Westin Care Limited

Westin Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Westin Care Home is a nursing home providing regulated activities (personal and nursing care) to up to 52 people. The service provides support to older people, people with dementia and mental health needs, and people with physical disabilities and sensory impairments. At the time of our inspection, there were 38 people using the service.

The service is laid out across two floors; the ground floor is named oak unit and the first floor is named willow unit. Both units offer communal dining, lounging, bathroom and toilet facilities. Bedrooms on both floors can be accessed by a lift, stairs or stair-lift. There is level access to the garden from the ground-floor. The manager's office is located adjacent to the reception area.

People's experience of using this service and what we found
The provider failed to implement a robust approach to infection prevention and control (IPC) practice. This meant people were placed at increased risk from the spread of infection. We identified gaps in relation to risk assessment, management and associated guidance. This placed people at increased risk of experiencing avoidable harm. There were sufficient numbers of suitably qualified staff to meet peoples' needs, and employment checks were in place to prevent unsuitable staff working in the service. Staff spoke confidently about how they would protect people from harm and abuse. Safeguarding processes meant actions were taken if potential safeguarding concerns were identified.

The registered manager was not involved with the day-to-day running of the service. Audits and checks had not always been used effectively and had failed to identify the concerns, errors and omissions we found during our inspection. Staff spoke about people in a person-centred way, we observed kind and caring interactions between people and staff. The manager was introducing new ways of working to improve continuity of care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was good (published January 2022).

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The inspection was prompted in part due to concerns received about pressure ulcer management. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led

sections of this full report.

After our inspection, the manager contacted us and told us about changes and improvements they had made in response to our feedback and findings at this inspection.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Westin Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to how the quality and safety of care provision is monitored, managed and assessed.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Westin Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team was made up of two inspectors and one 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.

Service and service type
Westin Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Westin Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The first day of this inspection was unannounced, the second day was announced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with ten people about their experiences of care provision at Westin Care Home. We spoke with eight staff, including the manager, nominated individual, care staff and unit managers. We spoke with one physiotherapist who was working in the service. We reviewed eight care plans, three staff recruitment files and various policies and procedures in relation to the running of the home.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We continued to have contact with the manager who updated us about changes made in response to our findings. We spoke with relatives of eight people.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- At the time of our inspection, the service was experiencing an outbreak of COVID-19. The provider failed to implement a robust approach to infection prevention and control (IPC) practice. For example, during our inspection we found bagged waste stored on the floors in a communal bathroom, toilet, and in peoples' en-suites. The laundry service was visibly unclean and cluttered. We observed a used COVID-19 test strip adjacent to the laundry sink. This meant people were placed at increased risk from the spread of infection.
- People were at increased risk of experiencing avoidable harm. Risk assessments and guidance were not always completed and consistent. For example, we identified that fire risk assessments had not been implemented for some people living in the home. This meant the provider could not be assured they had taken all reasonable steps to protect those people in the event of a fire.
- When measures were implemented to monitor skin integrity and prevent pressure ulcers developing, and deteriorating, they were not always implemented effectively. For example, the weight settings on specialist mattresses were not always correctly set. We reviewed settings on six mattresses, and found four were incorrect.
- The provider was not working in line with Health and Safety Executive guidance about best practice in relation to hot water temperatures. When staff supported people to have a bath or shower, thermometers were not always available for staff to check water temperatures were within a safe range. This meant people were at increased risk of experiencing avoidable harm, such as burns or scalds, when bathing.

Using medicines safely

- Medicines and topical creams requiring refrigerated storage, were not always stored in line with the provider's policy, or published guidance about best practice. Minimum and maximum temperatures provide a safe temperature range for refrigerated storage. Temperatures outside of the safe temperature range, can impact the efficacy of medicines and topical creams. The provider was not monitoring and recording the minimum and maximum temperatures of the medicines fridges.
- The provider could not always be assured that 'as required' (PRN) medicines, and topical creams, were being administered in line with peoples' assessed needs. For example, one person's assessment stated the person would not request medicines, and required staff to assess the person's needs daily. However, over a period of approximately four months, only eight entries were recorded to demonstrate the person's needs had been assessed. Records for the application of topical creams were not always completed to show creams were applied in line with prescribers' instructions. For example, one person's records showed creams had not been applied for two days.

The provider placed people at risk of experiencing avoidable harm because they failed to implement a

robust approach to infection prevention and control, risk assessment and risk management. Medicines and topical creams were not always managed in line with peoples' assessed needs, and the provider's policy. This was a of breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager said the ongoing Covid-19 outbreak had impacted the service; housekeeping staff were isolating after testing positive for Covid-19, and this meant the service was operating with one member of cleaning staff, rather than two. Where we observed shortfalls in cleanliness, the manager said that some cleaning tasks had not yet been completed.
● During our inspection, the manager implemented a system to ensure staff would monitor the minimum and maximum temperatures of the medicines fridges.
● Immediately after our inspection, the manager confirmed actions had been taken in response to our findings and feedback; a deep clean was undertaken, settings for all mattresses were checked and corresponding guidance was updated, to improve ease of understanding. The manager confirmed thermometers were introduced where needed, and a meeting was held with all staff to discuss the importance of IPC measures, including the immediate removal of bagged waste. The manager confirmed missing risk assessments were now in place.
● The provider ensured staff had access to sufficient quantities of personal protective equipment (PPE), including face masks, gloves and aprons.
● Staff received medicines training and regular competency checks were completed.
● The service had recently achieved a five-food hygiene rating from the Food Standards Agency.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse. Staff spoke confidently about how they would identify abuse and what actions they would take if abuse was suspected. Comments from staff included, "I'm always looking for marks and doing body checks. If I noticed anything I would report it straight away to the nurse or unit manager. If the unit manager didn't listen I would go to (manager's name)" and, "I would whistle blow to the manager and if they didn't do anything I would go to the regional director."
● The manager ensured safeguarding concerns were raised with the local authority safeguarding team when the need arose. People at the centre of safeguarding concerns were consulted and involved with decision making.
● During our inspection, two people raised potential safeguarding concerns with us. We reported these to the manager, who investigated the concerns and took immediate actions, including contacting the local authority safeguarding team.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment

