First Cheltenham Care Limited

Wentworth Court Care Home

Inspection report

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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

This comprehensive inspection took place on 14 and 15 August 2017. The first day was unannounced. At the time of the inspection 59 people were receiving care and support. The service is registered to provide a service to a maximum of 62 people. It specialises in the care of those who live with dementia. A registered manager was in post. 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.

During the inspection we followed up one legal requirement. This had been issued at the last inspection on 22 October 2016. This related to the maintenance of people's care records in association with their nutritional risks. The provider submitted an action plan which told us how this legal requirement would be met and stating this would be fully met by the end of April 2017. At this inspection we found records pertaining to people's nutritional risks had been improved and maintained well.

The arrangements in place helped to keep people safe. Risk assessments showed that risks to people's health and well-being were assessed and managed. Staff were fully aware of what support they needed to provide people with in order to keep them safe. One relative told us they considered their relative to be safe. They said, "I know [name] is safe here and that [name] is not going to be ill-treated." Relatives and people told us they were happy with the care provided. People were treated with dignity and respect. Comments referring to how well this was done were made by relatives on a website used to review the service.

Staff received training and support to be able to meet the needs of people who lived with dementia and challenging behaviour. Care was planned around people's individual needs and their preferences. Relatives were supported to be involved in the planning and reviewing of their relatives care. They were encouraged to speak on behalf of their relative if their relative could no longer do this for themselves. Relatives were encouraged to provide staff with information about their relative's lives. This information helped staff tailor people's care and provide activities which were meaningful. The staff knew those they cared for well and had built up good relationships with family members. A relative told us that when they visited, staff always knew about their relative and were able to tell them what had been going on for that person. A review comment from the website we visited said, "You always seem to know [name]."

People health needs were assessed and met by nurses employed by the provider and other visiting health care professionals. The service had trained staff so that certain health needs could be met by staff in the care home. This sometimes avoided the need for unsettling visits to the GP surgery or hospital. Staff worked closely with GP's, end of life specialists and the NHS rapid response teams to help achieve this. The principles of the Mental Capacity Act were followed. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Where people were deprived of their liberty this was done lawfully with authorised Deprivation of Liberty Safeguards in place or these having been applied for.

There were arrangements in place for complaints and areas of dissatisfaction to be expressed, listened to, investigated and resolved. There was an open and positive culture in place and senior management staff were keen to learn from and improve the service from the feedback they received. Relatives told us they felt comfortable in raising any concerns or areas of dissatisfaction they may have. They told us these were listened to and improvements made. Meetings were held with people, relatives and staff to aid communication and feedback. A strong leadership team had been established and although the registered manager was preparing to take a longer-term period of leave at the end of September 2017, she was confident that the service would be effectively managed in her absence. Effective monitoring systems were in place which ensured the service remained compliant with all necessary regulations and legislation and that action were taken to constantly improve 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?

Good

The service was safe. Risks which could potentially harm people were identified, assessed and managed in order to keep them safe.

People were protected from abuse and discrimination because staff knew how to identify potential concerns related to this. Managers adhered to relevant policies and procedures which were in place to safeguard people.

There were enough staff to meet people's needs and good recruitment practice protected people from those who may not be suitable to care for them.

Arrangements were in place to make sure people received their medicines appropriately and safely. Systems were in place to reduce medicine errors.

People lived in an environment which was kept clean. Infection control measures were in place to reduce cross contamination and reduce the impact of potential infection on people.

Is the service effective?

Good

The service was effective. People received appropriate support with their eating and drinking. They were provided with a diet that which supported their nutritional well-being. People's nutritional risks were identified, assessed and managed.

People were supported to make independent decisions and received their care in the least restrictive way possible. People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

People had access to health care professionals and their health care needs were identified and managed.

People received care and treatment from staff who had been trained and supported well. Staffs' knowledge and professional development was improved and people benefited from this.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind and who delivered care in an understanding and compassionate way.

Relatives were supported to be involved and given opportunities to speak on behalf of their relative.

People's preferences, likes and dislikes were explored. This information helped staff achieve a personalised approach to people's care.

People's dignity and privacy was maintained. People's right to family life was upheld and supported. Relationships which mattered to people were supported.

Is the service responsive?

Good

The service was responsive. Care was planned and delivered in a way which supported people's individual needs.

People were supported to take part in meaningful activities and to be part of the local community.

There were arrangements in place for people to raise their complaints, to have these listened to, taken seriously and addressed.

Is the service well-led?

Good

The service was well-led. People had benefited from strong leadership having been established. Plans were in place to ensure this was sustained.

Quality monitoring processes ensured the service remained compliant with relevant regulations and legislation which helped to protect people.

A positive culture was in place. People's relatives and staff were able to question decisions made, feedback their views and make suggestions which were acted on for the improvement of the service.

Staff commitment and achievements were recognised and celebrated.

Wentworth Court Care 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 14 and 15 August 2017 and was unannounced. The inspection team consisted of one inspector and one specialist advisor. The specialist advisor's experience was in dementia and mental health care.

