First Cheltenham Care Limited

Wentworth Court Care Home

Inspection report

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Date of inspection visit:
18 October 2016
20 October 2016
22 October 2016

Date of publication:
03 April 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18, 20 and 22 October 2016 and was unannounced. It was carried out because we had received information about the service which was of concern. The service was last inspected on 7, 8 and 9 September 2015. At that point it had been opened for five months, had eighteen people living there and had been rated as overall 'Good'. During this inspection the service was fully occupied with 62 people receiving care. The service specialises in the care of people who live with dementia and it employs nurses to care for people who are funded to receive 'nursing' care. The information of concern was explored during this inspection and we could not find evidence to substantiate these concerns.

We found records relating to people's nutritional needs were not sufficiently maintained. This put people at risk of potentially not receiving safe or appropriate care and treatment due to a lack of accurate information held about their needs. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the back of the full version of the report. We did however observe people receive the support they needed to eat and drink and there was evidence to show that some people's nutritional health had improved.

The registered manager had managed the service since October 2015. 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.

The registered manager and her senior management team had provided stability to the service. This team were now in a position to provide consistent and effective leadership to staff. They shared the same values, visions and expectations and these were communicated to the staff effectively. The provider had a quality monitoring system in place, which in places recorded detailed findings. The audit process had been effective in highlighting some gaps in practice and process but there was not always the evidence to show that the auditing process was fully completed.

Wentworth Court had been a previous care home which the current provider completely re-configured and extended. Existing areas of the building were complemented by the addition of areas of new build. People lived across two floors with the first floor being accessed by a passenger lift or stairs. Each person had their own bedroom which they could or were supported to personalise. Each bedroom had a private toilet and washing facilities [a wet room]. There were additional bathrooms and toilets which had been adapted to help those who required specialised equipment to bathe safely. Each floor had its own communal rooms where people sat, socialised and ate. The main reception area also offered a place to sit with an on-site café which was staffed on a regular basis. This provided an opportunity for family and friends to enjoy a coffee or tea with homemade cakes and pastries with their relative or friend. This facility was also open to and used by the local community. Leading off this was an outside court-yard style garden. People could sit inside and observe the seasons and the plants or they could enjoy the outside safely. In addition to this the main garden was fully enclosed. Major improvements to this had been carried in the last year. It provided people

with another outside place to enjoy with relatives, friends and staff. Following the improvements this included raised plant borders, chickens and a large shed. The shed was a project specifically designed to provide men with activities that would be more meaningful to them.

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Family members considered their relatives to be safe at Wentworth Court. There were arrangements in place to protect people from potential abuse. Visitors were confident they could raise concerns and these would be acted on. People were not discriminated against and behaviours which could be perceived as challenging were managed in a non-judgemental way and in the least restrictive way. All accidents and incidents were monitored and actions were taken to help reduce, for example, falls reoccurring. Risks to people were identified and managed.

The service's recruitment processes had not always been fully effective but the provider had recognised this and taken appropriate action to improve this. Staff employed had been closely monitored to ensure good character and had completed competency checks so the risk to people from this had been low. These improvements now needed to be embedded and sustained. Any poor practice or unacceptable staff behaviour was addressed straight away. There were enough staff to meet people's needs and staff were deployed in a way which helped to meet people's needs. People's medicines were managed safely and staff who administered these had been trained to do so safely.

People were supported to make choices on a daily basis and where possible to make independent decisions. Where they lacked mental capacity to do this appropriate people, such as relatives and legal representatives were given opportunities to speak on their behalf. Decisions made on behalf of people were made in line with current legislation and only in the person's best interests. Staff had received training and support to look after people who lived with dementia. Their skills and knowledge had improved over the last year and on-going training and support was planned in order to support good practice. People received support to eat and drink and to make choices about this. Arrangements were in place to ensure people had access to local health care professionals and specialists when needed.

People received care from staff who were kind and attentive. They were treated with respect, their dignity was maintained and they were afforded privacy at the appropriate times. People who mattered to those living at Wentworth Court were welcomed and also supported. Care plans had been improved and work was still in progress to make sure these recorded the necessary detail to support staff to deliver personalised care. Improvements to the senior staff team now meant these records could be better maintained going forward. Other arrangements such as staff hand-over meetings helped to ensure staff were updated with people's current care requirements.

People were supported to socialise and to join in activities which had some meaning to them. The contribution made by relatives in helping to maintain people's well-being, sometimes at difficult and upsetting times, was valued by the staff and seen as integral to people's overall holistic care. Senior managers were open to suggestions and ideas from relatives if these were aimed at improving the service and outcomes for people. People's relatives told us they felt able to raise areas of dissatisfaction or make a complaint. These were taken seriously by managers and addressed.

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. The service's recruitment process had not been fully effective but steps had been taken to address this.

There were enough staff on duty and they were deployed in a way that also helped to provide people with support when they needed it.

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

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

People were protected from risks that may have an impact on them.

Is the service effective?

Requires Improvement

The service was not always effective. Records related to people's nutritional needs were not maintained accurately enough. This put people potentially at risk of receiving inappropriate or unsafe care. People had however received support and were able to make choices around what they ate and drank.

People received care and treatment from staff who had been trained and supported to meet their needs. Where needed, additional and relevant training and support had either been provided or was planned for.

People were supported to make day to day decisions. People who lacked mental capacity and unable to make specific decisions were protected under the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

People had access to appropriate professionals to ensure their health needs were met.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind and attentive. People were treated with respect and their

right to privacy was upheld.
People's preferences were explored as well as their likes and dislikes and staff aimed to adopt a personalised approach to their care delivery.

Staff helped people maintain relationships with those they loved or who mattered to them. Relatives were able to speak on behalf of their relative and be involved in the planning of their relative's care.

