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Westcotes Rest Home

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?	**Inadequate**

Summary of findings

Overall summary

Westcotes Rest Home is a care home. People in care homes receive accommodation and nursing or person care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Westcotes rest home can accommodate up to 20 people in one adapted building. At the time of the inspection 14 people, some people of whom were living with dementia were in residence. The accommodation is provided over three floors with a passenger lift for access.

This inspection took place on 15 October 2018 and was unannounced. We returned announced on 16 October 2018 and unannounced on 1 November 2018.

There is no requirement for a registered manager to be in post at this service as the owner is a sole provider. The provider has the legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the previous inspection of 17 and 18 July 2018, we issued the provider with a warning notice. The warning notice detailed the failings of the provider with regards to Regulation 17. Good governance, of the Health and Social Care Act Regulated Activities Regulation 2014. We set a compliance date for 17 September 2018.

In addition, the previous inspection of 17 and 18 July 2018, identified 2 further breaches. Regulation 15 Premises and equipment and Regulation 12. Safe care and treatment. We asked the provider to complete an action plan to show what they would do and by when to improve the key question. Is the service safe to at least good. The provider did not submit an action plan.

We found minimal improvements had been made.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months.

The expectations is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social service care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it no longer rated as inadequate for any of the five key questions it will no longer be in specialist measures.

The provider did not have systems and processes in place to assure themselves of people's safety with regards to their health, care and welfare. Potential risks to people were not effectively assessed and accidents and incidents were not considered when reviewing people's safety. This placed people at continued risk. People were at risk as medicine administration processes were not robust. The monitoring of people's health, safety and welfare following a medicine incident were not consistently carried out.

People's safety was compromised as personal emergency evacuation plans were not reviewed and in some cases contained conflicting information. The fire risk assessment for the service had not been reviewed since it was initially completed. A lack of systems in place to respond to a fire placed people at risk of harm.

People resided in a service which was not well-maintained both internally and externally. We found external repairs were required and significant improvements were needed to provide people with an outdoor space, which was both safe and pleasant for them to spend their time. Internally we found bathing and shower facilities did not meet the needs of people with mobility difficulties as the current facilities were not accessible.

People were supported by sufficient staff to meet their personal care needs; however, staff were task focused, which included cooking and cleaning.

Information as to the training staff had received had not until recently been collated. There was no system by which the provider could identify what training staff had attended and when or where the training had elapsed to ensure staff had up to date training reflective of good practice. Staff were not supervised through one to one supervision meetings or group supervisions, for example team meetings.

We found people were supported to make decisions and to have control over their lives, however people's capacity to make informed decisions had not been assessed. We found people, or their relatives had not been provided with an opportunity to be involved in the development of care plans in order that their views and expectations about their care be taken into consideration.

Potential risks of people not eating or drinking sufficiently were not robustly assessed. Systems to assess risk were flawed and not understood by staff undertaking the assessment. Where potential risks had been noted, we found people's care plans and daily notes did not provide clear guidance as to the role of staff in meeting people's nutritional needs. People we spoke with were complimentary about the meals provided.

People's views had been sought about activities they wished to take part in. However, none of the ideas suggested by people had been acted upon. A visiting theatre had performed a show at the service, other activities were dependent upon staff's availability or the ability of people to occupy themselves.

The leadership or the service was not effective. This directly impacted on the quality of support and care people received and meant they did not experience the best possible health and quality of life outcomes.

The provider did not have systems and processes to assure themselves as to the quality of the service being provided. This lack of oversight as to the quality of the service and the services governance meant shortfalls and areas for development and improvement had not been identified and this placed people at risk of harm.

Policies and procedures did not reflect current good practice guidance or legislation.

Poor record keeping and communication meant people's safety, health and welfare were compromised as information was not always recorded or communicated amongst the staff team to ensure people's needs were met. Records were not stored safely to ensure confidentiality. Records were not routinely reviewed or analysed to identify trends or themes to improve the quality of life outcomes for people.

A number of external stakeholders had identified improvements were required in a number of areas, which had resulted in the developing of action plans to bring about improvement.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

The process for determining potential risks to people's safety, health and welfare were inadequate. The risk assessment process did not follow a clear risk assessment process.

Accidents and incidents were not analysed and were not considered when reviewing people's assessments and care plans to mitigate risk.