Prior to the inspection we reviewed the information we held about the service since the last inspection. We reviewed statutory notifications which are information the provider is legally required to send us about significant events. A Provider Information Return (PIR) was not requested prior to this inspection. This is a document that the provider submits to the Care Quality Commission and provides some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and when we made the judgements in this report.

During the inspection we spoke with two people who lived at the care home and three relatives. We 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 about their experiences. We spoke with the registered manager, deputy manager, clinical lead, education co-ordinator, the activities co-ordinator, the maintenance person, one nurse, one cook, the administrator, receptionist and three members of care staff. We sought the views of two health care professionals and one provided us with feedback. We sought the views of commissioners of the service. They chose to share information with us about things the service had reported to them. We reviewed the comments made by relatives on a particular website which could be used for this purpose and which the service monitored to gain feedback about their service.

We reviewed records relating to seven people's care. These included care plans, risks assessments and records relating to the management of people's behaviour and nutritional risk. We reviewed records and documents relating to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We reviewed a selection of people's medicines administration records and other records relating to the management of medicines.

We reviewed three staff recruitments files and requested that the staff training record be forwarded to us which it was. We were provided with information about how nurses were inducted when first employed by the provider. We reviewed the service improvement plan and were provided with a copy of this. We looked at the accident and incident audit and reviewed complaints records. We reviewed the minutes of a 'resident and relative' meeting. We were provided with and accepted information about various events, training and award successes and projects the service wanted us to know about. We visited areas inside the building and visited the gardens.

Good

Is the service safe?

Our findings

People were protected from risks which could potentially have an impact on their safety, health and welfare. Risks were identified, assessed and managed in order to maintain people's well-being.

People's care records stated what risks affected them personally and gave staff guidance on how to manage these. For example, safe moving and handling risk assessments and mobility care plans told staff what people's abilities were, what the risks were when supporting them to move and how to move people safely in order to reduce any identified risks. We observed people being supported to move safely by the care home staff.

The accident audit recorded the number of falls people experienced. It identified who in particular had repeated falls. The audit process looked at trends and patterns in the events leading up to a fall. This process helped to ensure all necessary strategies were in place to try and prevent further falls. Some people with complex needs however, did experience reoccurring falls. We looked at the planned support given to two people with complex needs. As part of the actions taken to try and reduce falls for these people a senior member of staff had sought further advice from health care professionals and falls specialists. Consequently these people's medicines, their mobility aids and the support provided by staff had all been reviewed. Staff were aware of who was at risk of falling and they monitored them closely. As we spoke with one member of staff, we observed them making regular observational checks on those who they knew were at risk of falling.

Staff were aware of the need to support people's choices and wishes in the safest and least restrictive way possible. They worked with people who would often refuse support which was aimed at keeping them safe. One person, assessed as a high risk of falling, wanted to take part in an activity which would require staffs' support to achieve this safely. Staff were keen to support this person's wish, so the risks involved in the person taking part in this activity were assessed. Staff subsequently supported the person to take part in the activity safely by adopting risk reducing strategies. For example, making sure the activity was done when two staff were available and with staff who had experience in supporting this type of activity. We were subsequently informed that the person had thoroughly enjoyed themselves.

People were protected from acts of discrimination and abuse. One relative said, "I know [name] is safe here and that [name] is not going to be ill-treated." They went onto say, "You can tell from the staffs' manner with people that they [people] are safe and treated well." Staff training records recorded training as having been provided in what constituted abuse and discrimination. Staff knew how to observe for potential abuse. For example, all bruises on people were reported and their cause investigated. Staff knew how to report allegations of abuse and any other concerns they may have. The provider's safeguarding policy and procedures were accessible to staff and were in line with the local authority's safeguarding procedures. Staff therefore shared appropriate and necessary information with appropriate external agencies, who also have responsibilities to keep people safe. One member of staff showed us where the relevant policies and procedures were kept and talked us through their responsibilities in safeguarding people. They were aware of the whistle blowing policy which enabled staff to report concerns about poor practice without fear of

reprisal. Another member of staff told us they felt confident they could raise a concern and it be managed correctly by senior staff.

People lived in a safe environment. The maintenance person carried out health and safety checks to ensure the environment, building and equipment remained safe. We reviewed fire safety records. Specialist contractors serviced and maintained the fire alarm system and fire-fighting equipment. The emergency lighting was also serviced on a regular basis. Staff had received fire safety training relevant to their roles. For example, we spoke with the laundry staff who regularly cleaned the tumble dryer filters which, if not cleaned, were a potential fire hazard. They also knew how to isolate the gas supply, in the laundry, in the event of needing to evacuate the building. The fire risk assessment was due to be reviewed and the service was waiting for this to be completed by a specialist company. People's personal emergency evacuation plans (PEEPs) were in place and up to date. These recorded the assistance people required in the event of needing to evacuate the building. These were reviewed as necessary and no less than weekly. This ensured the information contained in these records remained up to date for the emergency services, and staff who were unfamiliar with people.

