Mr & Mrs Y Charalambous

Westcott House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 30 April and was unannounced.

Westcott House provides residential and nursing care for up to 60 people living with dementia or who have mental health needs. Westcott House 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 accommodation at Westcott House is spread over three floors and includes a purpose-built single storey building as an annexe. There are two dining rooms and several lounge areas in both the buildings. The buildings are joined by a short outside walkway and there is a separate day activity centre at the service. On the day of our visit there were 59 people living at the home and one person who moved in that day.

The majority of people living at the home had cognitive impairment and six people had complex mental health needs. Six people were nursed in bed due to the advanced nature of their dementia

There was a registered manager in place. 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.

At our last inspection, we recommended that care plans should be written in a format to make them easier for staff to follow. However, at this inspection we found that care plans were still in the old format and that some were providing staff with out of date information about people's needs and risks. We highlighted where this had impact on people's safety and explored how the risks to people were managed.

We also previously recommended improvements to the range of activities and social interaction provided throughout the home to people living with dementia. On this visit, staff engaged with people in the communal areas. They were using some of the new equipment that the registered manager told us they had purchased to improve stimulation for people living with dementia.

The risks people face, due to their health conditions, were identified. There were good examples of risk management. However, some staff were not aware of the risks people faced or confident in managing some of these. We made a recommendation about increasing staff awareness and their learning on how to respond to certain risks.

There were also some poor hygiene practices that needed to be addressed. We have made a recommendation about staff refresher training in infection control.

People were protected from the risk of abuse and systems were in place to ensure that concerns were

identified and reported to the registered manager.

People were cared for by sufficient numbers of trained staff. There was good recruitment and retention of permanent staff. We could see that staff were working in every part of the building and supporting people in the communal areas.

People were receiving their medicines safely. The use of medicines for individuals was appropriate and under regular review. Medicines were stored safely and the recording of medicines given was being done accurately.

People were supported to maintain their health and to get treatment when they needed it. The service had developed effective relationships with health and social care professionals.

People were supported to eat and drink enough. Their nutritional needs had been assessed and there were systems in place to monitor people's fluid and food intake.

The environment was adapted to meet people's needs and premises were being kept clean. Improvements had been made in the last year, such as Wi-Fi being installed, and new dining room furniture purchased. The need for further improvements was recognised.

The Mental Capacity Act and the Deprivation of Liberty Safeguards were understood and legal requirements were applied. Any decisions made, or restrictions to people, were done in the person's best interests following a mental capacity assessment.

Staff communicated in a caring way. They demonstrated concern and warmth in their interactions with people. People's privacy was respected. Staff understood how vulnerable people were due to the progress of their dementia, their level of cognitive impairment and physical needs.

Relatives we spoke to told us they were able to visit whenever they wanted. They felt included in the care of their loved ones, but also trusted the staff to look after their relative when they were not there.

People and their relatives said they could complain by speaking to the registered manager and they were confident that any concerns would be dealt with. The registered manager worked with relatives and representatives to resolve complaints quickly.

There was a culture of openness. People and their relatives could communicate with the registered manager and the staff. There was a good working partnership with families and professionals. Staff worked well together and the registered manager was well- respected.

However, staff did not use the information held about people, including their needs, wishes and risks, routinely. Care records were not always accurate and kept up to date.

Although we received positive feedback from people, relatives and partners about the service, we were unable to give the service a Good rating. This is because of some inconsistent practice by staff, and management oversight needed to be improved. The registered manager has agreed to take action and changes need to be embedded with the service.

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 consistently safe.

Staff were not always aware of risks to people due to their health conditions.

People were not always protected from the spread of infection.

People were protected from abuse.

There were sufficient numbers of staff to care for people.

Medicines were stored and managed safely and correctly.

Is the service effective?

Good

The service was effective.

People's needs were met based on assessment and experience.

People's needs were met by staff who were trained and supervised.

People were supported to eat and drink enough and have a balanced diet.

People were supported to maintain their health and to get treatment when they needed it.

The environment was adapted to the needs of the people but further improvements were encouraged.

