Parkcare Homes (No.2) Limited

Westbury Lodge

Inspection report

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Westbury
Wiltshire
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

At the comprehensive inspection of this service in March 2016 we identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the provider with one warning notice and seven requirements stating they must take action. We shared our concerns with the local authority safeguarding and commissioning teams.

This inspection was carried out to assess whether the provider had taken action to meet the warning notice we issued. We will carry out a further unannounced comprehensive inspection to assess whether the actions taken in relation to the warning notices have been sustained, to assess whether action has been taken in relation to the seven requirements and provide an overall quality rating for the service.

This report only covers our findings in relation to the warning notice we issued and we have not changed the ratings since the inspection in March 2016. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Westbury Lodge on our website at www.cqc.org.uk.

At this inspection we found that the provider had taken action to address the issues highlighted in the warning notice.

A new manager had been appointed and had submitted an application to the Care Quality Commission (CQC) to become the registered manager. 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.

Due to the concerns raised and incidents regarding people with mobility concerns being safely accommodated at Westbury Lodge, the provider had decided no future placements would be accepted at Westbury Lodge above the ground level, where the person was not independent in their mobility. Everyone had received an in-house placement review in order to decide if they could continue to be safely accommodated at Westbury Lodge and if the service could effectively meet their needs. In addition placement reviews with the relevant local authorities had been requested for everyone living at Westbury Lodge, to be completed by the end of the year.

People who did not have the capacity to call for help should they require support, had all been risk assessed for the level of supervision needed when in their bedrooms. This meant staff completed regular checks in line with these risk assessments to ensure people were not left unchecked for prolonged periods of time.

Incidents were being reported and responded to appropriately. An incident reporting log was in place which showed what actions must be taken. Incidents were totalled and checked by the manager as part of their quality monitoring of the service. Staff told us they felt confident in reporting incidents and that they would

be dealt with appropriately commenting "We talk through incidents when they have happened. We are reporting incidents, it's not being pushed under the carpet and it's dealt with quickly".

Safeguarding procedures had been reviewed in the home and protocols for reporting had been revisited with staff in team meetings. Staff comments included "We have had a refresher of safeguarding training" and "Whenever something is wrong you report, I would feel happy especially now to do this".

The manager and regional manager had developed a comprehensive action plan to address the warning notice and other requirements in the inspection report where they were found to be in breach of regulations. We saw this plan was being updated and amended to reflect the progress made with improving the service. Feedback was obtained through meetings with people who use the service and staff. The meetings were used to explain the actions they were taking and the improvements they wanted to achieve.

We have not changed the rating for this key question from inadequate because to do so requires a full assessment of all the key lines of enquiry for this question. We will complete this assessment during our next planned comprehensive inspection .

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

We found action had been taken to improve the safety of people who use the service.

Due to the concerns raised and incidents regarding people with mobility concerns being safely accommodated at Westbury Lodge, the provider had decided no future placements would be accepted at Westbury Lodge above the ground level where the person was not independent in their mobility.

Everyone had received a placement review in order to decide if they could continue to be safely accommodated at Westbury and if the service could effectively meet their needs. In addition placement reviews with the relevant local authorities had been requested for everyone living at Westbury Lodge, to be completed by the end of the year.

People who did not have the capacity to call for help should they require support, had all been risk assessed for the level of supervision needed when in their bedrooms. This meant staff completed regular checks in line with these risk assessments to ensure people were not left unchecked for prolonged periods of time.

Risk assessments for people had been updated in line with their changing needs and were being reviewed regularly.

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a focused inspection of Westbury Lodge on 4 October 2016. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 8 and 10 March 2016 had been made. We inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting legal requirements in relation to that question and we issued a warning notice following the comprehensive inspection.

The inspection was undertaken by one inspector. Before our inspection we reviewed the information we held about the home This included the provider's action plan, which set out the action they would take to meet legal requirements.

At the visit to the home we spoke with two people who lived there, the regional manager, the deputy manager and two health care assistants. We spoke with two relatives by telephone after the inspection.

We reviewed records relating to people's care and other records relating to the management of the home. These included minutes of resident meetings, four people's care records and staff meeting minutes.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of Westbury Lodge on 8 and 10 March 2016 we found 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. There had been a communication breakdown in the home between staff and the previous 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. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result of the concerns, we issued a warning notice to the provider. The provider wrote to us with the action they were going to take to address risks to people's safety. At this inspection we found the provider had taken action to meet shortfalls in relation to the requirements of Regulation 12 described above.

Since the last inspection, a new manager had been appointed at the service. The manager had submitted an application to the Care Quality Commission (CQC) to apply to become the registered manager. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run. The manager has been supported by the regional manager, a new deputy manager and regular visits to the home have been made by the provider's quality assurance team.

The provider had told us to accommodate people with mobility concerns safely at Westbury Lodge, they were planning to install a lift. At this inspection we found work in line with this had started but would not continue. The regional manager explained installation of a lift was a much bigger project than had originally been identified and the result would mean losing a lot of internal space. For example the dining room people used to eat their meals and share activities would be significantly reduced in size. For this reason the planned lift installation was not going ahead.

The regional manager said alternative measures had been decided in relation to accommodating people safely. Everyone living at Westbury Lodge had received an in-house placement review in order to decide if they could continue to be safely accommodated at Westbury and if the service could effectively meet their needs. In addition placement reviews with the relevant local authorities had been requested for everyone living at Westbury Lodge, to be completed by the end of the year. Since our last comprehensive inspection two people had been supported to move to more suitable accommodation to meet their needs. The regional manager understood that this would have a significant impact on people who had lived at Westbury Lodge for a long time and for their relatives. However it had been recognised that the design of Westbury Lodge could not safely meet the needs of these people. The regional manager commented "The priority has been making sure people are safe".