Specialist servicing and on-going maintenance was also carried out on the water system, call bell system, passenger lift, lifting equipment, electric beds, all small electrical appliances, gas and electric utilities. Records showed that fixtures such as window restrictors and door alarms were checked on a regular basis. During the inspection a trip hazard was addressed and made safe as soon as it was identified. Since the last inspection alterations had been made to the décor of the care home which aimed to help people orientate themselves more easily. For example, bedroom doors had been painted different colours and something familiar to the person who occupied the room had been placed on the door. For example, a picture of a favourite pet or a picture of themselves when they were younger. One person we spoke with told us they always knew they were approaching their bedroom because of the colour of the door. Feedback from a relative in a recent relatives meeting confirmed this action had helped their relative find their bedroom. Toilet doors in communal areas had also been painted to help people locate these more easily. During the inspection we observed further decorating taking place. This was part of the provider's on-going and planned refurbishment work. The registered manager was taking this opportunity to alter some of the colour schemes on each floor. They told us relatives and people had been involved in choosing some of the new colours.

People received support and care when they needed it. Staff were organised in such a way on each shift to ensure people's needs and risks could be supported. One relative told us they had looked at other care homes prior to choosing Wentworth Court. They said, "We chose here because there always seemed to be staff around to help." One review comment from the website we visited said, "There was never a shortage of staff to attend to [name]'s complex needs." We observed communal areas to be supervised by at least one member of staff, at all times, when other staff were busy elsewhere. One member of staff told us they had been told by managers that people were not to be left unsupervised. The registered manager told us they monitored this arrangement daily to ensure their instruction was followed. Staff response times to call bells had also been monitored to ensure people received help when they needed it.

Staff recruitment files contained all the necessary checks and references to ensure people were protected from those who may not be suitable to look after them. We spoke with the administrator about the information they gathered during the recruitment stage. This included making sure appropriate and relevant references were sought from past employers. The registered manager checked to make sure a full and robust recruitment process had been followed before staff started work.

People lived in a clean environment where infection control measures were in place. Statutory notifications

from the provider had reported that several people had experienced chest infections earlier in the year. The registered manager confirmed that appropriate measures had been taken to reduce the spread of this infection. These had also been discussed with the attending GP. This had included trying to keep the people who were poorly separate from those who had not been affected, more regular cleaning of frequently touched services and advising visitors not to visit unless it was urgent. We observed some of the measures in place to prevent cross contamination and the spread of potential infection. These included staff wearing protective gloves and aprons when providing personal care and when handling food. Access to the kitchen was limited and only allowed if appropriate protective clothing was worn. One member of staff was the designated infection control lead. They ensured any actions issued from the infection control audit were completed and generally worked with staff to ensure good infection control practices were followed. Review comments from relatives on the website we visited described the care home as "clean, light and airy" and "always clean and warm."

We visited the laundry which looked tidy and clean. Arrangements were in place for the reduced handling and segregation of soiled laundry. This laundry was washed on a different washing cycle from the rest of the laundry in order to kill any bacteria present. All cleaning equipment was colour coded. This ensured the right cleaning equipment was used in the right places to avoid risks of cross contamination.

People's medicines were managed safely. Staff who administered medicines were trained to carry out this task and their competency was reviewed annually. People's medicine administration records (MARs) were well maintained. When administering medicines staff ensured that the correct time between doses had elapsed. This avoided risks of people being overdosed. The times of when some particular medicines were administered were specifically recorded. This was particularly seen when medicines for pain relief or anxiety had been administered. Some of these medicines had also been prescribed to be given "when required". Staff therefore needed to use their discretion as to when these needed to be used. These included for example, some pain relief and anxiety reducing medicines. Additional guidance called "protocols" were in place to help staff use these safely.

People's refusal to take their medicine was also recorded, monitored and discussed with the GP. Where people had continued to refuse medicines processes under the Mental Capacity Act 2005 had been followed and sometimes these resulted in people receiving their medicines covertly (meaning hidden in for example, their food or drink). Where this practice was followed records were clear about what medicines were to be administered in this way. Other records pertaining to the safe management of medicines were reviewed and observed to be well maintained. For example, records maintained for end of life medicines and medicines which were not used and returned to the pharmacy.

People received the support they needed to take their medicines. We observed medicines being administered at different times during the inspection. Staff wore red tabards which reminded other staff and visitors not to interrupt them at this time unless it was an emergency. This enabled staff to concentrate on the task and was in place to help reduce potential medicine errors. MARs were signed by staff only after people had taken their medicines. This helped to provide an accurate record of what medicines had actually been successfully administered. People were not rushed and they were given the support they needed to take their medicines. Explanations were given to people to help them understand why they needed to take their medicine.

Good

Is the service effective?

Our findings

At the last inspection on 18, 20 and 22 October 2016, we asked the provider to make improvements in how they maintained people's care records. This related to people's nutritional risks and the plans of care to manage these. During this inspection we found the provider had met this requirement and records pertaining to people's nutritional risk were improved.