Is the service responsive?

Good

The service was able to be responsive. Care plans sometimes lacked detail but work was in progress to improve these. There were other arrangements in place to ensure staff knew how to respond to people's needs.

People could raise their complaints and have these listened to, taken seriously and addressed.

People had opportunities to socialise and partake in meaningful activities.

Relationships with family and friends had been valued and encouraged. Community links had been developed which benefited people.

Expert advice had been taken to adapt the environment to the needs of people who lived with dementia.

Is the service well-led?

Requires Improvement

The service was well-led but improvements were needed in how the quality monitoring processes were finalised in order to ensure the overall process was effective in driving improvements and to keep the service compliant with necessary regulations.

People were protected by an open and transparent culture and the management team being clear to staff about their expectations and visions for the service.

Those representing people were able to give feedback and make suggestions on how to better improve the service. The management team were open to receiving these and gave feedback on what actions they took in response to these.

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 18, 20 and 22 October 2016 and was unannounced. Prior to the inspection we had received information of concern about the service which we followed up during the inspection. We also reviewed other information we held from commissioners and other visiting professionals. We also reviewed all statutory notifications received since the last inspection. which was on 7, 8 and 9 September 2015. Statutory notifications are information the provider is legally required to send us about significant events. This inspection was carried out by two inspectors on one day and one inspector on the other two days.

During the inspection we spoke with 13 members of staff which included staff who delivered care, ancillary staff and the registered manager. To learn about people's experience of the service we spoke with one person who lived at the care home and we used the Short Observational Framework for Inspection (SOFI). This is a particular way of observing care to help us understand the experience of people who could not talk with us. We also spoke with five relatives and one person's visitor. One relative emailed us with their comments about the service. We spoke with one health care professional.

We reviewed the care records of seven people and the medicines records of two people. We reviewed eight staff recruitment files. We also reviewed the service's training records, staff duty rosters, audits, records of complaints, a selection of meeting minutes and accident and incident records. We also attended a staff hand-over meeting between the day staff and night-staff and had a tour of the building and the garden.

Good

Is the service safe?

Our findings

The service was safe. People may have been at some risk of being cared for by unsuitable staff because recruitment processes had not always been robust. However shortfalls in the recruitment processes had been identified in an audit carried out on behalf of the provider in August 2016. We saw a list of various actions which had been taken in response to this. For example, missing references, gaps in employment and unsigned contracts had been followed up. During this inspection we initially reviewed five staff recruitment files. There were checks of people's criminal histories via the disclosure and barring service (DBS). However, not all the staff files contained evidence of a full recorded work history or if any gaps in employment had been explored. References from a staff member's previous work, when caring for vulnerable adults, had not been sought. In some cases there were just references from family, friends or colleagues instead. The reasons for staff leaving previous jobs had also not always been explored and recorded.

We discussed our findings with the management staff. They provided us with further evidence which, in some cases, gave an explanation as to why a reference from the last employer was not on file and had not been sought. For example, one staff member's previous place of work (a care home) had closed. The member of staff had however worked with a previous manager at Wentworth Court and had been known to them. They also provided evidence to show that the new staff had not been allowed to work alone until they had been assessed as fully competent to do so. This had meant new staff had been closely monitored, which reduced risks of people receiving care from those who may be unsuitable. We therefore reviewed a further three staff recruitment files and these were satisfactory. We were given evidence to confirm that all these staff had received induction training and had also been shadowed by more experience staff until they were assessed as competent to work alone. The management team had not identified any concerns relating to any of the previously employed staff. The registered manager confirmed that from now on, they would personally check all recruitment files to ensure the full recruitment process had been completed before a member of staff started work.

Prior to the inspection we received information which told us there was not enough staff to meet people's needs on a particular floor. We did not find evidence to substantiate this claim. During the inspection we inspected staff rosters over the period of time it was claimed the service was short staffed and for several days either side. We focused on the numbers of care staff who had been on duty. Rather than two members of care staff on duty as claimed we found there had always been four care staff on duty and sometimes five. On three occasions there had been six care staff. In addition there had been similar numbers on duty on the second floor. Also on duty, had been a nurse, the head of care and the clinical lead. All these staff confirmed they were able to help care staff when needed. Some confirmed they delivered care to people before focusing on other responsibilities. Also present and able to provide support and observe people were the activities team. This team consisted of four staff and there was usually between two and three of this team on duty at any given time. All these staff were in addition to the numbers of care staff on duty. Cleaning, laundry and kitchen duties were all carried out by other designated teams of staff.

The member of staff responsible for the care staffs' duty roster confirmed they never just allocated two staff to work on the floor. They commented, "This would not be enough." To determine the numbers of care staff

required they used a dependency tool, consulted with the registered manager and senior care staff about people's needs. Also taken into account were changes in people's needs and behaviour and where there were times people required more support. There was evidence to show that when it had been needed an additional member of staff had been put on duty to provide one to one care to a person. This extra support had not been funded by the local authority.

We asked a senior member of staff if they considered there to be enough staff on duty and they said, "Not always". They went on to explain this was when the medicines were administered. They explained medicine administration can take some staff longer than others (a medicine round taking anything from one hour to two hours to complete). Medicine rounds were completed by a nurse and sometimes one senior care assistant. They said at these times, and particularly on the morning medicine round, which was larger, it can have an impact on the staff available. The staff member responsible for the staff rosters explained that when a senior care assistant administered medicines, adjustments to how staff were deployed were made to compensate for this. We asked two more senior members of staff if they considered there to be enough staff. One member of staff's view was that people's care could be more personalised with more care staff and the second told us there were now enough staff, although when there had been more people with more complex needs there had not been. This member of staff also said it depends how many people require the support of the nurse as to how much help the nurse can give to the care staff. The night staff told us they usually worked with enough staff.

