New Century Care (Borough Green) Limited

Westbank Care Home

Inspection report

64 Sevenoaks Road
Borough Green
Kent
TN15 8AP
Tel: 01732 780066
Website: www.newcenturycare.co.uk

Date of inspection visit: 24 March 2015
Date of publication: 04/06/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 24 March 2015 and was unannounced.

Westbank is a care home that provides personal and nursing care to up to 40 older people. This includes people with a physical disability and some people living with dementia. There were 35 people using the service at the time of the inspection. The last inspection was carried out on 17 March 2014 when we found the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were met.

Westbank Care home is required to have a registered manager. 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. There was no registered manager at the service. The service had been without a registered manager since 6 March 2015. The provider had acted swiftly to appoint another manager who was yet to make an application to the Commission for registration. A

Summary of findings

registered manager from another service and the area manager had been overseeing the running of the service. They were continuing to work in the service to support the new manager.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

There were insufficient numbers of suitably qualified, skilled and experienced staff to meet people's needs. Agency staff were regularly used to cover staff vacancies and they did not always have a full understanding of people's needs and the care they required. Staff had not received the training, supervision and support they needed to effectively and safely care for people. Staff were not organised in a way that ensured people received care and support at the right time. People were often left waiting for unreasonable lengths of times for their meals.

Where people needed to make a decision about whether to receive a potentially lifesaving treatment, the correct process had not been followed to comply with the Mental Capacity Act 2005 to protect people's rights.

People were not consistently treated with dignity and respect. Staff talked over people's heads and some staff did not engage with them in a respectful way during mealtimes. There were also examples of staff treating people with kindness and compassion, for example listening to them, showing warmth and providing care at an appropriate pace. However, this was not consistent and staff did not have time to spend engaging with people in a positive way.

The service had a set of vision and values that promoted person centred care, but these were not consistently delivered by staff. The registered provider had not ensured that there were effective systems in place to monitor the quality of care and identify where the vision and values were not delivered. The registered provider had developed an action plan for improving other areas of the service and was working on completion of this.

Record keeping was inconsistent, which meant the registered provider could not check that people had received the care they needed.

People felt safe in the service and staff knew how to recognise and respond to signs of abuse. Staff were confident to "blow the whistle" on poor practice and knew how to do so.

Risks to people's safety had been assessed and minimised. Staff knew the procedures to follow in the event of an emergency. Equipment was serviced and tested regularly to ensure it was working well.

People received their prescribed medicines when they needed them and in a safe way. The storage of medicines was cluttered and nurses were sometimes interrupted by other staff when administering medicines. We have made a recommendation about the management of medicines.

The service was kept clean and hygienic. Steps had been taken to reduce the risk of infection spreading in the service.

Staff had not received sufficient appropriate training in dementia to ensure they were confident in communicating effectively with people and meeting their needs. The environment had not been assessed to ensure it met the needs of people with living with dementia. People living with dementia had not been supported in a person centred way to take part in activities of interest to them to avoid the risk of social isolation and boredom. We have made some recommendations about the care of people living with dementia.

The registered provider and managers understood the requirements of the Deprivation of Liberty Safeguards (DoLS) and had made applications to the relevant authority where people needed to be deprived of their liberty to ensure their safety.

People enjoyed their meals and had a variety of foods and drinks to choose from. People were provided with sufficient amounts of food and drink to meet their needs.

People had their health needs met and their health and welfare monitored. Staff reported concerns to the nurses on duty who contacted other health professionals as needed.

People had been involved in planning their care when they moved to the service, but had not always been aware of changes to their plan. The new manager had begun reviewing people's care plans with people and

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their families. People had been asked about what was important to them, but this information had not been used to plan their care. This meant that people did not always receive person centred care.

People knew how to make a complaint if they needed to and felt confident to do so. The complaints procedure was available in written format only. We have made a recommendation about the complaints procedure.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

There were not sufficient numbers of suitably qualified, skilled and experienced staff to meet people's needs.

People were protected from avoidable harm, bullying, harassment and abuse. Risks to individuals' safety were managed.

People received their prescribed medicines in a safe way.

