The Orders Of St. John Care Trust

OSJCT Westbury Court

Inspection report

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Date of inspection visit:
20 July 2016
21 July 2016

Date of publication:
01 November 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 20 and 21 July 2016 and was unannounced. The service was last inspected on 17 and 18 August 2015 when several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. These had included, insufficient systems and processes in place to manage people's risks, inadequate training and support for staff, people's consent had not been sought for the care and treatment they received, the principles of the Mental Capacity Act 2005 had not been followed, there had been a lack of personalised care, people's care plans were not followed and there had been poor records kept of the care that had been delivered. Overall there had been a lack of effective management and a lack of effective quality monitoring of the service's performance. The provider wrote to us and told us how they would address these breaches. They told us these would be fully met by the end of April 2016. During this inspection we found all of these breaches had been met and improvements to the care and services provided had been sustained.

Westbury Court provides care predominantly to older people. A maximum of 42 people can be accommodated but at the inspection 34 people were living in the care home. Accommodation was provided on two floors and a passenger lift gave access to the second level. Each person had their own bedroom with washing facilities and some had private toilet facilities. There were plenty of additional communal bathrooms and toilets. People were provided with areas to sit and a separate dining area. Communal areas were comfortable and varied in size with televisions and music systems. One communal room had been fitted with memorabilia and furniture from past years. This room was used as a quiet area to sit and for people who found the objects familiar and reassuring. A sheltered and safe garden provided outside space which could be enjoyed during the good weather. The care home provided the equipment people needed to be safely looked after and to promote independence.

The current registered manager had been in position since September 2015. They had started just after our last inspection had been completed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people's health and welfare were identified and managed. There were arrangements in place to help prevent people experiencing harm or abuse. There were enough suitable staff to meet people's needs. Staff had received training and support to be able to meet people's needs safely and effectively. People's medical needs were met and their medicines reviewed and administered safely. People received help to eat and drink and any nutritional risks were managed well. People were supported to make decisions and their choices and preferences were met by the staff whenever this was practicable to do. People who found this difficult to do, because of a lack of mental capacity, were supported and protected under the appropriate legislation. Any decision making carried out on behalf of a person was done in the person's best interests.

People and their representatives were involved with the planning of their care and had opportunities to

review plans of care with the staff. People's recorded care plans were followed by the staff and records of care were accurately maintained. There were arrangements in place for people to join in social activities, either on a one to one basis or in small groups. Regular outside entertainment was booked for people to enjoy. People's family and friends were able to visit at any time and their involvement encouraged and valued. People and visitors to the care home were able to raise a complaint or dissatisfaction and have this acknowledged, investigated and addressed. Complaints and any errors made by staff were viewed as opportunities of learning and a chance to look at how improvements could be further made.

How the care home was managed had changed significantly over the last year. The registered manager and her management team provided strong leadership. A consistent message had been delivered in relation to what their visions, values and expectations were. The staff culture had altered and a team approach was now in place with all staff understanding their roles and responsibilities. Where there were remaining pockets of resistance to the new way of working this had been, and remained being managed, fairly and in a supportive way. The registered manager however, had made it clear about what would not be tolerated and additional action was taken where needed to address on-going resistance.

People we spoke with and their representatives had noticed the changes and spoke about these positively. Staff members were also positive about the service's future and were committed to an improved future.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were protected against risks that may affect them. Environmental risks were also monitored, identified and managed.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

Arrangements were in place to make sure people received their medicines appropriately and safely.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

Is the service effective?

Good

The service was effective. People received care and treatment from staff who had been trained to provide this. Where staff were new to care there were arrangements in place to help them learn and improve their skills.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

Staff ensured people's health care needs were met.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Is the service caring?

Good

The service was caring. People's preferences and choices were explored and staff had worked hard to introduce and support a more personalised approach to care.

People were cared for by staff who were kind and who delivered care in a compassionate way.

People's dignity and privacy was maintained and information about their care only shared appropriately.

Staff helped people maintain relationships with those they loved and who mattered to them.

Is the service responsive?

Good

The service was able to be responsive. Care plans were managed well so staff had the guidance they needed to be able to respond to people's needs.

People or their representatives, where they wanted to be and it was appropriate were involved in the planning of people's care and in the reviewing of it.

People had opportunities to socialise and partake in activities. Staff had worked hard to improve these to make them more meaningful and individualised for people to enjoy.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed. Improvements in the care and services provided had resulted in less complaints being received.

Is the service well-led?

Good

The service was well-led. People had benefited from a strong manager having been appointed who had made significant changes and improvements to the service.

Robust arrangements were in place to continually monitor the quality of service and care being provided and to maintain the improvements already made.

The management team were open to people's suggestions and comments in order to improve the service going forward.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 20 and 21July 2016 and was unannounced. The inspection was carried out by one inspector. Before visiting the care home we reviewed the information we held about it. This included a review of all statutory notifications received since our previous inspection on 17 and 18 August 2015. Statutory notifications are information the provider is legally required to send to us about significant events. We also sought the views of commissioners on the care and services provided. Also, prior to the inspection the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with two people who used the service. Some people living there were unable to tell us about their experience because they were living with dementia. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with two relatives about the care their relative received. We spoke with eight members of staff including one representative of the provider and the registered manager. We attended one staff hand-over meeting.