The Mental Capacity Act was applied and decisions were made in people's best Interests.

Is the service caring?

Good

The service was caring.

People received support from staff who communicated and acted in a caring way.

People were supported to be involved in decisions about their care.

People's privacy was respected.

Is the service responsive?

Good

The service was responsive.

People were receiving care that was personal to them and their needs.

People had access to social interaction and appropriate activities.

People were able to express themselves without discrimination.

People and their relatives could complain and were confident their concerns would be dealt with.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The care planning system needed to be updated, and people's care records improved.

Management oversight of staff practice needed to be improved.

People and relatives felt they were listened to and involved.

Staff were able to contribute and there was an open culture.

Good partnerships with professionals and agencies were in place.

Westcott House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 30 April 2018 and was unannounced. The inspection was carried out by three inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed records held by the Care Quality Commission which included notifications, feedback and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. On this occasion, we had not yet asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and any improvements they plan to make. We talked to the registered manager about their plans and any improvements since the last inspection.

During the inspection, we talked with four people as well as ten relatives who were visiting during that day. We were unable to talk to many people about the care they received due to their level of cognitive impairment. We observed the support that people received in the communal and dining areas, and in the day centre, in order to understand people's experience of living at Westcott House.

We spoke with six of the care staff, two registered nurses, the kitchen staff and the registered manager. We looked at eight care plans that helped us to understand how well staff knew and cared for people and whether the plans matched the experiences of the people receiving care.

We checked five staff recruitment files, looked for evidence of staff training, and recent quality and safety

audits that had taken place in the home. We reviewed the medicines practice, audits and protocols, and the use and storage of medicines, thickeners and food supplements. We looked at a variety of documents that were relevant to the overall management and governance of the service.

We received written feedback from four health and social care professionals. This was about the care provided at Westcott House and the positive way that people with complex needs are supported.

Requires Improvement

Is the service safe?

Our findings

Most people at the care home were living with dementia and the majority could not tell us about their experiences. Staff told us that they knew people well to keep them safe. There were some good examples of managing risks. A staff member told us how they safely moved people. They said, "I would ensure there was enough space to do things, when using a hoist to make sure people were safe." We also saw two staff members transfer a person using a standing hoist from a wheelchair into a bathroom. They did this competently, explaining to the person all the time what they were doing.

A relative told us how when it had been hot recently and people were outside, the staff made sure they were wearing sun hats and had plenty to drink. This reduced the risk of sunburn and dehydration whilst enabling people to enjoy the garden safely. One person also told us, "When the warmer weather comes I will get out in the garden. Someone always comes with me in case I trip."

The registered manager showed us there was safe provision made for people who smoked near the front of the building or under a small section of covered walkway between the main house and the annexe. We saw that fire extinguishers were in place nearby. The fire doors were alarmed and the door that was not alarmed leads to a secure and enclosed garden area.

We looked at records and found that the risks that people faced, due to their health conditions, were identified. Where a person had epilepsy, there was a seizure chart in place and a care plan giving guidance to staff on what to do in the event of a seizure. The person had a moving and handling risk assessment, which stated, "Walks with a frame, but on bad day's staff to walk with him." This person was able to speak to us and confirmed that staff helped with this.

However, a person, whose care plan said they were "at risk of choking", was not being monitored at mealtime. When we asked about this, one staff member said, "He is fine. He will pull the bell if he is in trouble.' Another staff member however, told us he was at risk. This meant we could not be sure this risk was managed consistently. A nurse said that all staff were trained in what to do if someone was choking. However, one of the staff we spoke to did not know. They said, "I've never had it happen. I am not sure. I think I would pat them on the back and then offer them a drink of water." Although most staff had received some first aid training in the past two years, less than half of the staff had received training in dysphagia and problems with swallowing.