People were protected by systems for preventing the spread of infection.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff did not have the knowledge, skills and support they needed to carry out their roles.

People were asked for their consent, but where they were unable to make a decision the Mental Capacity Act had not been complied with.

People were supported to eat and drink enough to meet their needs.

People were supported to maintain good health.

Requires improvement

Is the service caring?
The service was not consistently caring.

Staff did not always know the personal histories and wishes of people they were caring for.

People were not always treated with dignity and respect.

People were involved in making decisions about their care.

Requires improvement

Is the service responsive?
The service was not consistently responsive

People did not always receive personalised care.

The service listened and responded to people's complaints.

Requires improvement

Is the service well-led?
The service was not well- led.

The service did not always promote a person- centred culture.

The service was inconsistent in the monitoring and improvement of the quality of the service.

Requires improvement

Westbank 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 24 March 2015 and was unannounced.

The inspection team included two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had personal experience of caring for older family members.

We gathered and reviewed information about the service before the inspection including information from the local authority and previous reports. We looked at notifications we had received from the provider. This is information the provider is required by law to tell us about. We looked at information staff had sent us about the service.

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. We examined records including five people's individual care records, three staff files, staff rotas and the staff training schedule. We sampled policies and procedures and audits of aspects of the service. We looked around the premises and spoke with ten people, five relatives, the newly appointed manager, the acting manager, the area manager, two nurses and four care staff.

The last full inspection was carried out 17 March 2014 when we found the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were met.

Requires improvement

Is the service safe?

Our findings

People said they felt safe in the service. One person said "The staff treat you well here". People told us that the staff helped them to move around the service in a safe way and were gentle when providing care. One person said, "I trust them to help me move around comfortably and they do," and another said, "They take care when helping me so I know I am in safe hands." A relative told us, "I have never felt my mother has been handled badly" and another said "[my relative] is safe and well-looked after." One person told us that they had not always been treated with the same care and respect by a member of agency staff working in the service as by permanent staff. They told us that when they had complained to the manager about this action had been taken and the agency staff was not employed again. People told us the managers had sought feedback about agency staff from them and from permanent staff and the managers refused to have some agency staff back if they were not happy with them.

People told us that although they felt staff provided safe care, the staff were very busy and did not have time to spend with them other than helping them with their personal care and meals. One person said, "The staff are too busy. They don't talk much."

The provider had identified risks to the operation of the service and had developed an action plan to reduce the risks. This was reviewed with the organisation's director of quality and governance and operational director on a weekly basis. The area manager told us that the largest current risk to the service was the high number of staff vacancies. Agency staff were used to cover vacancies and staff sickness, but people told us that the frequent changes in agency staff meant that staff did not always know what their needs were. Staff told us that they often operated below the normal staffing levels as agency staff could not always be sourced at short notice. Four staff told us that the staff shortages meant they could not spend as much time chatting with people and meeting their social needs as much as they would like to. The provider had not carried a recent out an assessment of the staffing needs for the service. The area manager told us that a tool was available to be used to determine individual's dependency levels and work out how many staff were required to be employed. This was included as a task within the provider's action plan, but had not yet been completed. The provider was in the process of recruiting more staff for the service.

The number of staff on duty matched the allocation on the staff rota on the day of our inspection. There were also three staff members who were shadowing other staff as part of their induction. Staff told us that they had to spend a lot of time inducting new staff and agency staff. A visitor to the service told us that they had noticed that sometimes a large proportion of the staff would be in the conservatory in a training session, which left too few staff left to care for people. Recently a lounge monitor (identified member of staff on each shift) had been introduced to remain in the lounge at all times during the day to supervise people and provide support. This person had a tabard to alert people to their dedicated role. We saw that the lounge monitor regularly checked whether people were safe and comfortable and responded when people asked for assistance.

During our inspection we saw that people waited a long time for their meals to be served. Some people were seated at a dining room table, but did not receive their meal until 20 minutes after others on the same table. Staff were delivering meals to people in their rooms as well as the dining room. Some staff were also required to help people to eat. There was a lack of leadership to organise staff during the meal time, which led to an ineffective system for distributing people's meals.