We inspected various documents and records relating to the people who lived at Westbury Court and the staff who worked there. These included five people's care files and three staff recruitment files. We reviewed the service's main staff training record as well as some training certificates. We reviewed personnel records relating to actions the provider had taken in response to staff performance issues. We reviewed records kept in relation to the management of medicines including two people's medicine administration records. We looked at the care home's complaints record and how people's concerns had been responded to.

We also inspected various records and documents relating to the running of the service. These included a selection of quality monitoring audits, an action plan, maintenance records and records relating to accident and incident monitoring. We completed a tour of the internal environment and viewed the outside space.

Good

Is the service safe?

Our findings

At our last inspection in August 2015 we found appropriate and effective systems and actions were not always in place to sufficiently assess and manage risks to people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to address this. They sent us an action plan which stated they would meet the regulation in full by the end of April 2016. At this inspection we found the provider had taken action to ensure risks to people were assessed and managed.

Systems were in place to keep people safe. For example, people's risk of developing pressure ulcers had been assessed. People who were at risk had received appropriate and on-going care to help prevent these from developing or, as in some cases, reoccurring. People's care plans gave staff relevant guidance on how to manage this risk. Where there had been a risk to people the guidance in the care plan had been followed. For example, people had been regularly repositioned to alleviate pressure from their skin. When this care had been delivered appropriate care records had been completed. These had been well maintained and showed this care had been delivered consistently. People had been provided with specialised equipment such as pressure relief mattresses and cushions to also help reduce the risk of pressure ulcers developing. Senior care staff were responsible for making sure this care had been delivered and the relevant records had been accurately maintained. Senior staff were carrying out this task with diligence. They were actively following up any gaps in record keeping to ensure the person had actually received the care.

We reviewed the care of one person we had met in August 2015. At that time the risks to this person and the risks they sometimes presented to others had not been fully identified and managed. Since then staff and visiting health care professionals had reviewed how this person's behaviour, which could be perceived as challenging, could be better managed. We observed staff proactively anticipating 'triggers' which may result in challenging behaviour being exhibited. If identified they managed these well. We observed staff communicating with and responding to this person in a way which helped to defuse potential challenging situations. For example, at busy times of the day, when staff were focusing on other people, this person's behaviour could become challenging and involve others around them. We observed staff organising themselves so there was always a member of staff available to address potential situations which could escalate unless defused. We observed the person responding well to staffs' interactions although their needs remained complex and challenging at times.

Accidents were monitored and in particular the circumstances leading up to a fall were looked at closely. Accident forms were now checked by the registered manager and her senior team so they had a true understanding of what had taken place. They ensured the correct preventative actions were taken following a fall. Where people continued to fall after preventative actions had been put in place, a further scrutiny of the circumstances leading up to a fall took place. The person's GP was involved to review the person medically. For example, an adjustment of a person's medicines or treatment of an unidentified condition, such as fluctuating blood pressure could help prevent further falls. In some cases a visit by an occupational or physiotherapist had helped. The registered manager explained they were often involved in people's care and always making observations of people's care. This helped them remain aware of what actions had been

effective and what had not been. They also personally reviewed the on-going management of more complex risks with senior staff to ensure the adopted actions were keeping people safe.

Staff recruitment records showed robust recruitment practices had been followed. This ensured the staff employed were suitable. Appropriate checks had been carried out before staff started work at Westbury Court. Clearances from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers and in particular, when past jobs had been with another care provider. Employment histories were requested and the reasons for any gaps explored at interview.

There were enough staff to meet people's needs. We spoke to the registered manager and two other senior members of staff about how they ensured adequate and consistent numbers of staff on duty. Recruitment of staff had been on-going since our last inspection as some staff had left (for various reasons.) The provider was still finding it a challenge to recruit nurses and there were no nurses employed by the provider working at night at Westbury Court. To ensure a nurse was on duty at all times the provider had addressed this by using agency nurses. To ensure continuity of care, the same nurses were used where possible. We spoke to two agency staff who confirmed they worked at the care home on a regular basis. They told us they knew what people's needs were, how individual care staff worked, the care home's routines and the registered manager's expectations.

One senior member of staff told us the way staff were rostered to work was "far more organised" since the registered manager started in post. They told us staff rosters were organised, not only to ensure there were enough staff in number but to ensure there was a balance of skill, knowledge and experience. They also told us the management staff were visible and happy to help deliver care when help was needed. Both, the staff with management responsibilities and care staff told us the majority of staff were committed to the registered manager's team approach. The care staff we spoke with had recognised that better management of staff absences and last minute sickness had resulted in more effective and evenly staffed shifts.

We spoke with two people who received support. They told us they sometimes had to wait to be helped to bed but this was not upsetting them or causing them a problem. They told us they recognised some people sometimes needed help before them. One of these people told us they did not always get their medicines at the time they particularly preferred to have them because of this. On further discussion with this person the time was their particular preference and the fact they sometimes got them later was not putting them at risk or making a difference to how they slept. We spoke to one member of staff about this preferences and they agreed that sometimes it was not possible to always meet this. They explained staff were sometimes busy with other people at that time but they also confirmed the person rarely got their tablets later than when they were prescribed and they also did not consider the shifts they worked to be understaffed.