Management staff confirmed that last minute staff sickness was sometimes difficult to cover and this had an impact. However, they also said that other care staff were very good and picked up extra hours to cover the absent staff. Staff sickness was closely monitored with every member of staff completing a return to work interview. Frequent absences from work were managed through the provider's HR policy and procedures. Agency care staff were used to ensure care staff numbers remained adequate. The current usage was low and it was explained that it was not always the best solution as people did not always react well to a stranger's face delivering their care. Where agency staff were needed the managers tried to get the same staff back.

Another concern reported to us was people falling because they were unsupervised due to a lack of staff. We discussed with managers and care staff the care of those who were at risk of falling. We reviewed the falls management of two people in particular who had been assessed as high risk. The falls audit showed these people fell frequently but not necessarily because staff were not nearby or available. In both cases the levels of risk had been reviewed and action taken to try and reduce a reoccurrence. In one case, a successful reduction of falls had followed the introduction of new actions. For the other it had been more difficult to get the person's agreement and understanding that they needed support from the staff. We observed care staff supervising these two people. When we spoke with the staff they were very aware of the risks to both these people. Two members of staff explained how they ensured they or their colleagues were always near to hand when one person in particular was mobilising. This was in order to try and provide the necessary support when needed. We saw that accidents and incidents were monitored generally and an analysis of these incidents took place.

We asked relatives if they considered there to be enough staff when they visited. One relative had the impression the care home was short of staff because they used agency staff. Another relative told us a relative of theirs had been left for over half an hour with "residents" in a communal room with no staff around. Another relative who also visited frequently said, "I have never been here when there has been no staff about."

We observed staff supervising people and attending to them when they needed support. We observed one

person in need of fairly urgent personal care support to maintain their dignity. The head of care, who was due to go off duty, helped another member of staff attend to this person, instead of going off duty. We also observed two care staff be instructed to leave the staff hand-over meeting as day staff were going off duty and staff needed to be present in the communal rooms and available to answer call bells. This action was taken prior to us sharing the latter concern with managers. From our observations, discussions with managers, staff and a review of duty rosters as well as the falls management records we could not evidence that people were put at risk or their needs were not being met because of a lack of staff.

When we asked relatives if they considered their relative to be safe at Wentworth Court they said, "We feel that [name] is very safe here" and "I have never seen anything that has caused me concern." Staff were aware of the potential risks associated with the abuse of vulnerable people. They had received training on what to look for and how to report any concerns. Managers reported safeguarding concerns to the appropriate agencies. People at Wentworth Court lived with dementia and mental health needs and despite staff needing to manage some very challenging situations we did not observe any discrimination towards people or the use of restraint. Staff had received training on how to manage and de-escalate situations which could become challenging and more training on this was planned. Staff competencies were checked and poor practice challenged. Managers had taken appropriate action where staff had caused concern or where there had been performance concerns. One concern of potential abuse, reported to the Care Quality Commission prior to the inspection, was discussed during this inspection and was acted on immediately and investigated by managers. These arrangements and actions helped to protect people from harm.

People received their medicines safely. It had also been reported to the Care Quality Commission that people's creams and ointments were not available in their bedrooms for care staff to use. The head of care explained these were not left in people's bedrooms because people tended to interfere with them. So from an infection control and safety stance they were kept in the clinic room. Monitoring of this arrangement had shown these were used correctly by staff. We observed medicines being administered and safe practice followed. Only staff who had received appropriate training carried out this task and there was evidence to show that staff competencies were reviewed. One such competency check was started during this inspection. There were arrangements in place to make sure medicines prescribed were available for use. To achieve this there were arrangements in place with a pharmacy that made regular deliveries of medicines to the care home. If needed staff also collected these. During the inspection one person was reviewed by their GP late morning and by late afternoon the prescription for a new medicine had been processed and the medicine delivered and administered. Another person's medicines were to be reviewed by a specialist health care professional to ensure they were still appropriately prescribed for the person's specific condition. The clinical lead (a specialist dementia practitioner) had been proactive in reviewing all medicines used for people living with dementia. By working with a local GP they had ensured these were all at therapeutic levels.

People lived in a safe environment. For example, the risk related to Legionella was monitored. Regular monitoring of water temperatures took place as well as the regular flushing through of all necessary water outlets. The maintenance person was able to show us records relating to this. After the inspection we were sent a risk assessment undertaken by an external company from two years ago that demonstrated actions identified to manage the risk at that time had been undertaken. Numerous other health and safety checks were carried out and staff received health and safety related training. The maintenance person kept robust records of all actions taken to keep people safe from hazards. We saw evidence of regular fire drills and a fire risk assessment.

Requires Improvement

Is the service effective?

Our findings

The records relating to people's nutritional needs were not always accurate or well maintained. In September 2016 the provider audited these records. They found relevant risk assessments and care plans had, either, not been completed or had not been appropriately reviewed. Following the audit improvements were made to these records. In the case of one person their family, as well as the care home's chef were involved in discussions about the person's nutritional needs. This was to ensure that everything possible was being done to support the person to eat and gain weight. Another person's care records had recorded a gain in weight following admission to the care home. This however, had not been sustained. The audit identified neither the relevant care plan or its reviews made no reference to this loss or how further loss of weight would be prevented. Following the audit these records were improved.

During the inspection we reviewed care records relating to people's nutritional needs and the monitoring of their weight. One care plan recorded the provision of a fortified diet but it made no mention of the calorie supplement the person was also receiving, which had been prescribed by the GP. Another person's records recorded a loss in weight. The person had been appropriately referred to their GP who had wanted a weekly weight completed for the next three weeks. We looked at the person's weight records which recorded, roughly, a review of the person weight, fortnightly. We asked why this person had not been weighed weekly as requested. We were told people were weighed fortnightly or monthly at Wentworth Court. The relevant care plan was brief giving little guidance for staff on how to prevent a further loss of weight. There was little information recorded about the actions taken since the GP's visit. We were able to evidence that this person had subsequently gained weight over a month.