A person's care plan said they were at risk due to a nut allergy. The registered manager told us the risk is not high and that there was a notice on the kitchen wall. However, when asked, the kitchen staff were not aware of anyone with a nut allergy. There was a low risk that the person may be given food that contained nuts. Another person's care plan stated they needed their feet raised when sitting as their legs were at risk of becoming swollen. However, they did not have their feet raised at our visit. Where people had a pressure-relieving mattress in place, there was nothing to indicate that staff were checking the settings for each person or knew what the pressure setting should be, depending on the person's weight. This is important to ensure that people who are nursed in bed would not develop pressure areas or sores. The registered

manager told us, after the inspection, that the mattress settings are pre-set for each person's weight. An alarm will indicate any problems to staff, and the maintenance person checks them weekly.

We recommend that all staff are regularly made aware about the risks people face and are trained to know how to respond.

People were protected from the risk of abuse as systems were in place to ensure that concerns were identified and reported to the manager. The registered manager had taken action in the past to dismiss staff who had potentially abused people. Staff said that they would always report any abuse they saw. One member of staff told us, "We won't tolerate that." There was a safeguarding policy in place and information for staff explaining the different types of abuse. Staff were aware of how to the contact the local authority with concerns if required. Records showed that most staff had received safeguarding training in the last two years. One relative told us they had, "peace of mind" and another said, "She (mum) is as safe as she could be. It is secure and well-staffed."

Lessons had been learnt following incidents where a person had left the home unsupervised. The person had managed to get into the car park on one occasion and outside the main gate on another, putting themselves at risk. Following these incidents, senior staff had completed "near miss" records and updated the person's risk assessment to make sure staff were aware. Although we did not see these at the time, the registered manager sent them to us after the inspection. The registered manager said the fire doors to the main car park were alarmed, and that staff were always alerted and able to bring the person back safely. They had not however, reported the incidents to the Local Authority, or notified us, of the safeguarding concern. The registered manager has now sought advice, and learnt that such incidents should be reported.

People were not always protected from the spread of infection. We noticed that unused incontinence pads were out of their packets in a shared bathroom and in a couple of people's own toilet areas. This was for ease of access for staff but it is not good hygiene practice. People did not all have their own sling to use with the portable hoists. This is also a hygiene issue. We also saw some of the toilets had no toilet paper or any paper towels. The cleaning of the bathrooms and toilets was in evidence on the day of our visit, although one dirty toilet was left uncleaned for some hours. Most staff used aprons and gloves when assisting with personal care. However, we saw one member of staff helping a person into the communal area before taking their apron off. One staff member said, "We are washing our hands all the time. If someone has an illness, we would isolate them and wash their clothes separately. We have to think about food hygiene too." Records showed that most staff were due for a two year refresher training for infection control or food hygiene.

We recommend that all staff receive refresher training in infection control, and that measures are put in place to ensure good practice is followed.

People were being cared for by sufficient numbers of trained staff. We could see that staff were working in every part of the building and supporting people in the communal areas. One relative said, "There are always lots of staff." One person told us that if they called for help, "Staff come fairly quickly." In addition, that, "Staff pop in and see me from time to time." The registered manager told us there were 14 staff on duty during the morning, including two trained nurses, 12 staff in the afternoon and nine at night, with two nurses. Staff told us that they did not feel rushed. One member of staff said, "There is enough staff. I have time to talk to people and give them choices." The home also had ancillary staff, which included two cleaners, two catering staff, one laundry staff, two maintenance staff, one administrator, and an activity coordinator.

People were being kept safe through the recruitment and management of staff. The registered manager told us how proud they were of the staff team who, they said, were dedicated to the people they cared for. The home did not rely on any agency staff. All recruitment files contained references, evidence of identification and the right to work in the UK. Disclosure and Barring System (DBS) checks had been completed. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. One staff member said that even though she had worked previously at the service she was expected to complete an application form and DBS. The nurses were registered with their own professional body.

People were receiving their medicines safely. The proper arrangements were in place in relation to the recording of medicines. The nurses had completed the medication administration record (MAR) for people correctly. In the case of 'as required' medicines (PRN), the MAR contained details of each medication and what it was for. Staff knew if PRN was given, they must write on the back of the chart the date time and reason for giving, and if it was effective. There was a homely remedy policy in place as some people were given homely remedies. Two people had covert medication. The appropriate documentation and signatures for this were kept in the MAR folder. Each person had their photograph on the front of their medicine record, and any allergies were noted. People who received medicine via a patch had this clearly marked on a body chart with the positioning of the patch.