The arrangements for managing people's medicines had been reviewed and altered. This followed a piece of work completed by the registered manager who investigated several previous medication errors. The provider termed a medication error as being anything from an incorrect dose being given to a person to signature gap on a medicine administration record (MAR). Once staff successfully administered medicines they had to sign the person's MAR to confirm the person has taken the medicine, or, record if the medicine had been refused or not given for another reason. Over half of the errors investigated were due to agency staff, who visited infrequently. Others were made by the care home's own staff. The actions taken involved reviewing all staffs' competencies and where needed additional training, support and reflective practice had been provided. Other actions had included ensuring the use of regular agency staff where possible, the reduction of interruptions to those administering medicines, for example, red tabards were worn to remind

people and other staff not to talk to the staff member administering the medicines. The task of answering the telephone had been delegated to another member of staff during medicine administration times. Where medicines were administered from, for example, medicine trolleys these were parked away from high distraction areas such as thoroughfares and in front of televisions. There were also changes to how the medicines were supplied and stored. This made checking the stock balance and the packaging before administration easier. Random spot checks of medicine stock and MARs were increased and how and when formal auditing took place had been reviewed. The process of ensuring how gaps on MARs were followed up had also been altered. All staff had become responsible for checking the previous staff members' practice of completing the MARs. They were now responsible for reporting any identified gaps straight away so these could be followed up.

Since implementing the above actions there had been no more medicine errors since May 2016. During the inspection however an error was identified. This involved two people on the same medicine and the same dose. Stock for one person had been used to administer the other person's dose. This was identified by staff when they carried out several of the above actions. In this case no harm had come to the people and it showed us that the systems introduced were effective. The cause for the 'medicine error' was to be followed up by the registered manager following the inspection.

We observed two routine medicine rounds. Relevant improved actions as described above were seen carried out in practice. People received the support they needed to take their medicines. When people asked questions about their medicines an answer and explanation was given. Medicines were stored securely and systems were in place for the safe destruction of medicines which were refused or no longer required. There were arrangements in place between the GP, supplying pharmacy and the care home to ensure end of life medicines were available when needed.

People were protected by the arrangements in place to prevent abuse. The registered manager told us they had "zero tolerance" of any form of abuse. All staff had received relevant training and knew what constituted abuse and what to do if an allegation of abuse was made to them or if they witnessed abuse. Staff adhered to the provider's policy and procedures relating to abuse and these were in line with and supported the local authority's policy and procedures for safeguarding people. Where there had been concerns about the safeguarding of a person, the service had shared information with relevant agencies. This meant that those agencies who also had a responsibility to safeguard people could take appropriate action. These agencies for example, included the Care Quality Commission, the County Council and police. Staff were able to tell us how they must report their concerns within their organisation. They were also aware of how to share concerns with the above external agencies.

People lived in a safe environment. The maintenance person, supported by the provider's estates department, made sure this remained the case. We saw well maintained records which recorded frequent monitoring and servicing of various systems and equipment. Relevant risk assessments had been completed to include one for fire safety and risks of Legionella. Contracts were in place with various specialist companies to support these arrangements. For example, a specialist company serviced and maintained all lifting equipment, which included passenger lifts, care hoists and slings. Similar arrangements were in place to maintain the nurse call system, emergency lighting, fire alarm and fire safety equipment.

People lived in a clean environment and suitable arrangements were in place to prevent the spread of potential infection. Areas we observed were clean and we saw cleaning staff carrying out their daily tasks. We were not aware of any unpleasant odours caused by a lack of cleaning. We observed staff taking precautions to reduce the risk of cross contamination. For example, staff wore plastic aprons and gloves

when delivering people's care and removed these and washed their hands before delivering another person's care. Protective clothing was also worn when delivering or supporting people with their food. Arrangements were in place to segregate soiled laundry so this was not handled unnecessarily. Laundry was washed in a separate area of the care home by designated staff who had received relevant training. One member of staff was responsible for auditing all infection control systems and practices. Actions from the last infection control audit had been minimal. The audit had been checked and signed off as satisfactory by the management staff.

Good

Is the service effective?

Our findings

At our last inspection in August 2015 we found staff had not been provided with adequate training and support to be able to sufficiently and safely meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to address this. They sent us an action plan which stated they would meet the regulation in full by the end of April 2016. At this inspection we found the provider had taken action to ensure staff were appropriately trained and supported.

People received care from staff who had the skills and knowledge to meet their needs. Staffs' on-going competencies were also monitored and maintained. When staff were new to care they received support to meet people's needs effectively and safely. The registered manager had reviewed all staffs' completed training and reviewed their competencies. They had looked at how often individual staff had received support sessions (known as supervision). Planned supervision had been re-commenced by the registered manager. This had given staff an opportunity to meet with the registered manager in order to review their training and support needs and discuss any other issues they may have. The registered manager had then carried out regular observations of staffs' practices and interactions which also helped them identify further training needs. The identified training needs had then been recorded on a very comprehensive training record, which had been implemented by the registered manager. This recorded in detail all trainings booked, completed and those which were due for update in the future. Missed training sessions were followed up with prompts to attend and then further action taken if not completed.