In other cases people's care records, related to their nutritional needs, also gave poor accounts of how relevant risks were to be addressed. For example, one person had been identified as being at risk of inhaling their food and choking. The care plan recorded some actions to help them swallow their drinks safely. However, the care plan and care plan reviews recorded different guidance and care. The care plan referred to the person requiring a "soft" textured diet. The care plan reviews sometimes referred to "pureed" textured food and sometimes "soft" textured food being given. It was therefore unclear from the record which texture of food the person was supposed to have to prevent potential choking. Inaccurate and poorly maintained records put people at risk of receiving inappropriate or unsafe care because staff and other professionals potentially have access to inaccurate or unclear information.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the case of these records, the breach of regulation was particularly evident because similar gaps in record keeping had already been identified and highlighted by the provider in September 2016 and were seen again during the inspection.

We observed the support people received at meal-times. These were calm and relaxed. We observed staff supporting people to make decisions about where they would like to eat. Most people ate in the dining

room but some preferred to eat in the lounge areas. Some people were supported to eat in bed or in specific recliner chairs which were in the lounge areas. The ground floor dining room appeared to lack space for the number of people and staff present, which a couple of relatives had also commented on. People were given a choice of two options at the beginning of lunch. On the ground floor we saw a picture of the food options pinned up in the dining room to use as a reminder and visual prompt for some people. If someone declined the options on offer they could have whatever they wanted as long as it was available. The chef said, "People can have what they want." She told us she found it rewarding to make people happy.

People seemed to enjoy the food very much. One relative told us the food was "good". Another said, "The food I think is very good." Another relative told us the meal-time experience had deteriorated since the care home had increased occupancy. They told us how people were supported to make choices was not as good as it had been. They were however very complimentary about the chef's involvement and cooking skills. Where people needed assistance with eating we observed staff providing this in a way which maintained the person's dignity. They did this by sitting down with the person, not rushing them and engaging with them throughout the meal. The chef was knowledgeable about the dietary needs of people and showed us how she ensured that any new people were asked about their likes and dislikes. In one person's nutritional care plan reference was made to the person being able to make independent choices but, for staff to remember that the person needed to be reminded of these. The chef was able to tell us how they met the needs of people on specific diets such as diabetic or gluten free.

We spoke with relatives and gathered their views on how effective they thought the care provided was. There were mixed views. One relative told us they did not consider their relative's toilet needs to be well met. They told us they had visited on several occasions and found their relative had been incontinent. A senior member of staff told us the expectation was for care staff to ask people, certainly before and after meals, if they wished to go to the toilet. If people refused staff were not to force them but return a little later to see if they would accept help to use the toilet. We observed people being helped to the toilet at the times mentioned and in-between. We also observed that one person's urine catheter bag was very full. The person told us it was feeling uncomfortable against their leg. The same senior member of staff told us they would have expected this to have been emptied before this point. They looked into what had happened and on this occasion, the bag had not been emptied before or after lunch. Another relative told us they considered staff to be very well meaning but they did not consider their relative's dementia needs to be particularly well catered for. Three further relatives spoke of the care provided and said, "I'm very pleased with [name] care" and "I think they look after [name] very well." The third relative told us their relative's care was "very good."

People were cared for by staff who received training and support to meet their needs. Since the last inspection there had been concerns expressed to commissioners of the service, by various visitors to the care home, that staff did not have the appropriate skills. The service advertised itself as 'specialist dementia care nursing home' and the registered manager told us relatives and professionals therefore came with high expectations. Two relatives had differing views on staffs' skills and knowledge in relation to dementia care. One relative said, "You can notice the difference between the Wentworth Court staff and agency staff. Wentworth staff are skilled at caring for the people you have here, they have obviously received training in dementia." The other relative said, "Although staff are well intentioned, kind and work very hard, I am not sure that the benefits of the dementia training are yet being displayed." One of the positive changes we noted since the last inspection was that there was now a core group of senior staff with the necessary knowledge and skills, who could provide additional support and guidance where there were gaps in knowledge or experience.

Since the last inspection training for staff had continued and developed. The provider had employed a member of staff with teaching qualifications as their Practice Educator. Their role included assisting nurses

with their revalidation and running all of the staff inductions. They also had experience in co-ordinating training. They told us the support and resources provided for staff training were "amazing". They had identified that further training and support was needed to either improve staffs' knowledge generally or improve confidence in their practice. For example, dementia care, the Mental Capacity Act and the management of challenging behaviours were subjects that had been identified where staff would benefit from further training. They confirmed that training had already been provided in these subjects and that more was planned.

We carried out an observation which showed that the above additional training and support may well be of benefit and would improve some outcomes for people. This was an observation of an activity with eight people. This was carried out in a noisy, busy environment with confusing visual cue's still taking place from a previous activity. The previous activity had been a film which one person had been watching. When setting up the new activity the sound to the film was turned down but the picture left on. Another person who had been calling out loudly was brought into the room to observe the new activity but they continued to call out. Although staff gave this person comforting attention it was a distraction for others. Several other care staff were continuously entering the room and walking across the centre of the activity area to carry out tasks. Those engaged in the activity required support to play the game (bingo) and this was given by one member of staff. The whole session was chaotic and not conducive to meeting the needs of those who lived with dementia. We fed back this observation to senior staff who agreed with us. On other occasions we observed staff being very aware of people's needs. We observed staff carrying out activities with smaller groups or on a one to one basis, interacting well with them and focusing on that one activity and the people involved.