Medicines were also stored safely. Both the room temperatures and refrigerator temperatures were recorded daily. The controlled medicines were appropriately stored, managed and checked. Boots the Chemist supplied medicines to the home, and they provided an annual audit. They also provided annual medicine update training to the staff, and these workbooks in the office. There had not been any recent medicines errors. Some people were prescribed thickeners and food supplements, and these were correctly kept in the medicines room. There was a list of people who needed thickeners in both the medicines and dining rooms. We were told all staff had been trained in how to mix and use it, and in the near future Nestle were going to provide an updates.

Good

Is the service effective?

Our findings

People's needs were met based on clinical assessment and staff knowledge and experience. A number of people had complex mental and physical health needs. Some had moved from another care home that was not able to meet their needs. Professionals trusted the expertise of the manager and one told us there was "A very good working knowledge" of people and their care needs. One relative had been very involved when the person they cared for moved to the care home. The relative told us, "We set things out with her preferences. It was a comprehensive assessment." Assessments of people's needs had been completed.

People had their needs met by staff who had been trained to give effective care and support. We heard from staff how they were supported to learn in their role. From training records, we saw that 21 of the staff had recently attended nutrition training and 16 attended a day on pressure care and tissue viability. One staff member was going through an induction process, although they had previously worked at the home. They felt well supported and told us, "The senior carer looks after me and shows me what I need to do." Another member of staff told us, "It was good training and relevant. I've done moving and handling, dementia care and health and safety."

A staff member, who had worked at the home for ten years, said that they had benefitted from further training in dementia care. They told us how they adapted their "tone of voice" and used "hand therapy" to calm people. They also were able to describe the way they worked with people whose behaviour was unpredictable or who refused to wash or dress. The member of staff said, "You get to know people and what they like, how to work around them or to distract them."

Staff were appraised on an annual basis and given an opportunity to self-assess their performance and their learning and development needs. Day to day supervision of staff was managed by the nurses, who were in turn supervised by the registered manager. There were one to one meetings held every six weeks. The registered manager also said, "I am usually here all day and would deal with any staffing matters straight away."

The registered manager told us that they were working with the new Quality in Care Homes team in Surrey Downs Clinical Commissioning Group. They had accessed updates on best practice, including on treatment of sepsis and on safeguarding. The Quality in Care Homes lead nurse later confirmed the care home and registered manager were actively engaged with the team's work. Some staff were attending falls training via this forum the week of the inspection.

The nurses, including the registered manager, were keeping their clinical skills and professional revalidation up to date. One nurse had recently completed their three-yearly revalidation. They talked about their completed mandatory training and updates on dressings and management of diabetes in the last year. The training records supported this. Staff team meetings were held once a month. At the last meeting, the subjects discussed included standards of work, notes and record and people's nail care. On the notice boards there was good practice information relating to health and safety in care homes and on preventing delirium.

People were supported to maintain their health and to get treatment when they needed it. The service had developed effective relationships with health and social care professionals. There were appropriate referrals to, and attendance by, the speech and language team, the community mental health team, diabetic nurse, podiatrist and optician. The GP visited once a week but also attended when people were unwell. One relative told us that staff had noticed straight away when their family member developed a cough. They called the GP and the person was treated and recovered. They said staff had noticed a small skin split and had arranged for a new pressure relieving mattress and cushion and they checked the person's skin more often.

Staff worked well together, and with other services, to ensure people received the care and support they needed. One person had a chronic leg ulcer of long standing pre-dating coming to the home. Staff managed the pressure area correctly and maintained records for handovers between staff so all knew the up to date information about care and treatment. There had been contact with the tissue viability nurse and how to manage the dressings were in the person's care plan. A relative told us that the health of the person they cared for had improved greatly since being at the care home. They had previously been on medication that made them more confused and not interested in doing anything. The nurses reviewed the medicines and encouraged the person to get up and go to the day centre. The relative told us, "Mum has picked up like a miracle since she's been here. She is now doing things again and joining in. They have done a brilliant job. It's like she's re-born."