Senior staff had been provided with appropriate training to carry out supervision sessions with their own team members. The registered manager confirmed that all staffs' training was up to date and the training record confirmed this. The only exceptions to this were staff on, for example, long-term sick leave. The registered manager explained they continued to observe staff practices and interactions to personally check staffs' on-going competencies and skills. They told us this also helped them to identify future team leaders and staff who had specific skills which could be used in, for example, lead roles.

The training record and lead role arrangements showed staff were supported to develop their knowledge and to take on extra responsibility if they wished to. Senior care staff had been provided with training and support to meet their additional responsibilities. We observed these staff to be skilled and confident in their roles. Lead roles were developed to provide staff with additional support in particular areas of care and practice. These staff usually had a particular interest in the area they led. They also were provided with opportunities to gain extra knowledge and skill in order to promote and support best practice in the area they led. Lead roles supported dementia care, wound care, dignity in care, activities and infection control practices.

When talking about opportunities for supervision one member of staff confirmed they had received these. They said, "I feel very supported by the managers and care leaders". One senior member of staff confirmed they were carrying out supervision meetings with a designated number of care staff. They also confirmed that the registered manager's use of reflective meetings and conversations generally were helping staff look

at situations and events and identify where improvements could be made. They said, "Staff are responding well and it is helping to empower them".

All new staff to Westbury Court completed the provider's induction training. This included training subjects which the provider considered necessary to complete to be able to carry out their roles and tasks safely and effectively. Subjects included, safe moving and handling, health and safety, infection control, safeguarding adults and the Mental Capacity Act 2005. Staff new to care were supported to complete the care certificate. This lays down a framework of training and support for new staff. Its aim is that new care staff will be able to deliver safe and effective care to a recognised standard once completed. One member of staff said, "I received a really good induction training here". This member of staff confirmed that the registered manager had met with them to ask if they were getting the support they needed. They told us they had appreciated the fact that the registered manager "had shown an interest in them".

Also at our last inspection in August 2015 we found people's consent had not been sought or obtained before their care had been delivered. Where people lacked mental capacity the principles of the Mental Capacity Act 2005 had not been fully considered and adhered to. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to address this. They sent us an action plan which stated they would meet the regulation in full by the end of April 2016. At this inspection we found the provider had taken action to ensure people's consent was sought before their care or treatment was delivered. People who lacked mental capacity were protected under the Mental Capacity Act 2005 (MCA).

Where people were able to provide consent this had been sought and obtained and the same had been done when any changes to their care and treatment were needed. When we reviewed people's care records we also found care staff had started the practice of recording the fact that people's consent had been sought and provided. This showed care staff were now considering people's rights as part of their care practice.

Staff were adhering to the MCA. The 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 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where it was suspected that a person may lack mental capacity and where a specific decision needed to be made, for example, about where they lived and about their care and treatment, a decision specific mental capacity assessment had been completed. One of the provider's admiral nurse's had been involved in supporting staff to complete these. An admiral nurse is a specialist dementia care nurse who gives expert practical, clinical and emotional support to those supporting people who live with dementia. We reviewed eight mental capacity assessments which related to people's accommodation and care and treatment and where these recorded the person lacked mental capacity to make their own decisions about this. We also saw that where people had an illness that may impair their ability to make decisions, support was given to them to make these independently if possible. Where specific decisions had been made on behalf of those who were unable to do this, records showed these decisions had been made by appropriate people and in the person's best interests. Appropriate people had included the person's legally appointed representative (where there was one), senior care staff and health and social care professionals such as the person's GP or Social Worker.

One person's care records recorded how a risk to that person had been managed in the least restrictive way

and that all relevant processes and records had been completed before doing this. This person had been prone to falling out of bed but lacked mental capacity to consent to any actions taken to keep them safe. A risk assessment for the use of bed rails had also assessed these as unsuitable for use in this person's case. Staff had assessed the person as likely to see these as a form of restraint and attempt to climb over them and causing harm to themselves. The least restrictive option had been chosen and a decision taken in the person's best interests to adopt this. This involved installing a bed which could almost lower to the floor with a padded mat that lay alongside it. Records showed that this option had been regularly evaluated and it was recorded each time as being the "the least restrictive option" in keeping the person safe. The fact that staff were recording it being 'the least restrictive option' again showed they were considering the relevant legislation in their practice.

Another person's mental capacity assessment recorded the person's inability to consent to being fed in order to maintain their nutritional well-being. The person's relevant care plan stated what support was needed and that this was given "in the person's best interests". Again, this record showed staff were considering the relevant legislation.

Where people lacked mental capacity and required to live at the care home in order to receive the care and treatment they required, but they were unable to independently leave, staff had also correctly applied to the local county council for Deprivation of Liberty Safeguards. 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where DoLS had been authorised staff adhered to the conditions stated within these safeguards.