All staff completed induction training when they started work which included a period of shadowing experienced staff in order to get to know the people and their needs. All staff received training on employment legislation and for example, in fire safety and safe moving and handling during this period. There was an induction check list in new starters' files that listed all the policies and processes of the service. As staff read about these or were given information on these the checklist was signed and completed. One new member of staff told us they had just completed their induction which had included these steps and they told us it had been helpful.

We saw study booklets completed on other subjects, such as safeguarding people, infection control and the Mental Capacity Act. Staff who were new to care and other new staff who could only evidence computer based training in previous employment, completed the care certificate. The training co-ordinator explained that this was necessary because staffs' competencies also needed to be checked. We saw certificated evidence of staff having completed the care certificate and evidence of care certificate booklets having been submitted for marking. The certificate takes staff through training modules and competency checks so they can deliver basic care safely and effectively. Staff then went on to complete other on-going training. About to commence, with all staff at all levels, was a 'Manager's Competency Assessment'. We were told this was designed to check and assess all staffs' required knowledge and skills for the role and levels of responsibility they held. We were informed that any gaps in this would be addressed through training and further support.

The training record we were provided with did not record many staff as having completed training in dementia care or in the management of challenging behaviour. The training co-ordinator confirmed that all staff completed basic awareness training in dementia care when they first began work. Most staff had also since completed further dementia care training. All staff had also been signed up for further dementia training through a recognised training organisation. This was at a level of study which would give them further understanding of the different dementia's people can live with and how it can affect people and their abilities. The provider subsequently explained that until training certificates were received from the training

provider, training was not recorded on the care home's main training record. The Practice Educator had explored what was needed to work towards accreditation with The Dementia Quality Mark (DQM). This followed the Department of Health's 'Living Well with Dementia Strategy'. We were informed that three staff had also just completed training as dementia link workers and were due to qualify in November 2016. Under the direction of the registered manager, who had completed the dementia leadership award, these staff would be responsible for promoting best practice in dementia care. They would attend a regular forum run county wide which would support them in this role and keep them updated. The newly appointed clinical lead had specialist dementia care experience and we were told they would be working closely with the Practice Educator to further develop training and support for staff in this area.

Specialist mental health care professionals had also delivered specific training related to the assessment and management of people's behaviours but one member of staff told us the approach was not fully embedded yet. We were also informed that twenty-four staff had completed training delivered by an external training provider in the management of challenging behaviours. Certificates for this training had not yet been issued.

The service supported younger staff who were completing an apprenticeship in health and social care. One of these students told us they had felt reassured because what they learnt on their days at college, they saw taking place in practice in the care home. For example, they had learnt about wearing protective aprons and gloves when delivering care and washing hands in-between as part of their infection control module. They told us they always observed this practice taking place when working in the care home. They also told us staff had time to talk to people which they liked.

Additional and more specific training and support had been given to staff. For example, most staff had attended a training day in London where they explored positive behaviours and approaches in care. Ten staff had completed a team building day where they learnt to problem solve and promote a team approach. Training in what meaningful activities were and the 'team approach' with regard to these had been provided.

People's consent prior to their care and treatment being provided was sought where this was possible. All those living in Wentworth Court required support in one way or another to make daily decisions. We observed staff giving people opportunities and support to make independent decisions. People who lacked mental capacity to make specific decisions were protected by the Mental Capacity Act 2005 because staff adhered to its principles. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.

Staff were aware of who held legal power of attorney for health and welfare on behalf of people. These legal representatives were consulted on decisions made about a person's care and treatment. One senior member of staff told us, people who held legal power of attorney (and those that did not but represented their relatives) usually acted in the person's best interests. However, at times relatives' demands, however well meaning, were not in the person's best interests. How one such situation was being managed was discussed with us during the inspection. This member of staff explained that the decision needing to be made would be discussed at a best interests meeting in order to protect the person and the staff delivering the care. This meeting would include the relative, staff and person's GP and a decision would be made in the person's best interest. In this case the final decision maker would however be the GP.

Where people had not been able to consent to living in a care home in order to receive the care and treatment they required, a decision about this had been made on their behalf and in their best interests. Staff had correctly completed applications for Deprivation of Liberty Safeguards (DoLS). 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). This process had also taken place when close monitoring and supervision of a person had resulted in a deprivation of the person's liberty.

People had access to health and social care professionals. We were informed there was a good working relationship between the care home and local GP surgeries. One GP had been designated to visit the care home on a regular basis. One member of staff from the care home had been designated to co-ordinate these visits. The GP's planned and regular visits were set up in the same room each time so people walked into a familiar room each time to see the GP; as they would have when visiting the GP's surgery. The same routine was followed each time so it was familiar and people sat outside the room a waited to be called in. We were told people had responded well to this arrangement and it enabled a private consultation to take place. There were plans to purchase an examination couch so people could also be examined in the same room as if in the GP's surgery. People's records told us they had been referred to other health care specialist when needed such as, physiotherapists, occupational therapists, speech and language therapists and mental health practitioners. Regular chiropody was also arranged and people were supported to attend dental and optical appointments.

Good

Is the service caring?

Our findings

People's relatives told us staff were attentive and caring. One relative confirmed this but also told us at times they felt some staff needed to be more sensitive and compassionate in their approach. They told us they felt some staffs' responses could be "rather abrupt and un-sensitive". Generally we observed very sensitive interactions which involved staff taking their time to listen to people, talking to them in a kind way and being attentive to those who became distressed. Staff showed empathy when people told them they did not feel well and they gave reassuring explanations to questions expressed by those who were confused. We only observed one interaction where we felt the member of staff could have improved their approach to the person. The interaction was not unkind or abrupt but the member of staff was going through the motions of a task and their verbal interaction was not overly personalised. When talking about how staff were towards their relative, another relative said, "They [staff] are really attentive." Another relative said, "The staffs' approach is excellent and nothing seems too much trouble". This relative said the staff gave a "more full on approach" at Wentworth Court than the person's previous care home. They explained by saying, "They [staff] are interested in [name], there is more interaction happening here with [name]." Another relative told us they found the staff to be "very friendly". One relative said, "My mother loves it here and the staff really care for her." One member of staff said, "There is a nice atmosphere here" and a fairly new member of staff described the staff as a "friendly, welcoming care team".