People's care records contained information about their nutritional risks, dietary requirements, the support they needed and a record of the support they received with regard to eating and drinking. People's weight was reviewed every other week and recorded. At the same time a nutritional assessment tool was used to determine levels of nutritional risk. Relevant information was shared with the care staff and kitchen staff. The cooks therefore were fully aware of who had lost weight, who had difficulty in swallowing and what people's specific dietary requirements were.

People's food choices had been improved and how their food was prepared had altered. New arrangements had been in place for a month prior to the inspection. Meals were now prepared by a specialist food producer. A senior member of staff told us staff had been unable to "quantify the nutritional value of each meal [they had provided]." The new arrangements had been explained to relatives so they understood the reasons for these. A senior member of staff told us staff would now be in a position to provide visiting health care professionals with more factual feedback about people's nutritional intake and progress.

Other benefits for people had included more choice and variety and better prepared texture-modified meals [soft and pureed foods] for people assessed as at risk of choking. It had provided the cooks with more time to bake fresh cakes, bread and to talk with people about their particular preferences and dietary needs. Monthly reviews were planned with the meal producer so that where needed alterations could be made to meet people's dietary needs. One relative spoke with us about their relative's improved appetite. They told us that their relative had "gained a healthy amount of weight" since their admission to the care home.

We observed people receiving the support they required at mealtimes. One relative told us the staff helped their relative to concentrate on their food and consequently their relative's weight and appetite had improved. They told us that without this help their relative would be disinterested and not eat their food. We also observed people being supported to make meal choices. One person was unable to make a decision when verbally given the options. However, when staff followed this up with a visual choice of meals they were able to independently decide what they wanted to eat.

Improvements had been made to the overall mealtime experience. Staff had made some alterations which helped people use retained skills. For example, bread was now toasted in the dining room [rather than the kitchen], placed in a toast rack on the dining table and people were supported to help themselves and apply their own butter, jam or marmalade. At lunchtime the same approach took place. Gravy-boats were in now use which people were supported to use. People now made a decision as to whether they wanted additional gravy and were supported to pour it over their own meal. Cooks served the meals from hot trollies and monitored the new improved dining experience.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) and if any conditions on authorisations to deprive a person of their liberty were being met. We also checked to see if the provider had properly trained and prepared their staff to understand the requirements of the MCA in general, and (where relevant) the specific requirements of the Deprivation of Liberty Safeguards (DoLS). 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. The MCA and DoLS require providers to submit applications to a 'supervisory body' for authority to deprive a person of their liberty.

The service adhered to the principles of the MCA. One person told us they had agreed that they needed more support with their daily living and they had given consent to live at Wentworth Court. They had also provided consent to be supported with their personal care which was recorded in their care records. They told us they valued the support staff gave them. They were supported to make independent daily decisions and to live their life in the least restrictive way possible. For example, they said, "The carer (member of staff) helps me to wash and shows me my clothes and I decide what I'm going to wear." This person told us they preferred to remain in their bedroom for most of the day, although they enjoyed the garden. They had therefore been provided with a key to the door in their bedroom which led into the garden. They told us they were able to unlock this and use the garden whenever they chose to. This practice supported this person to make independent decisions where they could and to live their life without unnecessary restrictions.

People who were unable to provide consent and make independent decisions had their mental capacity assessed. This was assessed against the specific decision that needed to be made. For example, needing to live in a care home in order for the care and treatment they required to be provided. We also saw mental capacity assessments having been completed in relation to certain other areas of care. We reviewed these and three mental capacity assessments specifically related to people's refusal to take their medicines. These recorded that people had been unable to understand why they required their medicines, retain information about their medicines and weigh up the risks to their health if they did not take these. Decisions about these medicines had subsequently been made on behalf of people and in their best interests. Where a decision had been made in a person's best interests, who had been involved in making this and the decision had been recorded. Where people were deprived of their liberty an application for a DoLS authorisation had been made. We reviewed five applications which had been authorised by the supervisory body. Staff knew who these authorisations applied to and in these cases there were no additional conditions applied.

The staff training record stated that staff had received training on the MCA and DoLS. We spoke with two members of the care staff who confirmed this to be the case. They were able to talk to us about the basic principles of this legislation and how they applied this in practice. For example, that they supported people to make independent decisions and provided care in the least restrictive way possible.

People had access to health and social care professionals. A GP visited the care home every other week to review people's health needs. A member of the nursing staff co-ordinated and attended each of these visits. This member of staff was then able to communicate necessary information back to colleagues. Arrangements like this had helped to improve working relationships between the care home and GP practice and improve communication about people's health needs. Other visiting heath care professionals were also given designated time by the staff when they visited. One health care professional said, "I'm always able to talk to one of the staff when I call and they will give me the information and feedback that I need."

The registered manager told us staff had worked successfully with the NHS rapid response teams. These teams were able to provide medical support and treatments [when possible to do so] in the care home. One relative told us how successful this had been for their relative when they had become poorly. For people who lived with dementia this sometimes avoided a potentially confusing and disorientating visit or admission to hospital.