People told us their health and care needs were met. One person said, "I think the care here is very good. I don't think you could get any better". When also talking about their care another person said "you can't fault it." Both people confirmed they were able to see their GP when needed. A relative spoke about their concerns about another care home their relative had stayed in. When comparing it with Westbury Court they said "here is excellent." People's care records showed they had access to health care and social care professionals as needed. Specialist health care professionals were also referred to and had included; speech and language therapists (SALT), physio and occupational therapists, continence and wound care specialists/advisors and mental health professionals. Regular visits were made by local GPs and visits in-between carried out when required. People also had access to eye care, NHS dental care and regular foot care. The Provider Information Return (PIR) recorded that better links were to be made with community health care professionals and senior staff we spoke with felt this had happened. We observed a local GP visit the care home one evening just to check up on various things with the staff. The NHS Rapid Response services had been used when one person had been in need of immediate treatment, such as intra-venous (by a vein) antibiotics which could be administered in the care home instead of hospital.

People's risks relating to their nutritional well-being were identified and managed. People's weight was monitored and fluctuations assessed and referred to the person's GP if needed. Staff used an assessment tool which helped them decide on what action should be taken according to the person's level of nutritional risk. We reviewed relevant care records which had been well maintained in relation to this. The action to be taken to support a person's nutritional well-being varied from providing additional prompting or supervision at mealtimes to providing more physical support such as feeding the person. Some people required their food and drink intake to be more closely monitored. We saw one example of a person's intake being monitored for three days before they were to be referred to a SALT. People were referred to a SALT when they had swallowing problems. The SALT assessed people's ability to swallow and the levels of risk for choking. They then decided on the most appropriate texture and consistency of food to be provided to them. This information was then shared with the kitchen staff who knew how to produce the different

textures of food.

Kitchen staff were also well informed about whose food required fortification, for example, when people required additional calories because they had lost weight. Fortification of food was done by adding extra butter, cream and powdered whole milk to people's foods. Kitchen staff were also aware of other specific dietary requirements such as those required by people with unstable diabetes and they were aware of potential allergens in food. They were also aware of people's likes and dislikes and met with people to gain feedback from these and about the food generally.
One person told us, "I have a cooked breakfast, milky drinks and a protein drink because I need to put weight on apparently". Another person said, "The food is good here".

We observed various levels of support being given to people at mealtimes. People were able to eat where they preferred to eat and had a choice of which dining room table they sat at. They had a choice of food and additional alternatives to these choices were also available. Mealtimes we observed to be sociable events. Tables had been laid with a table cloth, condiments and flowers to make them look attractive. Each table had a menu which helped people remember what the options were for each meal. There was also a blackboard in the dining room stating what the choices were for that day. We saw several people pick up the table menus and read them before their meal.

Good

Is the service caring?

Our findings

At our last inspection in August 2015 we found the care home's routines and the way the staff worked had resulted in a task-led/service-led approach to care. People's needs were not always being met when they needed or wanted them met. People's preferences had not always been considered when their care was delivered. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to address this. They sent us an action plan which stated they would meet the regulation in full by the end of April 2016. At this inspection we found people's care was predominantly delivered in a personalised way and people's preferences were considered and met where at all possible.

The registered manager had made changes to how care was delivered. They understood and believed in the concept of personalised care and they had promoted this and continued to. The provider had supported this change and had provided training on personalised care to the staff. We observed personalised care being delivered. The registered manager explained that some staff had found this new way of working harder to accept than others and in some cases this was still an issue. However, the registered manager remained clear that people's care would remain personalised to their needs and their preferences and choices would be met. Where needed staff were being supported and guided to meet these expectations and to work as a team to achieve this.

The registered manager said, "care must be delivered in a way which suits the residents and not in a way which suits the staff". When discussing this further they said, "We as care staff have to drop our own agenda". They said, "I want residents to want to live here" and "I want them to be happy here". They went on to explain that a lot of work and training had been done with staff to think differently about care delivery. This had been in order to get away from the belief that certain care tasks had to completed by certain times by certain staff. One senior member of staff told us staff in particular had not been used to working as a team and especially across a 24 hour time span. So, differences between the night and day staff expectations had needed to be explored and worked through. They told us their role had been to promote team working and to look at solutions which supported personalised care. They explained that initiatives such as 'resident of the day' although not in isolation, had helped. This involved one person being 'resident of the day', on one particular day, roughly each month. All departments in the care home focused on the same person on that day. For example, the care team spoke to the person about their care and treatment and reviewed and updated the person's care plans accordingly. The kitchen staff checked with the person to see if they still had relevant information relating to their dietary needs, choices and preferences. The housekeeping team ensured the person's bedroom was deep cleaned and the maintenance person checked with the person to see if any repairs or tasks were needed in their bedroom. This initiative helped staff be person focused as opposed to task focused.

We spoke with three other care staff who confirmed they preferred the new way of working because it meant people's needs were met as they wanted them met. One member of staff told us that some staff were still "disengaged" with the new approach. They said, "This can be difficult because most of us [staff] want the best care for people and the best inspection report you can get".

