment in place for each specific decision the person was unable to make. A best interest meeting had taken place and the person's family had been involved. There were documented questions and picture formats detailing what had been asked of the individual in order to reach the conclusion they lacked capacity for that decision.

We saw in one care plan a family member had signed a person's support plans and consented on the person's behalf to allow photos to be taken of the person. There was no document to support that this family member had the appropriate legal authority to be able to consent to decisions for this person. The acting manager confirmed that there was no person with the lasting power of attorney to make decisions for this person and was looking at referring to the court of protection to appoint a legal entity for this person. We told the acting manager this needs to be addressed without delay so this person's rights are not compromised in the meantime.

This was a breach of Regulation 11 (1) Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the lunchtime experience people had on two separate days. On the first day the pictorial menu in the dining room had not been completed but this was done on the second day. The staff were responsible for cooking the meals and we saw the meal option was different to the one stated on a menu in the kitchen. Staff explained this was due to the shopping not having been done commenting "The shopping needed to be done urgently" and "It's been all over the place with shopping, it's meant to be done online".

We observed people being given a plate of egg mayonnaise sandwiches, there was no other choice of

flavour or any other savoury options available, and people were not able to help themselves to the amount they may have wanted. There was a jug of blackcurrant squash and a jug of orange squash on two separate tables but no one was offered a drink until half way through the meal. Staff proceeded to fill up people's cups with the nearest drink on the table, no choice of flavour was offered. After people had finished their sandwiches they were encouraged to return their plates to the kitchen, they were not offered another sandwich.

Staff served up tinned fruit and evaporated milk for pudding. One person was on a soft diet recommended by the dietician and staff explained they had to blend this person's food. This person was not offered any pudding. We asked staff if this person did not like pudding and were informed they would only eat warm foods, such as custard. No alternative was offered to this person. We looked at this person's diet and nutritional care plan, and saw it stated how to prepare the meals and drinks, but there was no reference to not having a pudding if it was a cold option. We raised this with the deputy manager who agreed an alternative should have been offered and was going to address this with staff.

We spoke to people about the food and they said "More or less I get to choose what I want to eat", "We don't have a menu, so we don't know what it is until mealtimes" and "Food is sometimes good, sometimes not so nice". We looked at the records of temperature checking for the fridge and saw these had not been completed regularly. We informed the deputy manager of this who said staff should be recording it daily.

On the second day of inspection we were told that one staff had now taken on responsibility for completing the online shopping order and one staff member would be allocated to cook each day with other people living in the home who also enjoyed cooking and preparing food. We observed the lunchtime meal being prepared and it looked appetising and offered people choice.

Information arising from a recent safeguarding visit completed after our inspection has shown that people were still not been provided with choices at mealtimes, resulting in one person requesting money from staff to go and buy alternative snacks from a shop, because food was not being provided in line with this person's preferences.

This was a breach of Regulation 9 (3) (b) Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had specific health conditions there was information available alongside the care plan which explained more about the condition and how to support someone with it. We could see that health care appointments were being attended; however there were inconsistencies in the recording of this information. This had been highlighted in the action plan and for all health action plans to be put in place and reviewed. Care plans contained hospital transfer forms detailing essential information about each person should they be unable to communicate their needs and preferences to external health professionals.

People's bedrooms were personalised and decorated to their taste. Where people had chosen they had a name plaque on their door or a personal decoration that was important to them. One person said "In my bedroom I have all my things, I can decorate it how I like, I chose the colour". Relatives commented "They have decorated the lounge, it's lovely" and "The building is showing its age now, but they try and keep it clean and tidy". We observed that one person only had a stool seat in their bedroom and not a comfier armchair. We spoke with the acting manager who is going to look at obtaining a different chair for this person and explained the room had recently been reconfigured. The action plan had identified improvements needed and stated the service was to receive a deep clean and replacement items were to be raised and quoted for. The regional manager said a timescale had been set to address things within a three

month period.

Requires Improvement

Is the service caring?