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not being deployed to ensure people's needs were met. There was a reliance on agency staff who did not always know people's needs. There was a lack of organisation in the deployment of staff to ensure people received the care they needed.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

Staff records for newly recruited staff showed that appropriate procedures had been followed to check their suitability for their role. The records contained evidence of a check of their ID, a Disclosure and Barring Service (DBS) check, references and a full employment history. Staff had

Requires improvement

Is the service safe?

completed an application form and had been interviewed before being offered a post. Staff had been issued with a job description for their role. Staff employed as registered nurses had been checked to ensure their registration was up to date. An ongoing check was made to ensure they continued to remain on the register.

There had been concerns raised within the last 12 months in relation to keeping people's valuables safe within the service. The provider had reported the concerns and worked with the police and local authority who had investigated. The provider had made changes to the security of the property including the fitting of a coded lock to the front door and the installation of security alarms. People were encouraged not to bring valuables into the home, but secure storage facilities were provided for those that wished to use them. The provider had responded appropriately to the allegations and had worked in a transparent way with the local authority, families and police to make improvements to prevent incidents occurring again.

Staff understood how to recognise the signs of abuse. They had completed training in safeguarding people from abuse and had a policy to refer to which told them how to report allegations of abuse. Staff knew who they could contact outside of the service if they did not feel that they could raise their concerns with the provider.

Risks to individuals had been assessed, for example the risk of falling and the risk of pressure sores. Care plans had been written to reduce the risks and, where necessary, equipment had been provided, for example air mattresses to relieve pressure. Risk assessments had been reviewed on a monthly basis. Where people were living with dementia staff had been given guidance on how to support people when they became agitated to ensure they were not at risk of harming themselves or others.

Risks within the environment were assessed and managed. There was a procedure in place for staff to follow to evacuate the premises in an emergency, for example a fire. A fire drill had taken place the previous week. Staff were aware of the procedure and knew how to evacuate people safely. The fire alarm system was tested and serviced regularly. The provider employed a person responsible for the maintenance of the property. They had carried out weekly checks of the safety of the premises and the effectiveness of equipment, including call bells and mobility equipment. On the day of our inspection the air mattresses were being checked to ensure they were functioning effectively. The water system was being flushed through during our visit to reduce the risks of infection in the service and water temperatures were being checked to reduce the risk of scalding.

People told us that they received their prescribed medicines at the time they needed them. They said that nurses asked them if they needed their prescribed pain relief and that the nurses would arrange an appointment with a doctor if any medicines needed review. Medicines were stored securely, but the storage area was cluttered and some medicine cabinets were too small for the amount of medicines to be stored, meaning they were squeezed in and difficult to access. The medicines fridge had a thermometer and temperatures were recorded daily to ensure medicines were stored as directed. Records showed that people received their prescribed medicines. Nurses administering medicines wore red tabards with "do not disturb" on them, however we noted several occasions where they were interrupted by other staff. **We recommend that the registered provider refer to relevant professional guidance for the management of medicines.**

A team of housekeepers was employed to clean the service on a daily basis. Each team member had a schedule for the tasks they were to complete daily. This included areas of deep clean such as skirting boards, high level dusting and carpet cleaning. The service was clean and free from unpleasant odour on the day of our inspection. The carpets had recently been professionally cleaned throughout the premises in response to concerns about an odour. Housekeeping staff told us that they had the necessary equipment needed to keep the service clean. We saw that they followed safe practices to reduce the risk of infection such as using gloves, using different cleaning equipment in different areas of the premises and frequently washing their hands. There were two appointed lead staff for infection control in the service. An infection control audit carried out in February 2015 identified that effective hand-washing was not carried out by all care and nursing staff. The new manager had begun training sessions for staff in hand-washing. There were signs around the service instructing staff on correct hand washing procedures and hand wash gels, soaps and paper towels located around the premises.

Requires improvement

Is the service effective?