People did not consistently receive their medicine as prescribed. The medicine administration process was not robust.

Improvements were needed to the cleanliness of the service.

Is the service effective?

Inadequate

The service was not effective.

Staff were not supervised and their competence to carried out their role was not assessed.

The service did not follow up on referrals to health care professionals to ensure people's dietary needs were met in order that people required support from the appropriate health care professional.

People were positive about the meals.

The premises required improvement both internally and externally. Bathing and shower facilities did not meet the needs of people with mobility difficulties.

Training had not been provided to enable staff to assess people's competence to make informed decisions. A DoLS authorisation had been applied for.

People were positive about the meals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy and dignity was not always maintained as the premises were not well maintained.

People's rights to privacy through the safe storage of documentation was compromised.

People were positive about the care they received and were complimentary about the staff.

People told us their privacy and dignity was respected by staff.

Positive interactions between people using the service and staff were observed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans did not provide a comprehensive record of people's care needs. People's views were not sought or used to develop and review their care plans.

Opportunities for people to engage in activities were very limited. People's ideas for activities were not acted upon.

People were aware of how to raise a concern.

Is the service well-led?

Inadequate

The service was not well-led

The provider had not kept under review the day to day running of the service, this had compromised people's health, safety and welfare and placed them at risk and unsafe care.

The provider had not kept under review the maintenance of the premises, to ensure people were safe and their needs were met.

The lack of oversight of the service had resulted in areas of improvement not being identified.

The provider did not have systems in place as to the governance of the service. There were no reliable and effective systems to assure people's views were sought or opportunities given to influence the service they received.

Poor and ineffective record keeping and communication impacted on the on the safety and quality of the service provided.

External stakeholders had identified improvements were needed.

Westcotes Rest Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was carried out, in part to identify what improvements had been made following the Care Quality Commission (CQC) previous inspection of July 2018.

This inspection was also carried out to respond to information from a number of departments within the local authority (Leicester City) who had shared with us their concerns, following their auditing and inspection visits of Westcotes Rest Home.

The inspection was carried out by two inspectors and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection site visit took place on 15 and 16 October and 1 November 2018.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

We spoke with six people and spent time with others who used the service. We spoke with the manager and a senior carer.

We looked at the care plans and records of five people. We looked at a selection of medicine records. We looked at the minutes of meetings for staff. We looked at records which sought people's views about the service. We viewed records in relation to the maintenance of the environment and equipment along with quality monitoring audits.

Inadequate

Is the service safe?

Our findings

At our previous inspection of 17 and 18 July 2018 we found the registered person had not ensured risks to the people using the service were mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

At this inspection we found people's safety continued to be compromised as the process to assess potential risk was flawed. People's records contained risk assessment documents in a range of areas. For example, pressure sores, aspiration and falls. Each risk assessment document had identified the overall level of risk as being low, medium or high. The overall level of risk should be determined by the completion of a tool, which requires a set of questions to be answered and scored. The overall score then identifies the level of risk. We found the level of risk had not been reached by the implementation of the tool, nor was the tool known to the manager. The manager informed us, they had continued to use the documentation for assessing risk, used by the previous manager.

We also found, that accidents or incidents involving people who use the service had not been analysed and used to influence the level of potential risk. For example, a person had fallen on several occasions during a set period of time. The most recent fall being in September 2018. The person's initial risk assessment for falls had been undertaken in February 2014 and had been regularly reviewed, the most recent review being August 2018. The review of the risk assessment had not considered any accidents the person may have had, such as falls. Therefore, no action had been identified to reduce the potential risk of further falls.

For example, a person's care plan stated staff were to undertake hourly observations of the person to check on their safety. We found, where this had not been followed the person had experienced a fall, which meant they had sustained an injury.

Risk assessments determining people's risk of malnutrition were flawed as the level of risk had not been calculated using a tool to determine the level of risk. The risk assessment for a person who had lost weight had been written in November 2015, this had been regularly reviewed most recently in September 2018, where no changes were recorded. The review had not considered the person's weight loss or resulted in a review of their care plan.