The regional manager explained that no future placements would be accepted at Westbury Lodge above the ground level where the person was not independent in their mobility and the service was reviewing the age band of people coming to live in the home. The regional manager told us that Westbury Lodge will be changed from a nine bed home to an eight bed home. The provider has been asked to notify The Care Quality Commission in writing of any changes to their registration.

People who did not have the capacity to call for help should they require support, had all been risk assessed for the level of supervision needed when in their bedrooms. This meant staff completed regular checks in line with these risk assessments to ensure people were not left unchecked for prolonged periods of time. One staff member told us "We are checking on people in the least restrictive way, hopefully they don't see us; we then write on the daily check to record the person is safe". Staff explained that people spent less time in their rooms now and more time in the communal areas of the home.

We saw that the recording of checks was not always completed appropriately however. For example, for one person it was recorded on one day that checks at 30 minute intervals had all been completed, but did not show each time this had been done. On another day it did not record if any checks had been completed by staff. We could see that for large parts of the day some checks had not needed to be completed as this person had been in the communal areas with staff. We raised this to the regional manager about the recording of these checks and were informed this would be raised with staff so checks are documented clearly.

We asked the regional manager if emergency call bells were being put into the new planned en-suite bathrooms, and the regional manager confirmed this had not been discussed. The regional manager told us this would be raised at the next meeting with the surveyor which was happening a few days after this inspection, and saw no reason why emergency alarms should not be implemented in people's en-suite bathrooms as a safety measure.

We saw that incidents of falls had significantly reduced since suitable alternative placements had been found for two people previously living at Westbury Lodge. This confirmed that it had not been a suitable environment to accommodate people with mobility concerns above the ground floor. We saw the most recent fall had been recorded in the person's daily notes so all staff would be aware. This person had experienced a fall because of a health condition and was accommodated on the ground floor. The waking night staff had been spending one to one time with this person to ensure they were safe.

At our last comprehensive inspection we found there had been a communication breakdown in the home between staff and the registered manager which had compromised medical attention being sought in a timely manner for people after an accident or incident. We reviewed the incident folder and saw the provider's policy on incident management, reporting and investigation was at the front as a reminder for staff. An incident reporting log showed what actions must be taken including assessing if the person requires further medical treatment, notifying the registered manager, notifying the person's GP, informing the person's family and making any necessary notifications to safeguarding or CQC.

Incidents were totalled and checked by the manager as part of their quality monitoring of the service. The regional manager told us "We look at the lessons learnt and how we can change it and put an action plan in place, our incidents have reduced". Staff told us they felt confident in reporting incidents and that they would be dealt with appropriately commenting "We talk through incidents when they have happened. We are reporting incidents, it's not being pushed under the carpet and it's dealt with quickly", "If there is an incident we ask for help" and "We check if the person is safe, we get a senior to come and see, and make a 999 call if needed".

Risk assessments for people had been updated in line with their changing needs. For example, one person's risk assessment for moving and handling had been amended in May 2016 and recorded that this had been completed after the person had received a full review. Another risk assessment that had been updated directed staff to follow the care plan for information on how to support the person safely. We saw these were now being reviewed regularly. One staff told us risk assessments are in place for everything, people using the kettle, or having a bath, whenever someone tries something new, now there is an assessment put in place".

Documented updates for people who had been assessed as needing support in specific areas were in place. For example, one person had been assessed as needing a new suitable chair and another person had been assessed as needing a referral to an external health professional. The regional manager said "We are there to make people's decisions and wishes happen, we would risk assess something, it wouldn't be inconceivable to do".

Safeguarding procedures had been reviewed in the home and protocols for reporting had been revisited with staff in team meetings. We saw in the minutes of one team meeting this had been fully discussed with staff and they had completed a questionnaire to assess their level of knowledge in this area. Staff told us "We have had a refresher of safeguarding training", "Any concerns I would stop it instantly, then report it, it's like how you would care for your own family" and "Whenever something is wrong you report, I would feel happy especially now to do this".

A safeguarding folder was in place which documented a flowchart of how to escalate any safeguarding incidents. At 'Your Voice' meetings which were held for people living in the home information about what safeguarding meant would be discussed. People were asked what they thought abuse was and who the possible abusers could be. A safeguarding log was in place so any referrals made and action taken could be tracked and monitored. The regional manager told us "Staff have had online and face to face training in safeguarding. We talk safeguarding at every team meeting and individually as this was a massive thing".

Since the last inspection the provider had begun an extensive refurbishment of Westbury Lodge. The proposed changes included three en-suite facilities to existing bedrooms, a new medicine room, a complete new kitchen, a separate dining room with new appropriate furniture, a separate lounge and dining area with new furniture and redecoration of people's bedrooms all chosen by people living at Westbury Lodge.

All of the people who use the service and their relatives that we spoke with said they had noticed changes for the better in the home. One person told us "It's nice, I am happy living here". Relative's comments included "It's been a bit of a rollercoaster, they have modernised and made changes, it's nice", "When we take my relative out, they now say 'Going home' which is nice that [X] feels that way about the place", "It seems a lot better outwardly, the renovations are a lot better and the proposed bathrooms are good" and "Staff have been open and honest with us, it's been good, they haven't made excuses, but have said it like it is". One staff member told us "It lifts you up emotionally from what has happened, I know more now, it's not like I'm working in the dark anymore".