People were supported to eat and drink enough. Their nutritional needs had been assessed and there were systems in place to monitor people's fluid and food intake. Relatives told us they were happy with the food provided. The registered manager showed us the charts used every mealtime to record what people ate, and we could see these were completed. A number of people need help and encouragement to eat. There was guidance for staff to follow if people required specific support when eating and drinking. In consultation with the GP, the nurses were also trained to give subcutaneous fluids to avoid any unnecessary hospital admissions due to dehydration.

People who needed assistance to eat their meals had support. However, on the day of our visit, the lunch was served late and not everyone who needed help received it in good time. After lunchtime, we found one person asleep in their room, who had a plate of covered sandwiches by their bed. A member of staff said that sometimes the person slept through meal times or refused their meal. They returned later to offer them the food and make a fresh drink. We could see that a food and fluid chart was being maintained to monitor if the person ate and drank enough. We asked the registered manager about the wait for lunch and suggested deployment of staff at lunchtime may be an issue. They said they would consider this. Later they told us the dishwasher had broken that day, causing a delay with the lunch being served to people.

The environment was adapted to the needs of the people. For example, there was a lift to all floors and the both the main building and annexe had wide corridors so people in wheelchairs could be moved around freely. There was also some signposting for people to rooms and communal areas. In the lounges, there were comfortable chairs that had been raised for people and these areas provided a smaller homely setting for people. The mobile hoists in use had been serviced in the last six months to maintain their safe use.

People had to go outside to get to the day centre, or to the annexe. This path was potentially slippery when raining and wet. We asked the registered manager if they had plans to cover this path. They said they would look into this. We also noticed that in the entrance hallway and dining room, which were large open areas, it felt cold. People in the day centre needed blankets over them to keep them warm on that day. The registered manager said that they would continue to make improvements. We had confidence that the registered manager would take action and make plans to improve the home based on our feedback and we

will monitor the progress and improvement at our next inspection.

The Mental Capacity Act (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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The service applied the MCA correctly and made good use of best interest checklists. Mental capacity assessments had been carried out for individual decisions. This was recorded in people's care plans. Assessments included whether people were able to understand, weigh and retain information, about a specific decision. Where a relative had Lasting Power of Attorney (for health and welfare) that they had been asked to sign consent in their family member's best interest to have the 'flu inoculation. One person we spoke to, who had mental capacity, had signed their own consent to care. Another person, who was assessed as lacking capacity to decide on their care, was refusing help from staff to eat. Suggestions had been made by the speech and language therapist. A best interests meeting had been set up by the registered manager, and all the appropriate professionals were involved. This person had an independent advocate appointed by the Court of Protection.

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). The home cared for a high number of people who had cognitive impairment. Most people were not able to leave the home unsupervised for their own safety. A locked door, with keypad, was in operation in both buildings and on the outside gate. Some people had bed rails restricting them in bed. There was evidence that appropriate applications had been, or were being, made for DoLS authorisations. For one person, with complex needs, a multi-disciplinary meeting was held involving the DoLS team and GP. We heard from the local DoLS team, that the service did, "consider less restrictive options wherever possible" and people were encouraged to be independent, "within the context of risk management."

Good

Is the service caring?

Our findings

People received support from staff who communicated and acted in a caring way. Relatives spoke highly of the staff and the way they cared for people. One relative said, "The staff and manager are incredible, nothing is too much trouble for them." Another told us, "They are as accommodating as possible. The staff are friendly and helpful and very caring." We heard how one person could be aggressive due to their dementia. Their relative said that staff had got to know the person and communicated so well that this had ceased.

Staff demonstrated concern and warmth in their interactions with people. In the day activity centre, a member of staff asked all the people individually if they wanted a drink. They made sure their drink was on a table in front of them. We heard them saying, "Take your time, and don't rush." They were caring and gentle with each person. In the lounge areas, different staff were holding people's hands and talking calmly, and smiling at people, trying to engage them in an activity.