People's records did not provide sufficient information to ensure people's dietary needs were met and they were not at risk of malnutrition. For example, a person's food and fluid care plan, provided information as to what the person enjoyed eating and where they liked to eat their meals. The care plan stated that the person's weight was to be checked every month and staff to monitor and seek advice if needed. There was no further information to indicate what the person's optimum weight should be or the circumstances in terms of weight loss or gain should be noted before taking action. Records showed that the person in 2018 had lost over 7Kg in weight. Staff from the service had sent a fax to the person's doctor in August 2018 requesting a referral for the person due to their weight loss. There was no evidence in the person's records that staff had followed up their request with the doctor.

People's safety was compromised as personal emergency evacuation plans (PEEPs) were dated December 2016 and had not been reviewed in line with people's changing support needs. There was no evidence to support what information or potential risks had been considered or how the best route for a person's evacuation had been determined.

We found, in some instances the PEEP provided contradictory information. For example, two people's PEEPs stated they were to be evacuated to different zones. For one person, the PEEP stated staff were to support the person using a stand aid and wheelchair to Zone 7. The PEEP, then provided additional guidance, that the person was to be moved down the first flight of stairs using an additional piece of equipment referred to as an Evac Ski Pad, and to assist them to Zone 3. A second person's PEEP stated staff were to assist the person to Zone 8 by use of a zimmer frame, the PEEP then stated they were to support the person to Zone 1. This conflicting information posed a risk that staff would not know where to take people if a fire were to break out in the service and so placed people at risk of harm.

The fire risk assessment was dated 12 March 2014 and it had not been reviewed. There was a lack of evidence to show regular fire drills took place and information regarding staff training was not available and therefore we could not be confident that staff had received training in fire awareness. Westcotes Rest Home has two cellars. One of the cellars had been used to discard unwanted items, which included armchairs, mattresses, paperwork, electrical items and paint. We were concerned this was a potential fire hazard. The provider had cleared the cellar when we returned to the service on 1 November 2018.

Following the site visit on 15 and 16 October 2018, we made a referral of concern to Leicestershire Fire and Rescue Service.

The provider engaged external contractors to maintain and service equipment, which included electrical and gas systems, the fire system, the passenger lift and equipment used to support people in the delivery of their personal care, such as hoists and other mobility aids. All systems had a certificate to evidence they been assessed as safe at the time of the inspection.

We found shortfalls in the safe administration of medicine at this inspection. On the first day of this inspection we found a medicine capsule on the floor of the dining room. We took this to the senior carer, who was able to identify who the medicine was prescribed for. They told us, the medicine capsule must have been given on a previous day as the person that day had not taken their medicine in the dining room. This meant there had been a risk another person could have taken this medicine. We also noted a person sitting at the dining table had a tablet on their clothing, which a member of staff had noted. This showed that staff when administering medication were not ensuring people had swallowed their medicine, before signing the medicine administration record. We spoke with the manager on the inspection visit on 1 November 2018. We asked them whether they had investigated the incident of the medication capsule being found on the floor. They informed us that they had, however no conclusion had been reached. The manager confirmed there was no documentary evidence of their investigation.

On the second day of the inspection we found further evidence to support shortfalls in the administration of people's medicine. We noted on the desk in the office, amongst a pile of documents, a number of accident and incident forms. An incident report dated 30 May 2018 referred to a service user taking another person's medicine. A member of staff had left a person's medicine with them to fetch them a glass of water, however in their absence another person had taken the person's medicine. The document stated the incident had been reported to the local authority, however the Care Quality Commission (CQC) were not notified of this safeguarding incident.

We found the person who had taken medicine that was not prescribed for them was placed at continued risk. The instructions to undertake hourly observations over the next 24-hour period of the person, requested by the manger were not followed by the staff. The hourly observations of the person were recorded over an initial four-hour period, at which point there were no further records. The incident form showed that the health care advice was sought and a relative informed. The incident report recorded the advice given by the doctor.

This supports a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment.

People we spoke with told us that they received their medicine, however they didn't know what their medicines were for. People's comments included. One person said, "Yes, but I can't recollect what they are for." A second person said, "Lots of tablets but I don't know what they are." A third person told us, "Yes, the staff give me all my tables. I never ask what they are."

At the previous inspection in July 2018 we found people who had been prescribed PRN medicine (to be taken as and when required) did not always have a protocol in place to provide clear guidance as to how and in what circumstances the medicine was to be administered.

At this inspection we found the manager had liaised with a range of health care professionals requesting guidance on the use of PRN medicine. The majority of people had a protocol in place, a few remained outstanding and the manager told us people's doctors were currently providing these.