People's records showed that other health and social care professionals were involved in supporting people's health. These included speech and language therapists, physiotherapists, mental health practitioners, medical consultants and community nurses. Reviews by social workers/case managers also took place to ensure people's care placements were appropriate. People had access to regular foot care as well as NHS dental and eye care. We spoke with one relative who had supported their relative to attend a health appointment. If relatives could not support their relative to do this the staff took people to their appointments.

People were cared for by staff who received relevant training and support. All staff, when first employed, completed induction training. During this time they worked with more experienced staff who could act as mentors. Staff were expected to complete training which the provider considered necessary and to make themselves familiar with relevant policies and procedures. For example, fire safety, infection control, safe moving and handling and dementia awareness were some of the many subjects covered in the induction training. Staff who were new to care were supported to gain knowledge and competency by completing the care certificate. This lays down a framework of training and support which new care staff can receive. Once completed its aim is that staff new to care will be able to deliver safe and effective care to a recognised standard. All staff had to successfully complete a probationary period during which staffs' progress and competencies were assessed and monitored.

Staff then had access to a well co-ordinated and on-going programme of training and support. The education coordinator's role was to plan, deliver and co-ordinate staff training. Some staff had been provided with training which enabled them to carry out delegated health care related tasks. For example, the taking of people's bloods. For some people being able to have this done without leaving the care home, by a member of staff who was familiar to them avoided unnecessary distress. These staff were also able to support the work of the nurses.

Nurses were supported to update their practice and to attend courses which helped improve their skills and knowledge. For example, they had completed training in the management and administration of end of life medicines and wound care. Nurses also held specific lead roles. For example, one nurse held the lead role for wound care. They had been supported to gain further specialised skills in wound care management so they were able to advise and support colleagues.

Nurses who were newly qualified or who lacked experience in a care home setting were provided with appropriate support. We were shown an "accountability workbook" which nurses completed when first employed. Nurses were also supported to gain evidence required for their revalidation with the registering body, the Nursing and Midwifery Council (NMC). Time for training was planned and protected as was time for more specific reflection and discussion. For example, plans were in place for the seven dementia link workers to meet, reflect on their roles and decide how they could best support other staff in providing good outcomes for people who lived with dementia.

Good

Is the service caring?

Our findings

People were looked after by staff who were caring and compassionate and who were committed to improving people's quality of life. Staff knew the people they were looking after well. One relative said, "They're so kind, so patient and they really care about them [the people]. As we enter the door to visit, they [staff] always know about [name] and tell us how [name] has been; that is really reassuring."

We observed another relative be welcomed as they entered the care home. Casual and cheerful banter took place with staff and it was clear that this relative had a trusting and relaxed relationship with the staff. The relative later said, "You can talk to them [the staff] about anything, any worries and they are there."

Staff were patient and very supportive of the people they cared for. We observed staff taking time to help people understand what it was they were meant to be doing, what the staff were doing or wanting people to do. Staff showed warmth and affection towards people, for example, putting an arm around one person's shoulder and holding another person's hand. When staff took a break and spoke amongst themselves about the people they had been supporting, they spoke about them with genuine warmth and interest.

People were supported to worship if they wanted to and to retain their personal beliefs. One review comment from the website we visited was from a representative of a local church. They visited the care home regularly to give Holy Communion. They said, "I am so impressed with the care staff here, always kind and sympathetic towards the residents."

People were treated with respect and their dignity was maintained. When people became confused or anxious staff spoke in a reassuring way with them. When people could not manage simple tasks, staff offered support in a way which did not belittle them or cause embarrassment. For example, we observed one person being encouraged to follow a member of staff so they could help the person change their wet clothes. This person had been incontinent and this support was given in a kind and non- judgemental way.

Staff behaved in a professional manner and acted with knowledge and understanding when supporting people. For example, in needing to help one person who had become confused and anxious about how to sit in an armchair. One member of staff gave slow and simple verbal guidance. When it became apparent that the person was unable to follow this verbal instruction, another member of staff stepped in and also provided a visual prompt. They sat down on a chair in front of the person, alongside where staff wanted the person to sit, and used their hands to show the person that they were being invited to sit down in the chair next to them. Non-verbal prompts were given to support the verbal instruction and both staff did this with great patience. The person eventually sat down safely and relaxed.

When people became frustrated staff gave simple explanations and reassurance. For example, this was seen when staff supported another person to move from a wheelchair into an armchair by using a mechanical hoist. Simple and calm instruction was given along with some fun and laughter to distract the person from their anxiety. People who presented with behaviour which could be perceived as challenging, were responded to in a kind and supportive why. One relative spoke about their observations of how staff

managed situations like these. They said, "They never contradict them [the people]; they never argue with them."

People's privacy was maintained. Personal care was delivered behind closed doors. One person had removed their bed covers whilst in bed and these were replaced by a member of staff as they passed by the bedroom. Conversations about people's care or health and meetings such a staff hand-over took place in private. Information about people was kept confidential. Both electronic and paper care records were kept secure.