Staff were observed to be respectful towards people and seen to be maintaining people's dignity. One relative said, "We see the staff treating people with dignity when they have had accidents". Staff recognised when people needed more time, either because they required time to mentally process what was being said or what was happening around them or simply because they were older and less able to rush. Staff did not belittle or set out to embarrass people. Individual likes and dislikes were explored, usually with family members, so the care provided could be more personalised. When we spoke with staff and during our observations it was clear the staff knew what people liked and what worked for them. They were aware of what may cause a person distress or agitation; they knew the people they were caring for. One member of staff who had worked in another care home compared the two care homes with us and told us staff at Wentworth Court really aimed to personalise people's care. The registered manager confirmed that staff understood what personalised care looked like and that now the aim was to fully embed this in everyday practice.

One relative spoke about their relative being "challenging" and how the staff knew what worked and what did not work when their relative was upset and expressing frustration. They said, "They seem to know [name] and how to manage [name]." We observed staff managing such situations by knowing how to approach the person and knowing what worked in order to prevent further distress. One person responded well to a member of staff rubbing their shoulders, but the member of staff also knew when this person wanted to be left alone. Staff were non-judgemental in their approach and understood that when a form of behaviour, which could be perceived as being challenging, was expressed, the person was usually communicating in this way for a reason and it was their role to find out why and to support them. The registered manager said, "We don't hide dementia and everything that can come with it here." They went on to say, "We let them [the people] live with their dementia" but went on to explain that the staffs' role was to

support people to do this in the best way possible.

People who were unable to speak for themselves and who required others to speak on their behalf were protected as staff communicated with people's relatives and representatives about their care and treatment. One relative confirmed they were consulted with when decisions were made or when the care of their relative had to alter. They had been involved in discussions relating to their relative's medicines and changes made to this to try and improve their relative's quality of life. This relative said, "I do ask questions about [name's] care and the staff tell me where they are with this." This relative, as had others, had been able to consult with staff about their relative's care and treatment, have explanations given to them and be involved in the planning of their relatives care. Senior staff were aware of how and when to involve an Independent Mental Capacity Advocate (IMCA) when people did not have representatives to speak on their behalf and when specific decisions needed to be made.

People's privacy was maintained during personal care and conversations about people's care and treatment were carried out confidentially and with the appropriate representatives. Recorded information about people's care and treatment was predominantly held electronically under secure settings. Any other information was kept in offices or clinic rooms which were secured. The need to maintain confidentiality was discussed with staff during their induction training. Any breaches of confidentiality were managed through the provider's disciplinary processes.

Relatives told us they also felt supported and were able to talk to staff when they needed to. One relative said, "You can ask the staff anything." Another relative described their relief at their relative living at Wentworth Court (they had lived in other care homes) and the support they now received. They were waiting for a funding decision to be made but they said, "I don't want [name] to have to go from here." Another relative said, "They inform me of things I need to know and I'm always welcomed. In that respect they are very caring."

Good

Is the service responsive?

Our findings

People's care was planned with their involvement where this was possible. As the majority of people admitted to Wentworth Court were unable to fully contribute to this process relatives and legal representatives were usually involved. This gave people who knew the person well an opportunity to speak on their behalf. People's needs were assessed prior to their admission so staff could decide if they could meet these. This process also helped staff to identify the need for other things to be organised such as particular equipment or the support of specialist health care professionals. Positive relative involvement was seen by the staff as fundamental in helping a person to settle and increasing their quality of life. Visitors were free to visit when they wished and were made to feel welcomed. One relative said, "I'm always welcomed."

People's needs and their care and treatment requirements were recorded in a series of care plans. These records were electronic but hard copies could be printed for better access by appropriate people. One relative told us they felt involved in decisions made around the care of their relative, however, they had not seen the care plans and were unaware staff reviewed these. Another relative however, confirmed they had seen and discussed their relative's care plans with staff and they had agreed with the content.

A senior member of staff explained that a lot of work had been done to ensure the care plans were up to date. Work was now in progress to personalise these and improve the detail of the recorded guidance for the care staff. So, some care plans we reviewed gave better detail than others. For example, the care required for one person to improve their mobility and the actions now in place to help reduce falls had not yet resulted in an update of the relevant care plan. However, when we asked staff about what support they were giving the person, this was in line with the new actions senior staff had decided on and had discussed with them. Another person's wound care had altered and the relevant care plan had not been amended. However, what was required had been recorded in the care file's medical notes, which the nurse had read at the beginning of her shift so she was fully aware.

One member of the care team told us they received good updates on people's needs and care in the staff hand-over meetings. We attended one of these meetings which did predominantly ensure that pertinent information, about people's needs and the changes in these needs, were handed over to the in-coming staff. We therefore found care plans sometimes lacked specific guidance, but this was being addressed and other arrangements ensured staff were aware of what care or treatment was needed. Senior staff were very aware of the need for accurate and well maintained records. They were confident that improvements generally to these could be maintained because there was now a competent and consistent senior team in place to help ensure this was the case.