The pharmacist who supplies people's medicine to the service had visited the service to look at systems for the safe storage, administration and returning of medicine. We were shown the report of their visit of 19 September 2018 which stated the outcome of the visit was satisfactory and made no recommendations.

At our previous inspection in July 2018 we found the registered person had not maintained the premises and equipment to promote people's safety and reduce the risk of infection. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We found some improvements had been made.

Following the CQC's inspection in July 2018 we made a referral to the infection control and prevention service for Leicester, Leicestershire and Rutland.

The manager informed us that the infection control and prevention service had visited Westcotes Rest Home in August 2018, where areas for improvement were identified. The manager had undertaken an audit of mattresses, using a tool provided by the infection control and prevention service, dated 30 August 2018. The provider was informed on the same date that six mattresses needed replacing as a result of the audit. We looked at the mattresses within the service and found six mattresses to be heavily stained or mattresses covered with plastic to be ripped. When we returned on the 1 November 2018 we were informed new mattresses had been delivered.

The manager informed us they had made some changes following the visit by the infection control and prevention service had been implemented. For example, wall mounted dispensers had been sighted in a number of locations within the service, which housed personal protective equipment (PPE), gloves and aprons and were accessible to staff.

At the previous inspection in July 2018, we identified armchairs in communal areas, and in some bedrooms,

were heavily stained and malodorous with dirt and urine, which provided an infection control risk. At this inspection we found new armchairs had been purchased whilst others had been 'deep cleaned' by an external company. Carpets, which were identified as being stained or malodourous had been replaced, or were in the process of being replaced, whilst others had been cleaned. The kitchen which was previously found to be in a poor state of repair, had been replaced.

An audit by the Food Standards Agency in July 2018 had awarded a food hygiene rating of level 2 'improvement necessary'. (The ratings go from 0-5 with the top rating being '5'). The manager told us they would be requesting the Food Standards Agency return to undertake an inspection following the installation of the new kitchen.

At the inspection of July 2018, we found the rear courtyard contained an area screened by wooden fencing, which was used to store rubbish, which had included clinical waste. The courtyard was accessible to people using the service and was the only outdoor space available for people to access and relax. At this inspection we found some improvements had been made. A contract for the disposal of clinical waste was in place, which meant there was a system for the safe disposal of clinical waste. However, everyday household rubbish continued to be stored behind the screened area. The manager told us a contract had not been set up for its disposal, the provider instead paid for its removal on a weekly basis by a third party.

This supports a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Premises and equipment.

At the previous inspection in July 2018 we found a staff member was employed to cook and clean, however due to staff shortages they also provided personal care to people. We found the staff rota did not make it clear in what capacity the member of staff worked on a day to day basis.

The manager told us at the previous inspection that vacant positions were being advertised. However, the manager informed us the offer of a position was declined by the applicant. On the 1 November 2018, the manager said vacancies were being advertised.

At this inspection we found there were sufficient staff to meet people's personal care needs, however we found staff had not always kept people safe as they had not consistently monitored people to ensure their safety and welfare. Staff had minimal time to spend with people and were focused on the completion of tasks. The manager told us no additional staff had been recruited.

The staff rota had been revised, however it remained unclear on a day to day basis in what capacity staff were working, for example providing care, cleaning or cooking. At this inspection the person employed to cook and clean was on leave, therefore staff were responsible for the cooking and cleaning.

On the first day of the inspection, the senior carer who was responsible for the day to day running of the shift, which included administering medication, was answering the phone, cooking the lunchtime meal and facilitating the inspection until the arrival of the manager. The manager, on the first day of the inspection was not at Westcotes Rest Home upon our arrival, they were with the provider processing staff wages. The rota showed that the manager continued to be rostered to provide personal care.

Inadequate

Is the service effective?

Our findings

At the previous inspection of July 2018, we found some bathing and toilet facilities were in a poor state of repair and that facilities did not meet the needs of people. At this inspection we found some improvements had been made.

A shower facility on the ground floor had been repaired by the installation of a new fixed shower chair to the wall. However, the shower base was deep, which meant people had to step into the shower, there was no equipment to support a person such as a grab rail to get in or out of the shower. A toilet on the ground floor, which had had damaged tiling to the floor had been refurbished. The toilet however remained on a raised plinth, which made it difficult for people to use. Two further toilets on the ground floor still had stained floor covering.