The kitchen obviously worked to a routine in order to produce people's main meals. However, the cook explained that people had breakfast, for example, at various times and told us they had just freshly cooked one person a cooked breakfast at 10am. They said, "I would not want a fried egg and bacon that had been kept warm for hours so I cook it when they are ready for it". They explained that food was always available for people. So for example, if a person wanted to eat later in the evening or during the night there was always food that staff could provide.

We spoke to two people who explained that living in a communal setting meant they had to be flexible to a degree. They however confirmed their preferences and choices were "on the whole" supported and met. We observed other people making requests and these being supported and met at the time. For example, people were supported to go to the toilet when they wanted to go. The only delays we observed with this were when staff needed to fetch a hoist or find another member of staff to help them. Their intention however was to meet that person's need there and then. We observed the same when people requested a drink. This had not always been the case during our previous inspection.

We observed people being provided with support to make their own decisions. Often these decisions were simple ones but important to them. They included what they wanted to eat, where they wanted to sit, what they wanted to do with their time, whether they wanted to join an activity or not, who they wanted to sit next to and if they wanted to return to their bedroom or stay in a communal room. It was clear that the registered manager's expectations for a more personalised approach to care were being promoted by senior staff and practiced by the staff generally. There were enough staff committed to this way of working to ensure it was maintained.

We observed people's family and visitors being welcomed when they arrived. Visiting times were open and people were free to go out with family and friends if they wished to and were able to. We observed visitors receiving explanations to their questions and guidance on various things. For example, questions about how their relative was doing were answered. It was apparent that people who mattered to those who lived at Westbury Court were involved and included.

We observed staff to be caring and compassionate. We saw staff taking the time to really listen to people and to show they were genuinely interested in what the person was saying. We observed care staff taking the time to make sure people were comfortable and had what they needed close to them. We observed moments of distress and anxiety being addressed by staff by them comforting and reassuring the person. Staff were genuinely interested in trying to make people's lives more comfortable. When talking about the staffs' approach towards them one person told us the staff were "very caring". A relative told us "the care staff are lovely, really kind."

People's dignity was maintained. When talking with one member of senior staff, whose role it was to promote dignity in care, they said, "My bugbear is staff not covering ladies when they hoist them". However, they were able to confirm that staff practice relating to this had improved. When we observed a person being hoisted, sometimes from a distance, each time staff had remembered to cover the person appropriately. People's dignity was also maintained at mealtimes. People who had to be supported to eat their food were supported in a discreet and compassionate way. For example, staff remained focused on the person they were feeding; they conversed with them and not their colleagues. They did not offer food when people's mouths were already full or allow food debris to remain on people's faces or down their clothes protector.

People's privacy was also maintained during care delivery and at other times. For example, toilet doors were closed when people used the toilet and personal hygiene care was delivered behind closed doors. Staff

recognised people's bedrooms to be their own personal space and knocked on the door and waited for a response before entering. Discussions about people's care delivery were carried out away from other people's range of hearing. People's care records were kept secure and confidential although people could have access to these if they wished.

Good

Is the service responsive?

Our findings

At our last inspection in August 2015 we found staff were not always following the guidance written in people's care plans when delivering their care. We could not always evidence that people had received the care their care plan stated. People and their representatives had not been fully engaged in the process of planning and reviewing their care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to address this. They sent us an action plan which stated they would meet the regulation in full by the end of April 2016. At this inspection we found people's care plans were followed and staffs' records of the care provided had improved. People and their representatives had been provided with better opportunities and had been encouraged to be involved in the planning and reviewing of their care.

The registered manager told us all care records including care plans had been reviewed in the last year to ensure they accurately reflected people's care and health needs and their preferences and choices. Systems had been put in place to help people be more involved in the planning and reviewing of their care. When discussing with them how they had approached this they said, "It's about keeping the resident very much in the centre of any conversation about care". Where appropriate, for example, in the case of those who lacked mental capacity, people's representatives had been encouraged to be part of this process. The registered manager confirmed that most people and their representatives were keen to be involved although some chose not to be.

Staff had received training on how to write personalised care plans and better record the care they had delivered. One member of staff told us they had really enjoyed the provider's training sessions on this and had helped them write in a far more person focused way. This training had been effective as the records we reviewed had improved since our previous inspection.

Before admission to the care home people's needs were assessed. The Provider Information Return (PIR) referred to improvements being made to this process to make sure appropriate admissions took place and people's needs could be met. An assessment of people's needs was done by either visiting the person or, if that was not practical, by gathering as much information about them in other ways. We saw documented pre-admission assessments which recorded people's health and social needs as well as recording other pertinent information. If possible information had been gathered from the person themselves, their representatives and reports and assessments requested from involved health care professionals where possible. This process helped senior care staff decide whether they could meet the person's needs. Sometimes this process identified, for example, that additional or specialised equipment was need prior to an admission. The pre- admission assessment was also an opportunity to discuss with people and their representative's their worries, expectations and aspirations.