There were arrangements in place for people, relatives and other visitors to the care home to raise a complaint if they needed to do so. On admission to the care home people's relatives were made aware of the provider's complaints procedure. The service had received ten complaints in the last year and they had been robustly investigated and responded to in a timely way. Both the registered manager and head of care told us they operated an open door policy where anyone was able to approach them. They're aim was for

people and relatives to feel able to discuss their concerns or worries and to resolve these before people felt they needed to raise a complaint. So a proactive approach was being taken to avoid the need for a complaint. When asking about these arrangements one relative said, "[Name of registered manager] is lovely; I can ask her about anything that is worrying me." They also told us the head of care was approachable and responsive. They said, "[Name of head of care] will ring me up if I have left a message for them to get back to me about something I'm worried about." Another relative told us "I have not had to raise any concerns." They went on to explain they felt confident that if they did need to, they would be sorted out. Another relative had raised on-going concerns about lost laundry which had been responded to each time.

The registered manager's office was by the front door and her location was known to some people and relatives. We learnt that both these managers were visible and were generally seen out and about in the care home or seen delivering care. The head of care explained that senior care staff knew what to do if a complaint was made to them and then the most appropriate member of staff would investigate the issue raised. For example, care related complaints were more than often referred to them and nursing and health related issues looked at by a nurse. The registered manager, also investigated complaints and had oversight of all complaints received. How complaints were managed was audited so the provider could be confident that these were addressed appropriately. If the complainant did not feel confident in addressing a complaint to the staff in the care home or, it was more appropriate that the complaint go directly to the provider this was done.

People were supported to socialise and take part in activities. Relatives were encouraged to be involved and their contribution was viewed by staff as being crucial to people's well-being. We were subsequently informed that some relatives later became volunteers at the care home. One visitor told us they took a friend out for a drive on a regular basis because they felt it added to their friend's quality of life. They told us staff supported this to happen by reminding the person they were arriving and by helping them to get ready to go out. Many people received supportive visits by family and friends on a regular basis. Those that did not were known to the staff. They then provided additional social support for that person [if it was accepted] to avoid issues arising from self-isolation or loneliness. The activities team comprised of four members of staff. It was co-ordinated by a member of staff who held previous qualifications in occupational therapy and relevant experience and knowledge in the provision of meaningful activities. The team had links with an external forum which supported the providers of activities to promote a "whole home" approach. This approach meant meaningful activities and meaningful interactions were valued and seen as everyone's responsibility to provide. By exploring with people and their families people's life interests, hobbies and experiences this approach could be personalised.
We observed a television mounted high up on the wall in the ground-floor lounge. When the door was open, as it usually was, this could not be viewed by the half of the room who were seated behind the door. The television was constantly on and we commented on this as many people were not watching it. We were informed the television was kept on as one person became very upset if this was switched off. Although this was meeting this person's needs it was not necessarily responding to the preferences of others. We observed items which could be used in a recreational activity such as knitting, pens, pencils and colouring books, games and reading books to be located behind people's armchairs and not within easily reach for people. One member of staff told us it needed to be stored there so people did not harm themselves and to enable staff to work in a clutter free environment. One of the activity team said we try and leave things out for people to use independently but we often find it has been "tidied away". Whilst we understood that staff needed to work in a safe environment, this practice potentially limits people's independent recreational choices.
In the last year a major garden project had been completed with funding from the provider and with the help of monies donated to the care home and a grant for a shed referred to as the 'man shed'. We were shown a well-established easy and safe garden area where people could sit with staff, family and friends.

There was a plaque in place in memory of someone who had donated money so they could be remembered in their favourite place. People, who had a previous interest in gardening and those who had become interested with staff support, had helped to plant shrubs, flowers, herbs and vegetables. A member of staff told us one person who had particularly enjoyed a regular visit to the garden to help with the watering. A more recent arrival of chickens had added a further outside experience for people who enjoyed getting involved in feeding them and just spending time talking to them.

The social needs of people were being constantly reviewed by the team who had been aware that over half of the people who lived at Wentworth Court were men. They were also aware that some men were still relatively young when admitted and living with dementia. Activities specifically aimed at supporting men to mix and socialise together were being explored. One of these initiatives had been the 'man shed' and men had helped to paint this paint this. A ramp for easier access and heating were due to be installed. This stood alongside the newly formed garden and was to be used predominantly as a place where men could meet and carry out activities which were specifically meaningful to them.

Activities were also aimed at supporting physical strength and maintaining mobility. A specialist physiotherapist visited each week and led a therapeutic music and movement class which took into account the abilities of those attending. A dance therapist also visited and led chair based dance exercises to music. Singing was recognised as good therapy for people who lived with dementia and a regular singing group visited and took a lead in singing sessions. We were told about one person whose ability to verbally communicate was becoming more difficult and frustrating for them as their dementia progressed. They also rarely sat and rested. Staff told us this person "became moody" during these times and were aware of how they felt. However, the sessions had resulted in this person sitting and focusing on the singing which they did without any problems. The activities co-ordinator explained that for this person the benefits were very obvious. They said, "residents really enjoy it." Every day activities were also carried out such as taking a walk to the post office, to the doctors' surgery and local shops. A senior member of staff explained that a simple walk and time for meaningful interaction often improved people's well-being. We saw people being taken out by staff during the inspection. To enable trips further afield we were told a mini-bus was hired on a regular basis.

People were supported to be involved in family and personal celebrations, where this was appropriate. People's individual birthdays were marked through the presentation of a birthday cake and people and staff acknowledging this day. The same, if appropriate or if requested went for wedding anniversaries. One resident's relative had recently got married and they had asked if they could have a wedding lunch for 20 people at the home so their relative could be included. The chef said they were happy to provide this.