People's right to private family life was respected and maintained. People were supported to maintain relationships with people who mattered to them. Staff supported people to get ready for visits by their family and friends. Sometimes the staff provided emotional support to family members who found visiting upsetting. Comments from relatives and staff showed that the garden had been enjoyed by people and their visitors. We also observed relatives using the café area, where for example, they sat with their relative and enjoyed a drink and a piece of cake. Where it was appropriate, for example, when people could no longer express their preferences or wishes, relatives and representatives were encouraged to speak on their behalf. People's families and friends were afforded time to be able to speak with staff about their relatives' care. We observed the registered manager making herself available to speak with relatives when they wanted to do this. In order to help families be in involved in representing their relatives' and to make information they needed to do this more accessible, for example care plans, these could be printed off the service's electronic records system and produced in large print if required. They could also be emailed to relatives if secure email arrangements were in place.

People's preferences, their likes, dislikes and wishes were explored with them or their family members. These were recorded and this information helped staff to personalise the care they delivered. Staff were more able to have meaningful conversations with people if they knew something about their past lives, family and interests. This also helped in the planning of people's activities. For example, the garden provided people, who had previously been keen gardeners, with opportunities to pick flowers and harvest vegetables they had grown with staff support.

Staff thought about and considered the people they looked after because they genuinely wanted to improve their quality of life. For example, when one member of staff did their own shopping they bought items they knew one particular person would like. These were items that would not be readily accessible to this person unless the member of staff did this. These small items brought an extra quality to this person's life. This caring and considerate approach was adopted by other staff. For example, staff considered people when they had an errand to completed, such as going to the GP surgery or the pharmacy. Where it sometimes may have been easier not to do this they took the time to think about who would enjoy a trip out, help to get them ready and take them with them.

Statutory notifications sent to us told us that many people had been admitted to the care home for end of life care. Staff told us they were able to get advice and support from community nursing teams and palliative care specialists when needed. They were also able to source or had equipment needed to support end of life care. One review comment from the website we visited said, "In the last two weeks [name] required constant nursing. During this time, all the staff, but especially the nurses, showed great skills and professionalism and as a result, my [relative] experienced little distress or pain." One health care professional commented that this was another area where "the knowledge of the nursing staff has developed." People's care records showed people's end of life wishes had been explored so these could be met at the appropriate time. One relative said, "We have seen staff, who are on their break, go and sit with someone who is at the end of their life because they care about them and don't want them to be alone."

People were remembered by staff and shown respect after they had died. Plants had been planted in the garden by relatives, in memory of loved ones who had once been cared for at Wentworth Court. As we visited the garden, a member of staff spoke fondly of the people who were remembered in this way. This showed the relationships built between people, relatives and the staff were meaningful, as staff continued to fondly remember those they had looked after.

Good

Is the service responsive?

Our findings

People's needs were assessed and their support was planned around their individual needs, preferences and wishes. One relative told us they had been involved in the planning of their relative's care, as this person had been unable to do this for themselves. They had also been involved in reviewing their relative's care plans. One person told us the staff always checked with them to see if they were happy with the way their care was delivered. Another person told us their preference had been sought in relation to whether they wanted a male or female member of staff to deliver their intimate personal care. They said, "It did not matter to me but it was nice that they asked."

People's needs were assessed before they were admitted and we saw records which contained the information gathered at this stage. Care plans were then devised and gave staff the information they needed to be able to meet people's needs. Care delivery was sometimes adjusted and we observed staff doing this when it was needed. The care plans supported an individualised and tailored approach to care so they contained valuable information about the individual person which helped staff achieve this. For example, one person's mental capacity assessment recorded that they lacked mental capacity to understand why they needed to maintain their personal hygiene. Records stated they could often be resistive to the support they needed to maintain this. The care records clearly stated that the person's immediate wishes should be respected. Care plans then outlined how staff should try to deliver this care, for example, only at times when the person was more able to accept support. The additional work done in finding out about people's lives, their previous interests, preferences, likes and dislikes gave staff the information they needed to be able to have meaningful interactions with people. This helped to build up trusting relationships in which the person could be supported with their care needs.

Care plans also recorded information about what people could do independently and about the skills they retained. Staff adapted the support they gave around these in order to help people who lived with dementia retain independence and skills. Care plans were reviewed on a regular basis, usually monthly, or beforehand if needs altered, to ensure these contained relevant guidance. This helped to protect people from receiving unsafe or inappropriate care or treatment due to a lack of appropriate information about them.

Another person could also be resistive to staff support. They, at times, exhibited behaviour which could be perceived as challenging. How and when this presented itself could be unpredictable. The staff used positive behaviour management plans to support people's distress and behaviours. This was in line with the county's dementia care pathway. This pathway helped to meet national guidance issued by NICE (National Institute of Care Excellence) - 'Dementia - Supporting people with dementia and their carers in health and social care'.