At this inspection we found significant shortfalls in the maintenance of the premises and the facilities in which people had access to.

On the first floor there were two bathrooms, one had been used and continued to be used for storage. The second bathroom had a large shower base, however this had to be stepped into and the room in which it was located meant there was insufficient room to operate a hoist. On the third floor, there was a small bathroom with an assisted chair, which we were informed at the previous inspection of July 2018 had not worked for many years. There were no facilities at the service to support people to have a bath or shower who had limited mobility and required the assistance of equipment.

Westcotes Rest Home had three lounge areas and a dining room. The flooring in one of the lounges had recently been replaced, as our previous inspection of July 2018 had found significant staining and malodours in some communal areas. Other communal areas had had the carpets cleaned by external contractors. The dining area had not been improved, we found the flooring to be marked, the seat of a dining chair to be ripped and damaged edges to dining room tables.

At the previous inspection, we found improvements were needed in people's bedroom as storage facilities, including wardrobe doors and cabinets were damaged. The manager confirmed no action had been taken. Bedroom flooring in some rooms had been replaced and there were plans in place to replace the flooring of other rooms.

Westcotes Rest Home outdoor space for people to use comprised of a courtyard to the sides and rear of the service, which was accessed by two doors to the rear of the property. At the previous inspection in July 2018 we found this was not maintained and did not provide a pleasant place for people to enjoy. This inspection found no improvements had been made. Seating for people consisted of a plastic table and four chairs, which were damaged and broken. On the day of our inspection the table had a container full of cigarette butts and rain water, which was used by staff to extinguish their cigarettes. There continued to be outside planters, which in the main contained weeds, and a screened fenced area, where rubbish was stored.

We found both internally and externally, rotten window sills to some windows to the rear of the service, peeling or damaged paint surfaces on windows, window sills, walls, doors and door surrounds. The manager confirmed no paint work had been undertaken since our inspection of July 2018. We found some remedial work had been undertaken, as one external window sill had been replaced in part. The loose roof tile to the front of the property to one of the bay windows was still loose and plant pots to the front of the service still contained weeds.

This is a breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulation 15. Premises and equipment.

We could not be confident that staff had received the training they need to meet the needs of people who use the service. The manager informed us a training matrix was not in place to record the training staff had undertaken. This meant it was unclear as to what training staff had undertaken and when the training needed to be updated.

We found training certificates to support staff had undertaken training since our inspection of July 2018, in topics which included, medication awareness and moving and handling people safely.

Staff had not been provided with an opportunity to participate in supervisions, (one to one meeting to provide an opportunity for staff to develop and discuss work practices with a manager). The manager informed us that staff had not taken part in supervision since the previous inspection as these had not been scheduled. At the previous inspection of July 2018, we found staff records contained evidence to support staff had taken part in supervision. However, we found supervisions were not used as an opportunity to drive improvement, share ideas or used to inform staff about best practice guidance with a view to providing high quality care.

The manager told us they were aware that some people at the service were not able to make an informed decision about their care due to their health needs, for example those people living with dementia. Assessments to determine people's capacity to make informed decisions had not been undertaken, the manager explained they had not undertaken training to enable them to carry out the assessments.

This is a breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulation 18. Staffing.

People's nutritional needs were not effectively managed to promote people's health and welfare. For example, people's risk assessments and care plans for their nutritional needs did not provide sufficient information for staff to follow. Through the monitoring of people's food and fluid intake and people's weight to ensure action was taken to ensure people were not at risk of malnutrition. However, people told us they were happy with the food.

Records showed that a member of staff each morning and afternoon asked people what they wanted to eat from the options available. On the first day of our inspection, one person did not wish to eat what had been provided. A member of staff, at the wish of the person, sourced the meal they wanted from a local fish and chip shop.

A four-weekly menu had been recently developed and introduced into the service. The menu included a choice of cereals and toast for breakfast, two choices for the main meal of the day at lunchtime and two choices for tea in the afternoon, which on alternate days included a hot snack such as soup.
We spoke with people to seek their views about the food and drink. People we spoke with were

complimentary about the food. Their comments included. One person said, "Very nice." A second person said, Immaculate, nice to look at and very tasty." A third person said, "Very, very good. I can't complain."