Our findings

During our inspection we saw one example of a person being treated in an undignified manner. This person was sat on a commode chair (which is a chair used for assistive toileting purposes when a person cannot mobilise too far) in the communal dining room. The commode part was covered with a seat but this person stayed in this chair to participate in an activity at the table and during mealtimes. We raised this immediately with care staff who told us this was the only chair suitable for this person who needed the height of the arms to assist them with standing up. We looked in this person's care plan and saw it was documented this decision of seating had been made with a visiting occupational therapist and the previous registered manager. We raised this with the acting manager who agreed it was not dignified and alternative seating should have been sourced to accommodate this person's needs and would be addressed. On a recent safeguarding visit, completed by the local authority six weeks after our inspection it was confirmed this person is still using the commode as their seat in communal areas and more appropriate seating had still not been provided. This meant the person had been subjected to undignified treatment for a prolonged period of time.

This was a breach of Regulation 10 (1) Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff interactions were respectful of people's privacy. One person said "They knock on my door". A relative also commented "Staff ask permission of my relative when doing things". When we were being shown around the home the acting manager demonstrated respectfulness for people's private rooms, only showing us into rooms in which people were able to consent to us having a look.

People were treated with kindness and compassion in their day-to-day care. We observed many caring interactions from staff who knew people well, and recognised any potential frustrations and acted in a timely manner to help alleviate these for people. People appeared to be comfortable in the presence of staff and staff were proactive in offering support to those who could not articulate they needed assistance. People had communication dictionaries in place on their preferred method of communication. One person communicated using Makaton, which uses signs and symbols to help people communicate. During our inspection we observed staff communicating with this person in their preferred way and saw the person appeared happy and responsive in this interaction with staff.

People commented on the care they received saying "Nearly everyone (staff) I get on with, they are kind to me and help", "I came here because I was ill, it's not like your own home, the staff are very kind and nice", "It's fine living here, I like it because it's flexible" and "They know what I like".

We observed a conversation between two members of staff in regard to supporting a person with opening a letter. One staff said to ask the person if they would like help in reading the letter and after if they would like help in actioning anything in the letter. Another staff member told us "The people living here never cease to surprise me, one person who has always been non-verbal giggled the other day, it was so lovely to hear".

People's relatives described the care from staff with comments including "There are such a mix of disabilities that it can be hard sometimes", "Staff are caring, some are wonderful", "They do their upmost to help [X], I couldn't speak highly enough of the staff they are extremely caring", "Staff are caring, I can't fault their dedication" , "[X] looks to the staff as his family" and "It's her home, they couldn't help her more".

Staff told us that people were encouraged to be as independent as possible. One staff member said "The goal is to move towards independent living". Another staff member said "One person makes their own cup of tea, and we encourage people to put the shopping away and make their own breakfast". We saw in one person's care plan when referring to personal care routines, it read that staff were not to do everything for the person but to encourage their independence. One person told us "I have my room locked unless I am there". Another person said "I have copies of all of my care plans, so I can read them". In the entrance hall there was easy read information available for people on mental capacity, keeping safe and taking control to enable them to be informed on topics that may affect them.

At the time of our inspection no one was receiving end of life care. We reviewed care plans in relation to end of life and a clear user friendly document was in place for people detailing wishes and preferences for care at this time. We saw that for a few people these had not been completed but this had been identified on the regional manager's action plan.

Requires Improvement

Is the service responsive?

Our findings

We reviewed people's care plans which were personalised and each file contained information about the person's likes, dislikes, background history and people important to them. There was a personal profile page in place which had a photo of the person displayed and summarised important information about the person such as their health, regular medicines and culture and faith.

People's needs were not being reviewed regularly. Each individual had a keyworker who were responsible for reviewing people's care needs. A key worker is a named member of staff that is assigned to an individual to ensure that person's care needs are met. The information in the care plans was not being updated regularly which meant inconsistent information was often recorded about a person. This made it hard to ascertain the most current reflection of care needs for an individual. One person whose needs had changed recently had no documentation of a review since August 2015. Another person had received a nutritional needs review in September 2015, however it failed to record or address that this person had changed to a soft diet following dental treatment and advice two months prior to this review. This meant the care plans did not contain accurate information for staff to follow, which may put the person at risk of receiving inappropriate treatment which did not meet their current needs.

