Care Quality Commission

The Derby Care Home Limited

Westside Nursing Home

Inspection report

90 Western Road
Mickleover
Derby
Derbyshire
DE3 9GQ

Tel: 01332510084
Website: www.westsidenursinghome.co.uk

Date of inspection visit:
26 January 2022
27 January 2022
31 January 2022

Date of publication:
25 March 2022

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
Westside Care Home is a care home providing personal and nursing care to up to 26 people. At the time of our inspection there were 23 people using the service. The service has two floors with spacious communal areas.

People's experience of using this service and what we found
The risks to people's health were not always clearly documented, assessed or managed. People's records were not always detailed or legible. This increased risk of people not being supported safely.

Some areas of the home, including bedrooms and bathrooms were not kept clean and hygienic. Some equipment used to support people was dirty. Staff did not always follow the infection prevention policy and current relevant national guidance. This meant people and staff were not consistently protected from infections.

The management of the service did not have effective measures in place to identify shortfalls in infection prevention control and care planning.

Staff knew how to raise concerns about people's safety and there was a process in place to report any safeguarding issues. People's medicines were managed safely. Staff were recruited safely and had the training and experience they required to support people. Staff supported people to access health care professionals when required.

Staff worked closely with external professionals to ensure people received appropriate support with physical and mental health.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 22 November 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We received information of concern about infection prevention and control measures at this service.

We inspected and found there was a concern with infection prevention and control procedures and oversight at the service, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this report.

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 Westside Nursing Home on our website at www.cqc.org.uk.

Enforcement
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.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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? The service was not consistently safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not consistently well-led. Details are in our safe findings below.	**Requires Improvement**

Care Quality Commission

Westside Nursing 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 included checking the provider was meeting COVID-19 vaccination requirements. 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
One inspector completed a site visit and one inspector made telephone calls to relatives and staff to seek their feedback.

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

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 two people who used the service and six relatives about their experience of the care provided. We spoke with four care staff, one nursing staff and the manager. We spent time observing the care people received this helped us understand the experience of people who could not talk with us. We reviewed a range of records. This included four people's care records and their medication records. We looked at three staff files in relation to recruitment and staff supervision records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the manager to validate evidence found.

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
● Risk assessments relating to the health, safety and welfare of people using the service were not always completed and there were no plans for managing those risks. For example, we identified one person with diabetes and four people with swallowing difficulties who did not have appropriate risk assessments in place. The provider agreed to complete these risk assessments as soon as possible.
● Some of people's handwritten care plans were not legible and the staff were not able to read them easily. This increased the risk of important information about people's needs not being accessible when needed.
● Records of people's food and fluid intake were not always maintained. This put people at increased risk of malnutrition and dehydration.
● Some staff did not use personal protective equipment (PPE) effectively to safeguard staff and people using services. For example, one member of staff was observed supporting a person without the required surgical mask. Two members of staff were not wearing single use fluid-repellent surgical mask as per government guidance. This put people at risk of infection.
● Staff did not always check that professional visitors met COVID-19 vaccination requirements. For example, a CQC inspector was not asked to show the evidence of COVID-19 vaccination on the first or second day of the inspection. The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was not meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.
● Parts of the home, including bathrooms and bedrooms were not kept clean or hygienic. Cleaning was not done in line with the current government's guidance and the provider's own policy because the cleaning schedules were not consistently completed and there was no evidence that cleaning had taken place.
● Moving and handling equipment such as hoists were not cleaned or decontaminated after each use and between use by different people who use the service as per the providers' own policy.

Care homes (Vaccinations as Condition of Deployment)
From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service had not always ensured the requirement was being met.
We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action immediately, during and after the inspection. Following the inspection, they confirmed that cleaning was taking place, and suitable checks of the environment and equipment were in place.

Visiting in care homes
The provider followed the government guidance on visiting. For example, the provider followed the guidance on number of visitors allowed in the home when some staff tested positive for COVID-19.

Systems and processes to safeguard people from the risk of abuse
● People we spoke with told us they felt safe living at Westside Nursing Home. Most relatives told us they had no concerns about the safety of their loved ones. However, two relatives raised safeguarding concerns which are currently being investigated by the Local Authority.
● Staff we spoke with demonstrated a good understanding of their responsibilities to report any concerns they may have regarding people's safety and welfare.
●The service had a policy in place to support staff to confidently raise any concerns regarding practice and people's safety.
● All staff completed annual safeguarding training.

Staffing and recruitment
● We received mixed feedback from staff regarding the staffing levels at the home. Some staff told us that current staffing levels were too low, impacting on staff morale and at times, delaying people's care.
● The relatives and people we spoke to did not report concerns about staffing level. We have not observed concerns about staffing on any of the three days of our inspection.
● The provider followed safe recruitment practices. They completed relevant pre-employment checks which assured them potential employees were safe to work with people who used services, including a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● People's medicines were managed safely. Records showed people received their medicines as prescribed by their doctor. There were effective protocols for the safe administration of 'as required' medicines.
● Medicines were stored safely. The provider ensured the medicines were stored at the appropriate temperature and controlled medicines were stored in a locked cabinet as required.

Learning lessons when things go wrong
● There was a system in place to analyse and identify trends and patterns of accidents and incidents and learn lessons when things went wrong.
● The provider accepted responsibility for the shortfalls identified at the inspection and took action following our feedback.

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; Continuous learning and improving care

- There was no registered manager in post since 30 September 2020. The manager who was responsible for day to day running of the service had submitted the application to register with CQC and the application is currently being processed.
- Governance of the service was not always reliable and effective and there was no clear management structure. It was not clear who was responsible for the leadership at the home when the manager was not there.
- Some staff raised concerns about the leadership. One staff member told us, "I don't know what [the manager's] role is. You would go to the nurse in charge if you need anything."
- Audits did not identify or address some of the issues we found during the inspection. For example, the shortfalls in people's care plans and risk assessments. Audits would support the provider to understand and identify any risks that required mitigation.
- Not all staff understood what is expected of them. For example, the housekeeping staff did not have their daily responsibilities clearly defined and there were no cleaning schedules in place.
- Effective systems were not in place to ensure a good standard of cleanliness of the home. We saw bedrooms, a sluice and a communal bathroom which were not clean. A staff member told us, "Cleanliness is very poor, at times it is shocking. Domestic [staff] have to do the laundry too".

The provider had failed to implement a robust system of quality assurance or to identify and address the shortfalls in the service. This was a breach of Regulation 17 (1) (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We received mixed feedback regarding staff engagement in running of the home. Some staff told us the provider did not always act on their feedback and as a result their morale was low.
- We received mixed feedback from the relatives about their engagement. Some relatives told us they felt involved in the care of their loved ones, other raised concerns about poor communication.
- The service had good links with the local community and worked in partnership with other agencies to improve people's opportunities and wellbeing. The health professionals we spoke to had not shared any concerns about the service or staff's skills and stated the service followed their medical advice.

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 had responded to previous complaints appropriately.

● We found no evidence of the duty of candour being used; however, the manager understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

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 17 HSCA RA Regulations 2014 Good governance Systems and processes were not fully effective in ensuring people received consistent safe care and treatment. This placed people at risk of harm. Records were not accurately complete or kept up to date. Regulation 17 Good Governance (1) (2) (a) (b) (c)

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 effectively assess and mitigate risk to ensure people receive safe care and treatment, this put people at increased risk of harm. Regulation 12 (1) (2)

The enforcement action we took:

We issued a Warning Notice