We asked people for their views about the menu we found people did not know what they were having to eat for their main meal at lunchtime. One person told us, "The breakfast is really the same." A second person said, "Breakfast time, cereal and toast and two course meal for lunch. If you didn't like it they would give you something else."

We spent time with eleven people in the dining room at lunchtime. We asked people if they knew what they were having for lunch, everyone said they did not know. People sat at tables laid with cutlery, serviettes and condiments. Staff brought through people's meals, staff did not advise people what the meal was.

We noted equipment to support people with their eating was provided for two people to promote their independence. One person who required assistance was supported by a member of staff who sat with them offering encouragement. The member of staff asked everyone in turn if they were enjoying their meal, to which they replied yes.

People were supported to access health care services. On the second day of the inspection a person who was unwell was supported by staff to attend an appointment with their doctor, the appointment had been made that day by staff who were concerned about the person. However, improvements were needed to ensure the ongoing monitoring of people's care were robust. For example, liaising with doctors to ensure issues of concern, such as a person's weight loss were being acted upon.

We asked people if they had access to health care professionals. One person said, "Oh yes a lot of the time." A second person said, "They would get out the doctor or the paramedics." People told us they were accompanied to health care appointments. One person said, "Usually my [relative] takes me." A second person said, "A member of staff takes me." A third person said, "A staff member or my [relative] will go with me. They (staff) don't let me go on my own."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their bests interests and legally authorised under the MCA. The authorisation process for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The manager informed us a DoLS application had been submitted for one person.

Our observations showed staff sought people's consent prior to providing personal care and support, for example asking people if they wished to go through to the dining room for their lunchtime meal.

There had been no new admissions to Westcotes Rest Home since our inspection of July 2018. People who were currently in residence had had their initial needs assessed prior to moving into the service. Of the fourteen people in residence, ten people's care was funded which meant their initial assessments would have been undertaken by commissioners of a local authority. For the four people who funded their own care, their assessment would have been undertaken by the manager of the service prior to their admission.

Requires Improvement

Is the service caring?

Our findings

Our observations showed staff were focused on the completion of tasks and had limited time to spend with people listening and talking about things that were important to them. This showed staff did consider people's individual needs. This was supported by a lack of opportunity for people or their family members to develop and review care plans to ensure the service provided reflected their preferences and choices.

Personnel information about people was not stored in such a way as to ensure people's confidentiality, which had the potential to impact on people's right to privacy.

A lack of systems to ensure the service was clean, hygiene and well maintained and the lack of accessible bathing and showering facilities, meant people's dignity was compromised and their needs were not consistently met.

People shared with us their views when we asked them if they were treated with kindness and respect. One person said, "Oh yes very, oh yes very nice." A second person said, "Pretty good I think. There are a lot of changes, some leaving and they get new staff in. They show a bit of respect." A third person told us, "On yes, they (staff) are lovely. They come and cuddle me as soon as they come in. I enjoy being here with them." A fourth person said, "Oh yes, they (staff) are alright. They are a good crew. I pull their legs now and again. We have a laugh."

People shared with us their views as to whether their privacy and dignity was respected. One person said, "They knock on the door. I wash myself and they do my washing and cook my meals." A second person said, "On yes, well If I want the toilet they let me be. I wash myself and I don't undress in front of anybody."

People asked if they were involved in decision about their care and had contributed to the writing of their care plans. One person told us, "Reviews no. We have resident meetings. A group of us have meetings about every six months about holidays, day trips, meal times of if you have any problems."

We spent time with five people in one of the lounges in the morning. The television was turned on; however, no one was watching it. Two people were sleeping and we noted one person leaning to one side in their chair. A member of staff was seen adjusting the person, using a cushion to make them more comfortable. The member of staff asked if they would like a blanked and to have their feet up.

We observed positive interactions between people using the service and staff. We spent time with eleven people in the dining room at lunch time. We saw a member of staff provide assistance where required and sought people's views about the meal. A member of staff who had arrived for work, came in to say hello to everyone.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were in the process of being updated by the manager and a senior carer. However, the manager told us they had made little progress since the previous inspection of July 2018 as their time had been spent in other areas that required their attention. We found people's care plans were not always dated as to when they were written or reviewed or by whom.

People's care plans had not been developed with the involvement of the person using the service or a family member, which meant people had not had the opportunity to influence the care and support they received. We found one person's care plan contained both their name and that of another person.