One person had a visual impairment, but this was not referred to in much detail in the care plan, for example the degree and nature of what the person could see or specific ways of supporting the person in relation to this. Another person had been prescribed a high risk medicine which meant they needed to have regular blood tests. We could find no records that this person was having this done. The acting manager confirmed the person was attending health appointments for this reason but it had not been recorded.

We saw in people's care plans that decisions were referred to as having been 'discussed with family' but there was no recorded information regarding whom had been spoken too, when this discussion had taken place or any details of what was actually discussed and decided. One staff member told us a person's needs had changed dramatically and they would raise this but nothing had been done for that person. The acting manager told us the reviews for people had previously been inconsistent and everyone was going to receive a new review of needs.

One person was refusing support with personal care. Staff confirmed this person will go days without having a shower but had the capacity to make this decision, however there was no information documented to support this person had been spoken with and was choosing to make that decision. We reviewed the daily record for this person and saw a shower had been refused every day since the 18 February 2016. There was no written indication of any other type of personal care offered, or declined. Records documented this was 'discussed with family' but nothing further as to what was discussed with whom, when and what the outcome was.

We saw post it notes had been placed in some care plans identifying areas that needed updating. Further to this the regional managers action plan stated the care plans needed to be indicative of people's needs and ensure information was consistent across care plans. The audit also noted care plans were to be evaluated

on a monthly basis.

A communication book was available to record any events of the day and night that needed passing over to the next staff team on shift. This book contained details about different people living in the home that they might not have wanted shared with others. We saw the book was left on the dining room table throughout our visit available for anyone to pick up and read. We raised this in feedback with the acting manager who agreed it should not have been left out and was surprised staff were not keeping it in the locked cabinet which was in the dining room. This was going to be addressed with staff.

We observed fluid monitoring charts were in place for some individuals and these were being completed by staff when they had observed a person having a drink. However the charts did not contain the appropriate relevant information. For example there was no space provided to total the daily amount to ensure people's intake was sufficient. There was no information about how much fluid each person should be consuming to compare the recorded amount to, or who had recommended the person be placed on a fluid monitoring chart or why they needed to be monitored. This meant the fluid charts were not being effectively utilised to accurately monitor if a person was having the necessary intake of fluid they might need.

People's known allergies were recorded in the MAR's but one person had a food allergy. There was no information relating to this available in the kitchen for any staff preparing food to be aware of. The acting manager agreed it needed to be recorded in a more visible place.

This was a breach of Regulation 17 (2) (c) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Activities for people in the home had been identified by the regional manager's action plan as an area that needed reviewing. We saw people had individual activity planners in their care plans, however during our inspection these were not being adhered too. This was further reflected in the daily records. For example one person was meant to be having a foot spa twice a week but the daily record showed this has not been happening. Another person had it recorded that they were meant to have lunch out on the day of our inspection but this did not take place. One person told us "I don't like to do a lot, sometimes I go out, but there are no activities happening in the home". Staff comments included "There are not enough activities for people to do" and "Some people get more activities than others, there could be more in place".

The recorded activities people had on their planners included a lot of 'relaxing time', shower and hair wash and removing and changing clothes. In people's care plans however it contained information on their hobbies and interests which had not always been considered on the activity planner. The acting manager told us this needed addressing and that one member of staff was taking on the role of planning and resourcing activities for people. We saw on the regional manager's action plan everyone was to have their activity pan reviewed and updated with meaningful activities based on individual interests.

We saw staff trying to create activities for people whilst managing the other roles they had to complete within the home. One staff member sat and enjoyed a craft activity with one person. Another person looked happy to be going out to the shop accompanied by a staff member and told us "I am going to buy a book". In the afternoon we observed one person playing a game of dominos with a staff member. When the game had finished the staff said "That was a good game, I really enjoyed playing with you". Another person was being supported to use a laptop with staff to look up things of interest and research topics. During this interaction they enjoyed conversation about the things they were looking up and places they could visit. The staff member took their time with the person and appeared genuinely interested in the person's views sharing moments of humour with them. Afterwards the person told us "I like reading about real facts".

People's relatives praised the home for keeping them informed if their loved ones were unwell. Comments included "The home do ring me if [X] is unwell and inform me if something untoward happens, they keep me in touch", "They will always phone me" "They are very good at ringing me". Relatives also spoke about how nice it would be to receive communication about positive aspects of their relatives care, for example planned activities or any achievements.