One member of staff told us admissions could, sometimes, happen very quickly. They told us the person in charge may then just get enough information to be able to make a decision about admitting the person but the main detail may follow after the admission. At the time of the inspection one person needed to be discharged from hospital quickly but they were unable to return to their own home. Their health had

deteriorated and their main carer could no longer cope. This person already knew the care home and the staff knew them because they had stayed at Westbury Court previously on respite care (short stay). In this case this previous experience and knowledge of the care home resulted in a smooth admission. One other person told us, before they came to live at Westbury Court on a permanent basis, they had also experienced respite care. They told us they had been happy to move in permanently because they knew what they were coming to.

The care records we reviewed included people's care plans and we found these to be predominantly well maintained. Care plans had been reviewed monthly and amendments to the guidance for staff had been made as necessary. This meant staff and visiting health care professionals had access to up to date information about a person's needs and abilities. When we spoke with staff about people's care and observed people's care, what they told us and what we observed was in line with the person's care plans. We saw six monthly evaluations of people's care plans had taken place for some people. These had been carried out with the person where possible and then with a person's representative if they had chosen to be involved in this process.

People were able to join in social activities if they chose to. Activities included things like quizzes, bingo, baking, art and crafts, exercise sessions, watching films and poetry and music groups. People were asked what activity they would like to join in. If people wanted to do something other than what had been previously planned then the programme was altered. The registered manager explained that a lot of work had been done to make activities more meaningful and individualised. The registered manager explained this had involved making more use of, for example, the information gathered about people on admission and what staff already knew about people's likes and dislikes. Information about people's life experiences, preferences, previous hobbies and interests all helped to plan more personalised and meaningful activities for people.

Two people told us they particularly enjoyed visiting the public gardens which were next door to the care home so the care staff supported them to do this. Another person's care records also recorded visits to the gardens. Another person preferred time spent with staff on a one to one basis as opposed to joining in group activities. Their records showed that staff made time to go on walks with them and chat. On-going evaluations of how activities had gone and how engaged individual people had been helped staff assess how meaningful and individualised the activities were. People had also had opportunities to go on trips out which had included a trip to the river as well as picnics and general tours of the countryside.

One written compliment received by the care home referred to the activity coordinator. It said "things have got better since you have been here". One relative spoke to us about their relative's anxiety and distress and they said, "There are things going on most of the time here to keep [name] occupied". They felt this had resulted in a reduction of their relative's anxiety and distress. They told us this had not been the case in two previous care homes. At the time of the inspection the activities coordinator was not present. We did however witnessed staff being allocated time to coordinate and lead activities in the afternoons in their absence.

There were processes in place for people and their representatives to raise complaints, concerns and report their dissatisfaction. The registered manager told us they made themselves as available as possible for people and representatives to be able to do this. They said their door was always open, people could phone them, email them and if they left a message they would always get back to them. One relative told us the registered manager had very much been available when they had needed reassurances and answers to things that had "niggled" them. The registered manager had introduced systems which enabled her to be in a better position to fully investigate a complaint. Records for example, were now kept of who had been

responsible for a person's care or a particular task on a particular day. The registered manager explained that any complaint or area of dissatisfaction was now viewed as an opportunity for the "whole team" to analyse what the problem had been and improve on it.

An area of dissatisfaction had been raised by one person. This had been about a particular preference not met. The registered manager had spoken with the person to look at how staff could rectify this situation to the person's satisfaction. It had been explained to the person that in aiming to meet their preference the immediate needs of others sometimes had to take priority. We discussed with the registered manager and the person involved the progress made with rectifying this and it was clear more discussion was required. We reviewed the records pertaining to four complaints, the last received in January 2016. We looked at when these had been received, when they had been initially acknowledged and when they had been fully responded to. This process had happened within the provider's stated time frame. We also reviewed the investigation detail, outcomes and the actions taken to prevent a reoccurrence. In one case this had involved a meeting with family representatives to discuss a way forward.

The registered manager told us when she started in post the number of complaints and areas of dissatisfaction were almost "overwhelming". They explained as the year had progressed and following a very proactive approach by them to address people's "niggles" and "concerns" before they became a complaint, the numbers of complaints received had dropped significantly.

Good

Is the service well-led?

Our findings

At our last inspection in August 2015 we recommended that advice be sought in providing the staff with support and training in team building and motivation. We also recommended that advice and support be sought for the development of more robust quality assurance processes.

The provider had rectified these issues by employing a very capable and competent manager. This manager had started in post just after our last inspection. They had subsequently been registered with the Care Quality Commission to be the registered manager of Westbury Court. They were fully aware of what their responsibilities were and the improvements that were needed to the service. They had arranged their work and altered the systems in the care home to ensure these could be made and sustained. They had been provided with support from the provider to achieve this. They told us this support had been "very good".

The registered manager told us they had a strong and cohesive senior team in place. These staff were firmly behind the changes that had been made and shared the registered manager's visions and values. Although the management team were dealing with some residual resistance to the altered way of working, those we spoke with told us most staff were now committed to the improved standard of care and services provided to people. The staff we spoke with confirmed this.