People's care plans provided information, however we found the information they contained was not sufficiently detailed or not followed. For example, the manager informed us staff undertook hourly checks on a person to ensure they were safe, however this information was not recorded within the person's care plan. Records showed observations were undertaken, however not always as often as the manager informed us they should be.

People's care plans did not focus on people's strengths and were not used to ensure people's independence was maintained. Information gathered prior to people moving into the service included information on people's hobbies, interests, family and work life. We found there was limited use of this information to develop opportunities for people to continue with their interests.

At the previous inspection of July 2018, a 'residents meeting' had recently been held, where people had been asked for their views for ideas for activities during the summer. At this inspection, we asked the manager whether any of the ideas suggested, which had included visits to local parks, days trips to the seaside or a summer party or barbeque had taken place. The manager told us none of the suggestions had been acted upon.

This is a breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulation 9. Person-centred care.

One person using the service continued to attend a local day centre and one person told us they enjoyed knitting.

On the afternoon of the first day of our inspection, we saw a member of staff support three people to take part in a game of bingo. A majority of people sat within one of the lounges, we noted many people had their eyes shut and were not watching the television. There were no regular activities provided and the availability of staff to spend time with people was limited.

The manager had organised a theatre company to visit the service and perform a 'Broadway Show', which had taken place in September 2018. They told us the theatre company had been booked to return at Christmas to perform 'Winter Wonderland'.

We asked people how they occupied their time and what if any activities they took part in. One person said, "I read and my son comes every Tuesday. We have bible classes, it's very interesting and bingo. Sometimes we have parties at Christmas and birthdays, we have a cake and a spread on." A second person said, I'm always crocheting, making blankets. I love crocheting. I have to do something." When speaking of other people at the service, the person told us, "I never see them doing anything. They never read a book." A third person told us, "I read my soldier magazine." A fourth person said, "Read or watch telly or listen to the radio."

The manager informed us that no complaints, concerns or compliments had been received since our previous inspection of July 2018.

We asked people if they knew how to make a complaint. One person said. "Go to the manager, I've have not had to do it yet."

Information about how to make a complaint, or information about external organisations and advocacy services was not displayed within the service.

At the time of our inspection no one was in receipt of end of life care.

Inadequate

Is the service well-led?

Our findings

At our previous inspection of July 2018, we found the registered person did not have in place systems to ensure good governance of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We issued a warning notice, setting a

At this inspection we found continued and further evidence to support poor governance. The lack of oversight by the provider as to the day to day running of the service continued to adversely impact on people at Westcotes Rest Home. There is no requirement for a registered manager to be in post at this service as the owner is a sole provider. The provider has the legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations as to how the service is run.

We found there was a lack of culture in shaping the service around the needs and preferences of people that used it. There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation and negative outcomes for people who used the service. There were no effective systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff.

There was a lack of effective systems in place to monitor how incidents, allegations and complaints were acted on and this had led to people being placed at risk of harm and receiving care and support that was not safe.

At the previous inspection of July 2018, the manager informed us that the provider had not visited the service for a period more than two years. The manager informed us the provider had still not visited the service since the previous inspection. The manager told us they continued to visit the provider at their home address or contacted them by telephone or e-mail.

At the previous inspection of July 2018, we found policies and procedures had been reviewed but not signed by the registered person in November 2017. We found that whilst the policies and procedures had been reviewed the contents did not reflect current legislation and were either not fully implemented or not applicable to Westcotes Rest Home. The manager told us the provider was responsible for the policies and procedures. At this inspection, the manager told us there had been no changes to the policies and procedures. This meant, policies and procedures continued to refer to out of date legislation and not reflective of good practice.

At the last inspection of July 2018, we identified that the policy and procedure for quality monitoring had not been implemented. At this inspection the manager informed us policies and procedures had not been reviewed and no changes had been made. The provider's policy for quality monitoring of the service, referred to the service people should expect to be of the highest quality-care and accommodation possible and to be given a say in the running of the home. The policy states that people's views and that of their relatives will be sought through meetings and through annual surveys. Meetings involving people had been

held, but their views about activities had not been actioned. One meeting was held, to inform people that the kitchen was being updated and to advise them of the interim catering arrangements. The manager informed us people's views had not been sought since our inspection of July 2018 and the most recent surveys were carried out in 2016.