The home had a complaints procedure log which recorded all formal complaints received and the actions to be taken. We saw the last recorded complaint had been in December 2015, and on receiving the complaint an acknowledgement letter was sent and the appropriate process followed in line with the service's complaints policy. Care plans contained easy read versions of the complaints process so people were aware how to raise any potential concerns. One person told us "I would talk to the main one in charge if anything is wrong". Staff told us they would try and resolve people's informal concerns if they were able and if not would then seek help from a senior. We asked the acting manager if these informal concerns were also reported and recorded but there was no evidence of this documented.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. All the relatives we spoke with had received a feedback form and for people with communication difficulties, a pictorial format of feedback was documented in their care plans.

Staff told us a meeting with people had previously been held called 'Your voice'. We saw minutes from one of these meetings that showed topics of safeguarding, complaints and other information relating to the home had been discussed. The acting manager told us the home plans to re-establish these meetings and have them monthly, but on a more individual basis to ensure those people with more complex communication difficulties have the time and space to share their thoughts.

Requires Improvement

Is the service well-led?

Our findings

Four days prior to our inspection the registered manager had ceased employment with the service. The deputy manager had stepped up to be 'acting manager' during this interim period. The deputy manager had worked for the company for 13 years and had held the position of deputy for 3 years at Westbury Lodge.

The deputy manager was being supported by the regional manager who was making weekly visits to the service. A registered manager from another home was also providing support and acting as a mentor for the deputy manager. This registered manager was present on the second day of our inspection and the deputy manager was present throughout. We spoke with the regional manager by telephone a week after the inspection when they returned from leave. The deputy manager felt confident despite the challenges the home were currently facing and talked about her commitment to the service in achieving stability for people living and working in the home. The deputy manager commented "We're having physical support" by managers coming in.

The regional manager's action plan stated a priority was to ensure they had appropriate management cover to support the site. One staff member commented "The deputy always supported me, I can chat with her". Another staff said "I have confidence in the regional manager; she knows what she's doing".

At the time of our visit people and their relatives had not been informed of the registered manager's departure. Letters had been formulated and these were due to be sent to relatives after people living in the service had been told. The deputy said they planned to tell people the day of our second visit and this would be done on an individual basis with staff sitting with each person to explain and go through with it them in a way they understood. The deputy acknowledged that some people would need more time and support as would have questions and may become distressed by the changes.

The notification informing CQC about the de-registering of the registered manager had been sent in during the inspection and the regional manager informed us the post for a new manager was already being advertised. Six applications had been received and interviews were due to take place shortly.

Staff had been informed about the registered manager leaving in a meeting held by the regional manager the day prior to our inspection. We spoke with staff about how supported they felt in light of the recent changes and they told us they had felt the effects of the instability within the home but were on board with moving forward and improving things for the people living in the home. Comments from staff included "We have been reassured that things are going to be better, staff morale is low, there has been a blame culture", "Previously I haven't felt valued, I love the people here, I love my job", "No one asks how we feel", "We are starting afresh" and "I feel happy that we have turned a page, I think we are going to get the support now for staff". The deputy manager also commented "We have been treading water for some time, and now it's time for change".

The action plan stated that practice leadership was going to be carried out by the deputy manager. The deputy manager explained that she was being a visible presence for staff on the floor and helping them to

understand the documentation and polices that were being given to them to read and what it meant in practice. The deputy manager told us "I don't think the morale will take much to address, we can do it through team meetings, supervisions, moving forward, and building on communication, make the staff feel valued".

Staff told us team meetings had previously been irregular and not a productive experience. Comments included "Team meetings have been abysmal, nobody would listen or go forward, I stopped going, hopefully it will change", "Staff meetings have been irregular" and "Team meetings are not regular, as soon as the regional manager stepped in, it's been better". The deputy manager said the format of staff meetings going forward would be reviewed, as well as a whole group staff meeting; information will be delivered in smaller groups to staff on shift so they do not need to always come in on a day off. The plan is to make the content more positive and encouraging for staff. The deputy manager said a meeting had been held with staff to identify their expectations within their roles.