Our findings

People told us they were happy with the way staff helped them. They said that staff came when they pressed their buzzer and that if they could not help them they would send another person who could. People said they felt staff were trained to meet their needs and knew what help they needed. However people did not always feel that agency staff were competent in meeting their needs. One person said, "Some are good, some are so-so" and another said, "I don't think they always know about me, I have to tell them how to help get me out of bed." A relative told us that some agency staff, for whom English was their second language, had difficulty communicating with people living with dementia.

Staff had not received regular supervision with their line manager and no appraisals had taken place since 2013. The management team were aware of this and had developed a schedule for supervision and appraisals for all staff going forward. Staff experience of their induction to the service was varied. One staff told us, "I didn't have much of an induction, I just worked alongside another carer." Another staff told us, "I had training sessions and shadowed another staff, it could have been better, but was ok." Records showed that there was a one day induction to the service that included orientation to the building, fire safety, infection control and meeting people using the service. On the day of the inspection three staff were on their induction and were shadowing more senior staff. The manager told us that the new induction standards developed by Skills for Care (the national training organisation for social care) were being used for new starters. We saw an example of an induction in progress for a new starter.

Agency staff told us that they did not always have time to read all the care plans before providing care as they were often required to cover shifts at short notice. They relied on a handover from the previous shift, but they said they did not always receive much information about people's needs. Permanent staff working in the service confirmed that the handover was not always very useful in providing information about people's needs and the current position regarding their care. This meant agency staff were not always aware of people's needs or the risks they may face and therefore they could not be expected to provide effective care at all times.

The area manager provided us with a copy of the training records for the service. Records of the training staff were required to carry out to effectively care for people showed gaps in the training they had completed. Of the 21 care and nursing staff employed only six had completed training in Health and Safety, 12 in record keeping, 16 in safe moving and handling, 11 in first aid and 14 in dementia. Falls prevention had been identified on the training schedule as required by staff, but no care or nursing staff had completed this. Training had been booked in fire safety, infection control, nutrition, dysphagia, record keeping, care planning, the mental capacity act and moving and handling for dates throughout 2015. Further training had not been scheduled for first aid or health and safety. Only five out of 14 care staff had completed or were working toward a relevant qualification in health and social care.

Staff had not received appropriate support, training, professional development, supervision and appraisal to enable them to carry out their duties effectively. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

Staff told us that they were not satisfied that the training they had received in dementia was sufficient to equip them to care for people living with dementia. The training consisted of a three hour awareness session. The service supported people who were at differing stages of their journey living with dementia. Some people had very limited verbal communication skills and required skilled workers to help them express their needs and engage in meaningful occupation. **We recommend that the registered provider seek further guidance on appropriate training for staff in caring for people living with dementia.**

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The manager understood when an application should be made and the area manager had made applications in respect of some people and was awaiting the authorisations.

Requires improvement

Is the service effective?

There were procedures in place and guidance in relation to the Mental Capacity Act 2005 (MCA) which included steps that staff should take to comply with legal requirements. We saw staff obtaining people's consent before providing support. Staff understood the MCA and were aware that people's capacity may change in relation to different decisions. We found two people's care plans contained a "Do not attempt CPR" instruction that had been signed by a healthcare professional on behalf of the person with evidence of discussion with family members. It was not clear whether the person was unable to make their own decision about this as there was no record of an assessment of their capacity to make this decision. There was no evidence that a best interest meeting had taken place to make this decision. The manager was unsure and said they would review the "Do not resuscitate orders" that were in place.

Where people had bed rails to stop them falling out of bed they had given their consent to the use of this restraint or a decision had been made in their best interests where they were unable to consent.

The correct process had not been followed to comply with the Mental Capacity Act in respect of people making decisions about potentially lifesaving treatment. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

People told us they enjoyed the meals provided and had a choice of what they ate. They told us that there were always two options of meal, but that they could ask for an alternative if they wished. One person told us they often preferred a jacket potato and that this was provided with no problem. Staff told us that they would often write down a reminder for people of what they had ordered for their meal as they sometimes forgot. The cook told us that there was always plenty of each meal available. This helped people with dementia to make choices at meal times rather than beforehand and then changing their minds. During lunchtime people were offered second helpings and there were condiments available to them.