The policy in addition referred to an 'annual development plan', that was fully costed, that identified specific and measurable goals with the actions and resources allocated to achieve them. The continued lack of implementation of this policy meant significant shortfalls had impacted on the service, the quality of care and accommodation people could reasonably expect to receive.

We found continued shortfalls in the accommodation, which included the maintenance of the building, its fixtures and furnishing. The lack of suitable facilities had a direct impact on people, which risked their safety, health and welfare. For example, bathing and showering facilities were not suitable to people with mobility difficulties, people were denied the opportunity to an outdoor space that was pleasant where they could sit and relax; and the furnishings for some meant they slept on heavily stained mattresses. A lack of oversight had resulted in the fire risk assessment being out of date, a lack of fire drills taking place and people's personal emergency evacuation plans not being accurate or reviewed.

We found record management to be poor, which included the storage of documents which did not conform to the Data Protection Act 2018. We found some documents relating to people's health, care and welfare were found on the desk of the office, to which anyone could access. There was no system to ensure records relating to people's care were routinely kept up to date. For example, a number of accident and incident reports were found on the desk of the office. These had not been analysed or used to review and update people's care plans and risk assessments.

There was a continued lack of support and guidance provided to staff. Staff had not had the opportunity to take part in supervision since our inspection of July 2018 and one staff meeting had taken place. This meeting had been set up to provide an opportunity for staff from the local authority commissioning team, who were regularly visiting the service due to concerns, an opportunity to talk with staff about the importance of good record keeping. Staff meetings are a valuable tool in sharing ideas and implementing change to benefit those using the service and the staff employed.

People commented positively when asked about the manager. However, the manager was not given the time they needed to manage the service and bring about improvements needed. The provider had not reviewed the resources required to bring about changes identified by the Care Quality Commission and other external agencies. Resources to effectively manage the day to day running of the service and bring about improvements were unchanged. The provider had not visited the service and the manager had limited time to implement the changes required. The manager was responsible for processing wages, providing personal care due to staff shortages, liaising with external stakeholders and day to day issues, which included the ordering of groceries.

The manager confirmed other agencies had identified shortfalls, which meant they had an action plan identifying the improvements they had identified. These included the local authorities commissioning team, health and safety, food safety and the infection control and prevention service. The provider had failed to submit an action plan to the Care Quality Commission following the inspection of July 2018, detailing how and by when they would become compliant with the regulations.

The provider is required to display the rating from inspections awarded by the Care Quality Commission (CQC), both within the service and where applicable on their web profile. The provider had displayed their

rating on the website, however it was not displayed within the service. The manager was not aware that the rating had to be displayed. They confirmed they would make the previous inspection report accessible and display the rating.

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

The provider did not have a good understanding of the requirements of their registration with the Care Quality Commission. All necessary notifications had not been made to the CQC, for example on our visit in October 2018 we found an incident for about a medicine error, which we had not been informed of. On our returned visit on the 1 November 2018, we found a person had sustained a serious injury, which the CQC had not been informed of.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notifications of other incidents

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider was failing to notify the Commission about incidents in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to work collaboratively with people using the service or their representative in the assessment and care planning process.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received the appropriate professional development through training, supervision and appraisal.

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 provider had failed to ensure the safe care and treatment of people. Risk assessments were flawed as the system and process to assess and review risk was inadequate. Potential risks were not mitigated. Risk assessments were not reviewed with consideration to changes in people's needs nor did they consider accidents or incidents. The medicine administration process was not robust. Medicine incidents were not analysed or used to develop good practice or review systems to ensure they were safe. Referrals to health care professionals were not always timely. Systems were not in place to ensure referrals were followed up. Risk assessments to promote people's safety in the event of fire or an emergency were not robust or routinely reviewed.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to provide a clean and well-maintained property. Showering and bathing facilities were inadequate for people as they could not be accessed by service users with mobility difficulties.

The enforcement action we took:

Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to keep an oversight of the service provided. The provider had failed to develop and implement systems and processes to assure themselves as to the quality and safety of the service provided. The provider had failed to develop and implement systems and processes to monitor and mitigate risks. The provider had failed to keep and maintain accurate, contemporaneous and complete records. The provider had failed to keep records securely consistent with Data Protection legislation.

The enforcement action we took:

Urgent conditions on registration