The culture in the home had not been a positive one and the core values of the home had become lost with many staff unaware of what these were. One staff member said "No one has ever spoken to me about the homes visions and values". Another staff member said "There's so much going on, I just go with the flow, it's not about the staff, it's about the people living here that's important". The deputy manager told us "We need some structure in the home, not to institutionalise it but so people living here know what to expect and at what times". The regional manager spoke to us about the one vacant room the home had saying "We are in no hurry to fill it as we want to sort out the quality of the home first. It had been decided to use this room as a temporary sleep room for staff on shift as the other sleep room was located next to a person who could be loudly vocal during the night.

There had been a lack of accountability within the home which was starting to be addressed through appropriate disciplinary actions. We saw letters had been issued to staff where necessary and a meeting held. Back to work interviews had been conducted and for persistent unexplained sickness a written warning had been issued. There had been a period of some staff giving and then retracting their notice to leave which was causing disruption for the people being supported in the home. This had now been addressed by the deputy and regional manager and it had been made clear notice will not be retracted once given. For on-going disciplinary action this was being managed by the regional manager who was monitoring competency, risk assessing and putting an action plan in place.

The service is required to notify CQC about significant events. We use this information to monitor the service and ensure they respond appropriately to keeping people safe. During the inspection we found not all notifications relating to falls where injuries were sustained had been notified to CQC. We raised this with the deputy manager who informed us this had not previously been part of her role and the previous registered manager had taken responsibility for submitting notifications. We discussed what notifications must be sent to CQC and the deputy manager told us going forward she will be taking over the responsibility of this alongside the next recruited manager.

This was a breach of Regulation 18 (2) (a) Notification of other incidents of the of the Care Quality Commission (Registration) Regulations 2009.

The provider did not have effective systems in place to monitor the quality of care and support people received. At the time of the inspection the deputy manager and a senior staff were trying to reorganise the office and sort through the piles of paperwork that had been left unfiled on every available surface. This meant there was not much to see in the way of what the service was monitoring or auditing. The deputy manager explained it may have been completed by the previous registered manager but she was unaware

of what things had been audited and where this had been documented.

The registered manager from another home was able to locate some evidence of auditing but it was not consistent and had not picked up things we identified during our inspection. A review of the service had been completed by the regional manager in October 2015, identifying actions needing to be done including supervisions, DoLS, and keyworker meetings. However these had not been actioned.

An infection control audit had been completed in February 2016 and a monthly safety check audit in January 2016. This had checked items such as the fire extinguishers and mobility equipment and had identified actions and what would be done to address these.

We saw some medicine audits had been carried out recently but the name of the person signed as having completed the audit admitted they had not been the one to do this audit and their name had been falsely signed. This meant the audit was of no value. The deputy manager explained she was taking over responsibility for the medicines audit which would be done monthly. The regional manager said the audits had not been appropriate or consistently completed. The action plan identified what needed to be monitored and who will be taking the responsibility for this. The regional manager will then be checking these have been done. The company's own quality lead will also be working alongside the home and completing regular checks. The regional manager told us that a "Three month timescale has been set for Westbury lodge to be where we want it to be".

This was a breach of Regulation 17 (2) (a) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents Not all notifications relating to injury to a service user had been reported to CQC. Regulation 18 (2) (a) (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always provided with choice during mealtime. One person on a soft diet was prevented from having a pudding and not offered an alternative. Regulation 9 (3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect One person was experiencing undignified treatment by not been provided with appropriate seating. This person was sat on a commode chair in communal areas. Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent One person was under constant supervision and unable to access the community alone. The service had not applied for a DoLS to protect this person. Consent was given by family who

did not have the appropriate legal authority to make decisions on a person's behalf. Regulation 11 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being managed safely. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care plans were not being updated regularly which meant inconsistent information was often recorded about a person. People were not receiving regular reviews of their needs. Monitoring charts were not completed appropriately. Regulation 17 (2) (c). There was not effective quality monitoring systems in place to monitor the service. Some audits had been falsified. Regulation 17 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving appropriate support, supervision and training relevant to their role. Regulation 18 (2) (a).

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service was not doing all that was reasonably practicable to mitigate risks to people and keep them safe. Regulation 12 (2) (b).

The enforcement action we took:

Warning Notice