At lunchtime, we observed how staff carefully and gently put protective covers onto those who needed assistance to eat. We heard a staff member say to one person, "Are you going to have supper my love." When an argument broke out between two people who were waiting for their lunch, another person called out for help. A staff member responded, without panic, and stroked the back of the person who was upset which calmed her down.

People, and their relatives, were supported to be involved in decisions about their care. One member of staff told us, "Everyone has the right to make choices and have preferences." One person was able to tell us how he chose to spend time in his room. Another relative said that staff always asked them what they thought and included them in planning their family member's care.

A member of staff kindly accompanied one person to go outside to have a cigarette. They helped the person by placing their hand near the back of the person to steady them.

Where people were not able to communicate their views, staff said they knew how to interpret people's behaviour. A staff member told us how one person who was restless could get easily agitated. They said, "All the staff need to listen to her. She likes to talk. If she wants something, she bangs her fists." A nurse explained how they needed to monitor people's body language, facial expression and signs of restlessness, as many people could not tell them how they were feeling or if they were in pain. One staff member said, "We get to know people and how to manage them… people are unpredictable at times."

Most people were dressed appropriately and well. A visitor said they often turned up without telling anyone but found their relative was always, "Shaved and dressed." One staff member told us that some women liked to choose their clothes and have their make-up on. They said this meant giving more time to people's care but it was important. They said they did this because they liked, "Making people happy."

People's privacy was respected. People we saw were vulnerable due to the progress of their dementia, their level of cognitive impairment and physical needs. Most staff demonstrated an awareness of this and showed

compassion and respect. We noticed a room where one person was wearing only a hospital gown in bed. We asked why this was. A staff member told us it was difficult to get a nightdress on this person as her arms were much contracted. The person felt cold. Staff found a cardigan and kindly helped the person to put this on while explaining to them what they were doing. They also told us how they often sat with the person and held their hand, which they found a great comfort. One staff member told us what motivated her to care. "They are all somebodies mother or father, I think of that, and they need looking after."

Staff told us that they would knock on people's doors before entering, even where a person may not be able to respond. A relative confirmed this, saying, "Staff keep things personal and private (to each person) and knock on the door before entering." A staff member said, "When I am doing personal care I would close the door and make sure I cover them."

Relatives we spoke to told us they were able to visit whenever they wanted. They felt included in the care of their loved ones, but also trusted the staff to look after their relative when they were not there. One said they appreciated the tea and coffee that was made available in the lobby. Visitors could help themselves from a flask of hot water, tea bags, coffee and packets of biscuits.

Good

Is the service responsive?

Our findings

People were receiving care that was personal to them and their needs. The care plans contained a section called "This is Me" which included information on people's social, spiritual and emotional needs. These aimed to allow staff to get to know people's personal history, their interests, likes and dislikes so they could interact in a meaningful way. We spoke with some relatives of people who had helped to complete this. One said that because their family member always liked singing and music, staff made sure they were included in entertainment in the day centre and had music playing. One person said the staff had involved both him and his brother in his plan. The person told us, "I have a file with notes about me and what's wrong with me."

We did notice that the 'This is me' section contained differing levels of information. Some were very complete and others contained very little information. In one person's plan, a person had asked that female staff to attend to their personal care. When we asked a member of staff about this, they were unaware of this, saying, "I don't think she minds. I don't really know I haven't looked at her history." The registered manager said that the level of information depended on how involved relatives were or how long they had lived at the home and the documents were updated as soon as relatives told them information.

Apart from the example above where a member of staff did not know the gender preference of carers for one person, staff had worked at the home long enough to know people and their preferences and they met these. We noted that some people's rooms were sparse with few personal belongings, whilst others were more personalised. When asked, staff they did not know why this was so. The registered manager told us that some people destroyed, or broke objects in their room, and they had to be removed. Efforts were made to personalise these rooms. For example, a bright mural was being painted on the wall of one person's room. This provided interest and distraction for the person who exhibited some behaviour that was challenging. The registered manager also said that when staff shopped they looked out for clothes or objects people might like to bring in for them.