A positive behaviour management plan detailed what behaviour the person may exhibit when not distressed and then behaviours which may be exhibited when distressed. These were categorised according to the severity of distress using the traffic light system, red for severe distress and challenging behaviour, amber and green for what was termed as "baseline" behaviour – no distress. Work had been done to identify what may trigger this person's distress and their subsequent levels of challenging behaviour. The positive

behaviour management plan gave staff guidance on how to support each level of behaviour. Incidents of challenging behaviour were recorded and analysed to ensure the management plan was effective. We reviewed the records of another person who exhibited challenging behaviour. The same pathway was followed and their behaviour management plans were particular to their behaviour and needs. A review of these behaviour management plans and other care records showed that staff had followed the suggested course of action. For example, this had included, when safe to do so, leaving the person to calm down and returning later, or providing a quieter and less stimulating environment.

Where behaviour management plans were implemented and followed, but people continued to exhibit distress which led to challenging behaviour, visiting health care professionals and staff continued to try and identify possible triggers. One visiting health care professional commented that this could be things like, pain, constipation, infection and environmental influences. They commented that staff had become more knowledgeable about these and more proficient in doing this in the time they had worked with them. They commented that the on-going training given to staff on dementia care and the management of people's behaviours had helped with this. Medicines designed to reduce anxiety and distress were sometimes prescribed and used to compliment the positive behaviour management plan. Information given by the staff and people's care records showed that staff tried different approaches to manage people's distress and anxiety before using the prescribed medicines.

People were supported to take part in meaningful activities. Staff responsible for the organisation and delivery of activities were skilled and had relevant knowledge and expertise in this area. An activities co-ordinator led a team of activity staff and they took the lead in supporting people with their activities. However, all the staff understood the value of meaningful activities in relation to promoting people's well-being. One member of staff said, "We have a whole home approach to people's activities." To further build on this approach workers from a nationally recognised enterprise had been invited to visit the care home to help identify further ways of improving people's well-being. The enterprise's goal was to "get people in care homes out and about more" and by doing this "enhance their mental, physical and emotional well-being." The care home had a designated activities room where small groups and one to one activities could take place without interruption. There was also money made available to support activities. The work done on gathering information around people's 'life histories' was used to identify and personalise people's activities and to make them more meaningful to an individual person.

Outside spaces had been created and had evolved since the last inspection and people had enjoyed using these with support from staff and family members. A courtyard style garden, off the main reception area, had continued to provide a more enclosed, safe space for people to walk and sit. This area could be clearly viewed by staff from a distance and therefore people could use this independently but still be monitored from inside. Pieces of art designed to be displayed outside had been added to this space since the last inspection and had been a product of successful links with a local art group. The main garden had also evolved since the last inspection and raised planting areas were now full of flowers herbs and vegetables which had been chosen and grown by the people. Chickens remained on site and were now visited on a regular basis by several people who had grown attached to them.

Activities had taken place over the last year which had been designed to appeal to certain groups of people and individuals and which brought people and their family members together. For, example the building of the brightly coloured bird boxes seen attached to the trees had promoted and used some people's past experience and knowledge in building these. They had been able to share this knowledge and their skills with each other and the staff who supported them in this activity. This had promoted self-worth, confidence and we were told it had brought enjoyment. We saw that small ornaments had been placed under a tree, which we were told was part of the building of a 'fairy garden'. This activity had resulted in people's younger

relatives visiting the 'fairy garden' when they visited. We saw photographic evidence of people's involvement with various activities which were showed the activity to be meaningful to the person taking part.

Since the last inspection items which people could use in an independent activity had been made more accessible. We therefore observed for example, books, pencils, pens and paper, various games and a selection of hats on a stand, all now within people's reach. The designated activities room had been moved to an easier and more prominent place for people to use and it had direct access onto the garden. During the inspection people had come together to arrange flowers for the dining room, which people had grown in the garden. The café in the reception area was now used on a regular basis by people with their family and friends. A weekly coffee morning had become popular with people, relatives and members of the local community. Links with other care homes, church groups, a local theatre and other community groups had evolved and become stronger. A mini-bus had also been purchased since the last inspection. This had improved people's opportunities to go on planned and spontaneous trips out. The mini-bus was also able to transport people in wheelchairs. We spoke with one person who staff told us usually remained in their bedroom and rarely chose not to join in activities. This person told us they had been out a couple of times in "the new mini-bus" and had "thoroughly enjoyed" going out for to a coffee and cake.

People, their family members and others were able to raise complaints and concerns. Information about how to make a complaint was on display and had been provided on people's admission. Two relatives confirmed they were able to raise any issues of concern and these were dealt with immediately. They told us senior staff were approachable and wanted their queries and worries to be resolved. In this respect one relative said, "The management team are on top of it." One review comment from the website we visited said, "Whilst I had a few concerns, I was always able to raise them, I was listened to and action was taken to make improvements." A record of all complaints and areas of dissatisfaction had been kept. This was irrespective of how these had been received or their level of seriousness. For example, they were usually received verbally in person or by phone or by email. We looked at the records of five complaints/areas of dissatisfaction which had been raised in the last six months. Records included the initial issue/s raised, a record of any investigation carried out and staff statements if gathered, the response/s to the complainant and a record of the actions taken subsequently.