Community links were still being developed. The care home had very much wanted to be part of the local community since it had opened and the registered manager said, "We go out into the local community and we invite them in." A year on from the last inspection the coffee bar in the main reception was now used on a regular basis. Visitors enjoyed this with their relative or friend and on a weekly basis a coffee morning was held. This had become successful with a couple of relatives telling us they regularly attended. They confirmed that people local to the care home had also attended. Links had been developed with local groups and the local church. A Church of England Vicar visited on a monthly basis and had attended with people from a local sheltered housing complex to celebrate Harvest Festival at Wentworth Court. We were told people's individual faiths were respected. To help staff understand one person's particular faith a member of staff, with the same faith, had delivered a teaching session to staff to help them understand what was accepted and what was not accepted practice.

The environment had been designed to provide a mix of large open spaces and areas that were domestic in

style. During the inspection we walked with a person who wanted to return to their bedroom. We observed the corridor to be long and to have very few, obvious, visual differences between the walls, door frames and doors. The hand rail along the corridor was a different colour. The person could not remember where their bedroom was and they asked questions about whether they were going in the right direction several times. We fed our observation back to the managers. One member of staff told us they had also felt that this long corridor required more obvious, visual cues to help people orientate themselves. They told us this had been fed back to the senior management team. The senior management team subsequently told us that expert advice had been taken when the care home was commissioned to ensure it was dementia friendly. They also told us some changes to the environment had been made since that. This had included painting the hand rails a different colour, new named door plates for each bedroom door and improved signage throughout the building.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had managed the service since October 2015. They had been registered with the Care Quality Commission as the registered manager of Wentworth Court since January 2016. They had previously been a registered manager of another care home so had relevant experience. They were not a nurse by profession so required a suitably qualified and experienced nurse to advice and lead on all nursing/clinical related issues. Prior to the inspection we had received concerns that nursing and clinical decisions had been made by an inappropriate person. We discussed this with the management team and the registered manager confirmed this had not been the case since she had been managing the service. There had been several changes in the position of clinical lead since the care home opened in May 2015. A new clinical lead had been recruited six weeks prior to this inspection.

The quality of the service was monitored on behalf of the provider by a variety of audits including medicines management, infection control and care planning. These were in the main robust and assisted the service in identifying risk and concerns. Audits had been designed around the Care Quality Commission's five domains – safe, caring, effective, responsive and well- led. These audits had been completed regularly and sometimes with considerable detail. However, in some instances there was a lack of documentary evidence to show that these monitoring systems improved the quality and safety of the care provided. Some of the monitoring forms lacked detail around what actions were needed, who was responsible for completing these and if they had been completed. For example, in an audit of 'safe' there was a recruitment audit undertaken on 22 August 2016. An action had been identified that "two references" were needed for some staff with a two week deadline. However, there was no evidence of an action plan detailing how this would be done. A care plan audit undertaken on 15 September 2016 detailed that six people's care plans were overdue for a review. There were no recorded actions or evidence here if any reviews had been completed. It would therefore sometimes be difficult for managers to have an oversight of what actions were required, when these actions needed to be completed by, if they had been completed and if they had been successful in driving improvement in the service.

Relatives told us the senior management team were visible and approachable. The registered manager told us they carried out regular "walk-around" in order to just observe and talk to people and staff. Staff spoken with told us they knew the registered manager and head of care were always available if they needed to talk with them.

A variety of staff meetings were held by the management team to support general communication as well as communicate their expectations and visions. Meetings were sometimes split into specific staff groups and held therefore with nurses, senior care staff and ancillary staff. The registered manager told us they now felt they had a senior management team around them who shared the same values, expectations and visions as her. She told us they were now able to provide positive and consistent leadership and they wanted to develop the service further. One relative commented, "There is a degree of stability that wasn't there a year ago. Among the senior team are some really excellent staff."

The registered manager said, "I live and breathe the whole team approach" and through this they told us

their main aim was to "meet people's needs". They also explained this was best done by having "happy staff". We spoke to one member of staff about the last meeting they attended. They told us they had found this to be a "negative" experience. They told us the management staff had focused on telling them what improvements they had wanted to see without wanting to hear what the obstacles were in achieving this. We were told relative meetings were taking place quarterly however, we saw evidence that this had not been consistent. One relative told us the only reason she knew a relative meeting was being held was because she asked. Another relative also was unaware of relative meetings having been organised. Another relative however said, "[Name of registered manager] has set up regular relatives meetings which are an opportunity to discuss the home's running and processes." Relatives' awareness of the meeting appeared to be inconsistent but we were told that relatives' email addresses were now being taken to aid general communication about such things.

The registered manager told us they promoted an open and transparent culture. They said, "We are totally transparent." Duty of Candour was therefore discussed in senior management meetings, recognised and upheld. This is a legal requirement for all providers of care and treatment to be open and honest with people about incidents and errors that occur. To offer an explanation and an apology to those effected. The registered manager said, "I and the senior management team take things seriously. I want things done properly."

The views of people and their relatives had been sought in the last year. Fifty questionnaires had been distributed requesting feedback on the services provided and six had been returned. These had predominantly positive comments but where areas for improvement had been highlighted, actions to address these had been put up for people to read in the reception area. These included issues with the laundry which two relatives had shared with us. It was planned that feedback would be sought on the actions taken. Further comments had been sought from relatives in November 2016 in a less informal way and we were provided with fifteen examples of positive comments about the service. These ranges from staff being caring, being able to talk through things, compliments on the improvements to the garden, good food to relatives noticing an improvement in their relative since their admission.

The registered manager and head of care told us people frequently gave them additional feedback on various areas/issues either verbally when they visited or by email. One relative commented to us that the registered manager was "receptive to views and suggestions from relatives and others". The management staff told us reviews could also be made about the care home on www. Carehome.co.uk. When we reviewed this website there was one review, which was positive, dated July 2015. The registered manager told us more specific and focused questionnaires would be developed for use in the future.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use the service were not protected against the risks associated with inaccurate and poorly maintained care records. This was in relation to their nutritional care. Regulation 17 (2) (c).