● Staff were recruited safely. Checks included those undertaken with the applicants' previous employers in care, and the Disclosure and Barring Service (DBS). Checks with the DBS are important because they inform employers when a person has a criminal conviction, and so maybe unsuitable to work in health and social care settings.

● The manager used a staffing dependency tool to determine staffing levels. We saw there were sufficient numbers of suitably qualified staff to meet peoples' needs and relatives confirmed this. Comments from relatives included, "There always seems to be someone [staff] there when you need them, they always come if we need them" and, "Yes, they seem to have a lot of staff."

● Staff told us they had enough time to provide person-centred care. Comments from staff included, "The residents, it's nice to be able to properly care for them; we have time to sit with them and stuff like that" and, "It's busy, but you have time to do the personal touch."

● At the time of our inspection, there was a COVID-19 outbreak. A sign displayed on the front doors of the service, stated no visitors were allowed access. We spoke with the manager who confirmed people were being supported to receive visitors. Due to the COVID-19 outbreak, the manager told us they were encouraging people to hold visits outside in the garden.

Learning lessons when things go wrong

● The manager monitored accidents and incidents to prevent a recurrence, and learn lessons when things went wrong.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The nominated individual confirmed a manager was responsible for day to day running of the service. A manager was registered with CQC, however they were not in day to day charge of the service and visited once or twice weekly.
- Checks and audits had not always been used effectively and had failed to identify the concerns, errors and omissions we found during our inspection. For example, checks had not identified that fire risk assessments were not in place for some people.
- Registered manager visits had not always assessed the quality and accuracy of checks undertaken in their absence. For example, one registered manager visit confirmed, "All [IPC] audits completed and up to date." Although IPC audits were up to date, they had failed to identify the shortfalls we found at our inspection.
- The registered manager was not involved with assessing and monitoring the quality and safety of care provision at Westin Care Home. Additionally, the registered manager was not taking responsibility for driving improvements in the service.

The provider's failure to ensure governance systems were used effectively to monitor the quality and safety of care provision, was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Registered managers are appointed by the provider, and registered with the Care Quality Commission (CQC). They should be in day-to-day charge of services providing regulated activities (nursing and personal care).
- The registered manager was not present on both days of the inspection. Relatives and staff we spoke with did not always know who the registered manager was. The service user guide we reviewed, gave the name of the manager as the acting registered manager for the service.
- At the time of this inspection, the manager was applying to be registered with CQC. The provider confirmed the manager would replace the current registered manager, and assume day-to-day running of the service in the near future.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff spoke about people in a person-centred way, and we observed caring and person-centred interactions between staff and people. One person said, "Staff are lovely and helpful."

● The manager told us they, and staff, had worked hard prior to our inspection to improve the quality of care provision for people. The manager confirmed this had positively impacted people. For example, one person with plans to move from the service, had chosen to stay.
● The service had recently received compliments from friends and relatives of people receiving care at Westin Care Home. Comments we reviewed included, "Thank-you very much for the kindness and care you gave to our dear friend" and, "To everyone who has looked after my mum, thank-you so much. We are so glad mum spent her last week in your care."
● In Oak unit, because the majority of people were testing positive for COVID-19, the service had chosen to isolate people who were not positive. This meant that those people with dementia, who wouldn't understand the need to isolate, were able to walk around freely.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The manager had recently undertaken surveys with people, and relevant stakeholders. Actions were taken in response to feedback received. For example, one person had fed back that food portion sizes were too big, the manager spoke with staff in the kitchen and requested smaller portions at mealtimes.

Continuous learning and improving care
● The manager was working to improve care provision and implement new ways of working. For example, the manager had recently introduced 'flash meetings' so staff could receive important updates, and information about people they supported.
● The manager responded to complaints in a timely way and apologised when the need arose.

Working in partnership with others
● The service was working with a local hospital at the time of our inspection, to support people with rehabilitation and a return home; this meant physiotherapists were working in the service with some people. We spoke with one physiotherapist who said, "I have been welcomed very well. I've been to a few care homes previously, and the staff here seem to care."
● We saw referrals were made to healthcare professionals when the need arose, for example the GP and chiropodist.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider displayed their statement about duty of candour at the entrance of the service that included information about how the service would act in an open and transparent way if something went wrong.
● The manager was aware of their responsibility to act openly and honestly when things went wrong, including offering an apology when needed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider placed people at risk of experiencing avoidable harm because they failed to implement a robust approach to infection prevention and control, risk assessment and risk management. Medicines and topical creams were not always managed in line with peoples' assessed needs, and the provider's policy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure governance systems were used effectively to monitor the quality and safety of care provision.