We learned that one person was in a same sex relationship. The registered manager said, "Staff treat them absolutely as it should be. They have a partner who visits and is welcomed." The care plan mentioned there was a partner, who had helped with the assessment information. The registered manager showed us some Alzheimer's Society information that they were using to develop some practice guidance for staff in working with people who identified as Lesbian, Gay, Bi-sexual or Trans-gender.

Several people were helped to maintain their faith. One person went out to their church and a holy communion service was held at the care home on the first Wednesday of each month. Another person was a Jehovah's Witness and this was respected. The registered manager stated, "There is no discrimination."

At the time of our visit there was no one receiving end of life care. The care plans we saw did not include information on people's wishes for end of life. The registered manager told us they always document people's future wishes where this was known. We saw that people's consent had been sought for any clinical decision not to resuscitate them in the event of cardiac arrest.

People were stimulated with social interaction and appropriate activities. We had previously recommended improvements to the range of activities and social interaction provided throughout the home for people living with dementia. The registered manager said they had taken the suggestions on board. They had invested in new equipment and staff engaged in an activity with people who did not attend the day centre. They said, "Although we could always do better, we do try." We did see that staff were engaging with people in the main lounge areas with jigsaw puzzles, therapy dolls or small musical instruments. Some people were given a hand massage by staff. Later in the afternoon, a small group activity in the annexe lounge, led by staff, using a large balloon. The staff member told us about a person who loved to talk about their travels.

Although most people rarely went out, one person told us, "I go out once a week with a friend." She also told us that staff had bought clothes for her to go to her husband's funeral and had organised a taxi for her. The registered manager said many people did not want to go out but they took people into the local town on occasions. A trip had been arranged last summer. The registered manager had contacted a local transport company with the intention of increasing the opportunities for people to go out.

Staff told us about the day activity centre. One member of staff said, "We always ask people if they want to go to the day centre." This was a bright room, decorated with colourful bunting. There were plenty of activities, scrapbooks and games as well as a television. Staff ran a music session. They helped people to remember old songs and people enjoyed this and joined in the singing. It was a happy atmosphere.

People and their relatives said they could complain by speaking to the registered manager and they were confident that any concerns would be dealt with. There were two complaints that had been raised in the last six months, and actions were taken as a result. A member of staff was able to describe what they would do if anyone complained. They told us they would act quickly; they would inform the registered manager and then complete a written report of the complaint. The registered manager said they worked with relatives and representatives to resolve complaints quickly.

A complaints procedure was displayed in the hallway, and there was a symbol version to help people understand what they could do.

We could see that staff and relatives communicated well. One relative we spoke with said that, "A while back there were a few issues but they have now been solved. Mum has new windows in her room now and a new hospital bed, so we are very pleased. We can't fault the place." Another relative said that a special chair was ordered for her mother. This meant they were, "Much more comfortable."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, we recommended that improvements were made to the way people's care plans were written and used by staff. The registered manager said a senior carer was taken off the staff rota so that they could review care plans and continually update these. Despite this, at this inspection, we found that what was written in the care plans was not always up to date or complete. Care plans were in a clinical format that was not easy to read and they did not give staff the up to date picture of people's needs and risks. For example, a person who had complex mental health needs had a risk assessment, which stated they needed "close supervision" as they were at risk of poisoning from drinking inappropriate fluids and at risk of falls. We saw this person walking around independently and going outside with no staff supervision. The registered manager said that the person had settled and the risks reduced, but the care plan did not reflect this.

Although staff told us about the support people needed, they also said that they did not make use of care plans. One member of staff said, "The nurse will tell us what to do," and that they relied on the "handovers". We noticed a use of language in the risk assessments that was not appropriate for people living with dementia. For example, risk assessments that said "risk of absconding."