People were offered drinks throughout the day. Jugs of water and juice were available in the communal areas and each person's bedroom. Hot drinks were served at breakfast, mid-morning, mid-afternoon and in the evening. People told us they could get a hot drink by requesting this from the serving hatch during the day and that staff would make them a hot drink in the evening or night. Cold drinks were provided alongside people's meals. The manager had developed a chart to help staff monitor and record people's fluid intake where they were at risk of dehydration. This had not yet been implemented so we were unable to check the effectiveness of this system.

People had assessments of the risk of malnutrition and where they were at risk they had a monthly check of their weight. Where people's risk increased nursing staff had responded by referring the person to their doctor. Some people had been prescribed nutritional supplements and these were administered as prescribed. Some people required an increase in the frequency of their weight monitoring. This had happened in most instances, but we found one person's needs required them to be weighed weekly, and they had only been weighed monthly.

People said they could see a doctor or other health professional when they needed to. On the day of the inspection a person had been having troubles with their hearing aid and an audiologist had been contacted to visit later that day. People had been referred to their doctor or to other services if their condition required it. These interventions were recorded in the care records. Staff understood how to monitor people's skin condition and when they should report any concerns to the nurse on duty. Repositioning charts were in place for people at risk of pressure sores. Staff understood their responsibilities for repositioning people. Most people were repositioned in their chair or bed every four hours, but staff told us that this was more frequent for those at higher risk. The nurse on duty informed us that there was no one with a pressure sore at the time of the inspection, but that care plans were followed to address redness on the skin and apply prescribed creams.

The environment provided people with the opportunity to socialise in the communal areas or to have privacy within their own bedroom. People's bedrooms had been personalised to provide them with a comfortable living space. There was a large rear garden that people could use and the property was on one level to enable people with mobility difficulties to move around the service safely. The premises had not been assessed with the needs of people living with dementia in mind. There was a lack of consideration to relevant guidance on appropriate decoration and layout of the premises. There were some

Requires improvement

Is the service effective?

signs on bathroom doors to guide people, but a lack of signing to help people find their way around the home. Areas of the home looked the same as did people's bedroom doors. This did not help people find their way to their own bedroom. Senior management we spoke with during the inspection were aware of the availability of the guidance, but had not yet sourced this. **We recommend that the registered provider seek further guidance on providing a dementia friendly environment.**

Requires improvement

Is the service caring?

Our findings

People told us that the staff were kind and treated them with respect. One person said of a member of care staff, "I don't know of anyone better, can't do enough for you." A relative told us, "I am happy with the care and the way they treat [my relative]." Some people felt the high number of agency staff used in the service did not always make them feel comfortable. One person said "They don't always know my name." People told us that the staff did not spend much time talking with them outside of providing their personal care or helping them with other tasks such as eating meals.

People said that they felt confident to tell staff how they wanted to be cared for. One person told us, "I tell them how I want to live." People said that they were able to make decisions about how they spent their time, what they ate and drank and when they saw visitors. However, this did not apply for people who were further advanced in their dementia and they relied on staff to know them and meet their needs without them having to ask.

We saw examples of positive approaches by staff when they were supporting people, but we also saw practices that did not demonstrate respect or compassion. During lunchtime staff turned on music, but did not switch off the television. This created a loud and confusing environment which some people, who were not able to mobilise, were unable to move away from. We pointed this out to the manager who rectified the matter immediately and spoke with staff. A member of housekeeping staff was vacuuming along the corridor outside people's rooms whilst they were eating. This was not very considerate practice.

Staff that were supporting people to eat did not always sit down and engage with them. We saw two staff members standing over people helping them to eat. One person appeared to be seeking eye contact with the staff member, but this was not given. A nurse came into the dining room and spoke with a staff member, over the head of a person, about the completion of a behaviour chart for another person. We also saw that one person was helped to eat their main meal and dessert by two different staff members. Some people required the use of a plate guard to enable them to eat one handed without spilling their food. Staff did not ensure that two people had this around the right way which meant they spilt food into their lap.