Some of the actions taken to resolve an issue had included, reminders to staff to follow best practice at all times, more detailed conversations with staff to identify any training or support needs, increased monitoring for example, of call bell response times and discussions with staff about why these needed to improve. Where people remained in their bedroom and this had caused concern to relatives, staff had been told to ensure they record all visits and interactions with these people so relatives could see they were not isolated. The registered manager told us that anyone could contact her at any time if they were unhappy about something. One member of staff said, "She [registered manager] will always do this [make themselves available], I don't know how she manages it and everything else, she is quite amazing really."

Feedback from people, good or bad, was used for learning purposes and to improve the service. One member of staff told us about the feedback given to them by a relative. They told us that often relatives who visit on a regular basis were able to observe things that could be improved. In this case, a relative had been sitting with their relative in the lounge. They had observed and picked up on comments made to them by their relative about where the new mini-bus was parked. It had been blocking people's ability to watch the local community pass by the front of the care home, which they enjoyed doing. The member of staff told us that as soon as the relative fed this back to them they could see the problem. They said they were able to address this immediately by moving the mini-bus and making sure a new parking bay was allotted for it.

Good

Is the service well-led?

Our findings

People had benefited from strong leadership having been established. Comments about the registered manager included, "she's onto things straight away", "she's truly amazing" and "always there for you." One health care professional commented that they had received "positive feedback" from families about the care home. This health care professional considered the service to be well managed. The registered manager had been in post since January 2016 and had created an effective senior management team. Since the last inspection in October 2016 this team had further evolved and become stronger and clearer in both their expectations and visions for the service.

There was a clearly defined management structure. Senior care staff were employed to support the delivery of people's care on a day to day basis and to ensure the smooth running of the daily shifts. Two members of the care team were informed of their successful promotion to senior care staff on one of the days of the inspection. We spoke with all three senior care staff and from talking with them and observing them at work, they clearly had the skills needed to direct and support the care team. Nursing staff worked alongside the care staff and managed people's health needs. They were organised and supervised by the clinical lead. Ancillary staff had their own heads of department who worked closely with the senior management team. A new administrator was in post and was part of the senior management team.

We were told that a Director of the company (the provider) visited at least monthly and could be contacted at any time in-between. The registered manager told us they were in frequent contact with this person who was formally reported to on a weekly basis. This weekly report included for example, feedback and progress on issues relating to people's care, management of staff, complaints, current risks and business related information.

Quality monitoring processes were in place to ensure the service ran safely and that necessary regulations and legislation were met. The quality of the service was monitored through audits, completed by the registered manager, senior management team and other staff. A quality and compliance consultant also visited the care home each week to carry out audits and follow ups on behalf of the provider. An example of how effective the staffs' checking systems were was seen when inspecting people's medicines. A medicine error had been identified when staff had checked people's medicine administration records (MARs). It was explained to us that one medicine prescribed for one person should not have been be administered with another. Both medicines were still been recorded on the MAR because one had not been removed when the new one had been prescribed. The person in this case had come to no harm but action had been taken jointly by the GP, the pharmacist and the care home to ensure processes between them did not allow this to happen again.

Audits identified areas for improvement and actions were recorded and completed to address any shortfalls. The visiting consultant recorded necessary actions for staff to follow up. They also reviewed previously recorded actions to check if these had been completed. They then recorded these as "done". To consolidate the results of several audits and to make it easier for the registered manager to follow and track necessary actions, a service improvement plan had been implemented. We were provided with a copy of this new

document and we discussed the progress made on some of the actions recorded on it. This one document provided a clear record of when actions had been completed, what actions were 'works in progress and what needed to be addressed. For example, the auditing of the call bell response times was included on this record. This record demonstrated that there was a quality monitoring system in place which was being effectively followed and which resulted in improvements being made to the service.

Regular meetings were held with different groups so the registered manager could give updates, communicate necessary news and seek feedback and suggestions. Meetings were held with people and relatives, all staff and then with different teams. Some meetings were role specific so for example, meetings were held with kitchen staff, domestics, senior care staff, nurses, activity staff and dementia link workers. All staff spoken with told us the registered manager was approachable and available to speak with when needed. Minutes of the relative's meeting held on 2 August 2017 showed that a range of topics had been discussed. Relatives had raised questions and had these answered and had been able to give feedback. For example, on the laundry, cleaning at the weekends and the food. Their views had also been sought on various things such as the altered dining experience, changes made to the environment and the food.

Staff achievements were recognised and a positive working culture had been developed by the registered manager. When talking with staff it was clear they were proud to be working at Wentworth Court. They were committed to the people they supported and to improving their quality of life. Information had been shared with people and relatives about two care industry awards, which had been won by staff for outstanding contribution. One had been won by the activities co-ordinator in the Making a Difference for Dementia category. This had been for their development of the care home's dementia friendly garden and the positive impact it had on people and their relatives. In doing this they had involved the people who lived at Wentworth Court, their relatives, local experts and businesses. They had applied for and gained money from a local grant in order to help with this project. The other had been won by the educator for Inspiring Leadership category. This had included his work as the home's educator, the introduction of an apprenticeship programme in supporting young people to enter the care industry. It had also included work completed as part of the senior management team and the positive impact this had on Wentworth Court's development.