The registered manager told us of some improvements to the record keeping and that most staff had recently completed training. Despite this, there were gaps in records. For example, a care plan stated when a person should have showers but the personal care checklist had not been completed to show these had taken place regularly. The registered manager said, "I tend to spend most of my time out there with staff and people. Our role has changed and we haven't managed the records as well. We are looking into computerisation for record keeping."

We recommend that the registered manager look at alternative methods for care planning, which can support staff practice and reflect the need for person-centred care.

There was inconsistent practice by staff, which could have an impact on people's safety and hygiene. Some staff had worked at the home a long time and we could see the registered manager relied on them and the nurses to supervise staff. However, management oversight of staff practice could be improved, in particular in managing risks for people. For example, with the person who had left the building unsupervised in the past, staff were not able to tell us how they kept this person safe now. With hygiene, the registered manager had carried out a recent infection control audit and no actions identified, whilst we found improvements were needed.

Learning from incidents could also be improved. Action had been taken after a person had fallen a number of times. A low bed and sensor had been ordered so staff would be alerted and be able to attend to assist them to stay safe. The registered manager had also referred people to the falls clinic. However, the book recording falls was brief and gave no details of the patterns of falls or actions taken and it was not up to date. This meant it was difficult to look at patterns of falls across the home and assess whether there was further action that could have been taken to prevent falls. The registered manager said they kept the detail of each fall in people's care files.

People and relatives felt listened to and that there was an open culture. One relative said that they did not feel they needed to attend any meetings as they and the staff got on well and were able to discuss their family member's care regularly. The registered manager was available to people, relatives and staff during the day. A relative told us that they could "Communicate with the manager, and know she will respond." And another relative said, "The manager is hands on and notices things."

Staff told us that the ethos of the service was about, "Caring for the residents and trying to value them as an individual." Several staff had worked at the care home for over 10 years. We were told, "Staff stay a long time. Sometimes people leave, but they come back. She is a very good manager." When we asked staff what made them stay, they said," It is very rewarding working here." And, "There is good team working."

The registered manager told us that they were, "Most proud of the staff," and their ability to recruit and retain the right staff. They also said they believed in valuing and rewarding staff. They noticed good work and praised the staff. People and their relatives and were able to contribute their views at regular meetings. The meetings were also informative. For example, at a recent meeting the registered manager invited someone to speak about the Deprivation of Liberty Safeguards and what it meant to people.

We heard from social care professionals who had supported people to move into the care home. One said that the registered manager had "built a good working partnership" with them and with families. They referred to people who had complex social and health needs who had settled well at the care home. One person had been moved twice before due to challenges. Another was not expected to improve but had done so. They said of the registered manager, that they had been "professional at all times" and that staff worked with outside help and expertise to support people if needed.

The registered manager told us of the work they were doing with the Quality Care Home team, including a new innovative "Red Bag" pilot scheme. This meant essential information and their medicines travel with a person when they are admitted unexpectedly to hospital. Westcott House have signed up to be one of the first waves of homes in the area to trial this with people and report back. We received feedback from this team that the registered manager was keen to improve and try this new approach.

The registered manager carried out regular safety checks. Electrical testing was done monthly and fire alarm tests each week. Water flushes were carried out every three months to prevent legionella bacteria developing. A clinical waste contract and a current maintenance contract for the lift were in place. A weekly maintenance checklist showed actions such as extra cleaning or gardening. There was a business continuity plan. This included arrangements if the building became unusable or unsafe or there was a loss of service. There were contacts for the staff if an emergency occurred. One member of staff told us they all knew where this was kept and senior staff knew who to contact.

A business plan for 2018-2019 had been written. This, however, reported a number of improvements that had already been done, mainly in relation to the building and equipment. The new profiling beds had been purchased for those who needed them. Wi-Fi had been installed allowing some people to connect to their families using Skype. In the annexe building, a new call bell system was now in place.

Although we received positive feedback from people, relatives and partners, about the management we judged we were unable to give the service a Good rating in Well-led. This is because we found shortfalls in the recording and staff awareness about people's care and risks. The registered manager has already taken action, based on our feedback and we will monitor this at the next inspection.