When discussing the registered manager's visions for the care home they said, "It's to be a 'home' for all residents and I want the staff team to want to be here and to work as a family". They went on to explain what they meant by this when they discussed their values. These included everyone being "kind and caring towards each other" and "respecting one and other". They said they wanted the service to "provide an excellent standard of care". The registered manager discussed with us some of the behaviours they would not tolerate and two of these included, "not giving people choice" and staff remaining "disengaged" from their vision and values despite having been given all the support needed to promote and practice these. Staff we spoke with liked the registered manager, They said they found her "supportive", "easy to talk with" and "visible". Similar comments were made by the people and relatives we spoke with. The provider's representative told us the registered manager had been "fully committed" to making the changes and improvements needed to the service. They told us these had been achieved and maintained.

The registered manager told us they operated in a transparent way and expected others to do the same. They told us staff had been supported to understand that errors, accidents and complaints could all be learnt from and used to make improvements to the service. They told us staff originally thought it was "not their responsibility" or "it did not involve them". They told us the team approach had meant that these things were "everyone's concern". One member of staff told us, "It's very much a team approach now". They said, "[name of registered manager] expectations are well known. The management staff are consistent in what they say".

The registered manager used the provider's quality monitoring tools to assess the standard of care and services provided. These helped them identify shortfalls which could then be addressed. They also had their own methods of monitoring practices and standards of service which they used and then discussed the

findings with the staff in order to make improvements. One such example, involved looking at how meal-times were managed and reflecting on what people's experiences were. Various improvements and adjustments had been made to meal-times following this, such as making sure tables were prepared and looking inviting for people. Some people had been identified as requiring their meals to be served first so episodes of anxiety and distress were reduced.

We reviewed a selection of provider set audits completed by staff in the care home over the last three months. These audits were part of an on-going cycle of audits which spanned across a year. There were minimal actions identified on the audits we reviewed. The registered manager explained this was what they would expect to see after a year's worth of improvements. In particular if what had been put in to place had been maintained and sustained. These audits were checked by the provider's representative when they visited and usually signed off as completed. The registered manager explained they had implemented their own personal "holistic action plan" in April 2016. This included the requirements from our last inspection, those from the provider's annual quality monitoring audit carried out just prior to the registered manager starting in post and improvements the registered manager had personally identified. The provider's representative told us this had been a full and comprehensive plan of actions addressing all the improvements which needed to happen. They explained they had accepted this plan as they could see it was meaningful to the registered manager who felt they could better work to their own plan.

We were shown the action plan which sat in a prominent position for all staff to see. It was a working document with dates added where actions had been met, updates on work in progress and adjustments made as audits over the year had picked up additional actions to meet. The registered manager explained the action plan had evolved and developed and it was discussed and reflected on at each staff meeting. This was an example of the registered manager's team approach where all staff had a part to play in meeting the actions on the 'holistic action plan'. Staff we spoke with were fully aware of it and what progress had been made.

The provider's annual quality audit of the care home's scrutinised all systems, practices and standards of service. This was carried out by members of the provider's quality audit team and had been completed in April 2016. This rigorous process drilled down deeper against the audits completed throughout the year and was designed to pick up on further improvements which could be made. It also gave an overall rating and placed the service's performance alongside the performance of the provider's other services. The service's quality rating was known to other registered managers in the group. It also identified trends and patterns which could be addressed on a corporate level. The registered manager was able to respond to some of the findings which they had already done so. This quality monitoring tool could be used as a self-assessment tool by the registered manager half way through the year (or at any other point) so they could assess where they were with the provider's expectations.

The registered manager regularly attended registered manager meetings where they could give and receive peer support to colleagues. In these meetings they were included in the provider's wider planning and updated on issues concerning them. The provider also organised regular forums/meetings for other groups of staff and the registered manager was keen for their staff to attend these. The Provider Information Return (PIR) recorded a plan for attendance of these to be promoted and supported in the future at Westbury Court. For example, all the provider's activity co-ordinators attended a specific forum to discuss up and coming provider plans for home activities and they could swap and discuss ideas with other co-ordinators. The tissue viability/wound care lead also attended a similar forum where they were updated by company leads on the latest best practices in wound care. They could also discuss any particular concerns they had with the specialist. There were also forums for dementia lead workers and dignity in care leads.

People's views and the views of those who visited were sought on the care and services provided at Westbury Court. This had been done for some time now by the activity co-ordinator who gathered people's views by either talking to them on a one to one basis or by chatting to small groups. People's feedback and ideas were recorded and the registered manager used this to help her gauge people's satisfaction levels and to plan further improvements to the service. The Provider Information Return (PIR) recorded that people's views and ideas were to be sought about colour coding each floor area to help orientate people. People's views had already been sought and their comments taken into consideration when the dining room/communal lounge area had been recently refurbished. We spoke to one person who also attended the activity fund raising meetings. They, as a person who lived at Westbury Court, represented others who lived there. They told us they were able to ask questions about how raised monies were spent and put forward ideas for future fund raising events. Comments also placed on a national website (Carehome.co.uk) used by people and representatives to provide feedback on services, were monitored and sometimes responded to by the registered manager. Work had been carried out to make people who lived at Westbury Court more aware of the comments being made. We were informed it was the provider's intention to soon re-introduce the use of questionnaires to obtain people's views as part of their quality assurance programme.