However, we also saw examples of positive practice. An agency staff spent time chatting with a person and was warm and attentive. They leant in to hear what the person was saying and show they were listening. Another staff responded in a sensitive way to a person who became confused and verbally aggressive when offered to go to the dining room. The staff member said to the person, "I am sorry if I have upset you" and they moved away, gave the person space and then approached them again a short while later to provide them support to go to the dining room. A staff member helping a person eat was attentive and watched to see when the person was ready for their next mouthful.

Some staff were laughing and joking with people which created a warm and friendly atmosphere. Staff told us that they tried to spend as much time as possible with people, but that they did not have the time to chat with people as much as they would like to. One person said, "I always try to walk around and say hello to everyone at the start of my shift, but it is difficult to chat at other times as you are always so busy with personal care." Staff that worked regularly in the home knew people well and knew what their preferences were. One staff member said, "It's not just like an office job, I really care about my job." Not all staff that were working in the service knew people well. Information about people's life history was available in their records, but this was not always incorporated into the care plans or known about by staff.

Staff were not consistently caring and compassionate when supporting people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010[which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

People were not aware of what was written in their care plans. Some people remembered being asked about how they wanted their care delivered when they first moved to the home, but said this had not been reviewed with them since then. A relative told us they had been involved in planning their relative's care. The care records showed that people and their families had been involved in planning their care when they moved to the service. The records did not demonstrate that people had been consistently

Requires improvement

Is the service caring?

involved in reviewing their care plans on an ongoing basis. The manager showed us that they had begun to review a person's care plan and had recorded notes of a discussion with the person's family.

A residents and relatives meeting was scheduled for later that week. The manager told us this was an opportunity for people to meet him, to provide feedback on the service and to have a say in how care was provided. A notice informing people about the meeting was displayed around the service. A letter had been sent to relatives inviting them to the meeting.

People's privacy was respected when they received personal care. We saw staff knocking on people's doors before entering and ensuring that doors and curtains were closed when providing care. Care records were stored in the nurses' office. This was not locked when we arrived for the inspection, but the manager addressed this with staff and it was locked for the remainder of the day when staff were away from the office. Staff did not consistently ensure the privacy of people's information as we heard staff discussing information about a person's behaviour in front of another person.

People were encouraged to be independent. One person had a note on their bedroom door that said, "I am independent do not disturb." People told us they received care when they needed it, but that staff did not do more than they needed.

Visiting was welcomed at any time. People could choose to see their visitors in the lounge, conservatory or their own bedroom. There was also a small visitor's room with comfortable seating that people could use.

Requires improvement

Is the service responsive?

Our findings

People were satisfied that they received the care, treatment and support they needed at the time they needed it. One person said, "I tell them what I want done" and another said, "They help me when I need it." People told us that staff came quickly when they used the call bell. Staff responded to people's call bells within an appropriate timeframe. Records of the response times showed that people waited no longer than four minutes.

People had been asked about the things that were important to them when they first moved to the service. Information had been obtained from the person, and their families, about their life history and what they enjoyed doing. A lifestyle questionnaire had been completed. However this information had not always been used to form the care plan. For example, one person's assessment included information about their interest in wildlife and birds, but this had not been reflected in their social needs plan to ensure they could continue to pursue this interest. The person's care plan did not provide staff with any information on how to support them to be meaningfully occupied in a person centred way.

The care plans contained information about people's preferences in relation to their night time care and some preferences about how they liked to receive their personal care. Their preference of bath or shower and how often they would like this was not recorded. Records showed that one person had not had a shower or bath for a period of ten days. There was no evidence that a bath or shower had been offered to the resident and refused. The nurse in charge told us that the person would often refuse, but that care staff did not always know how to re-approach the person to persuade them. The person's care plan did not reflect their preferences around this or provide staff with guidance on how to respond and ensure the person received their care in the way they wanted. Most care plans had been reviewed on a monthly basis and this was recorded. One care plan had not been reviewed since December 2014.

Staff knew what food and drinks people liked, for example one staff said, "I know they prefer lemonade and that is the best way to make sure they drink enough." Staff knew how they liked their hot drinks and where agency staff did not know this we saw that they asked people directly.

We saw a care plan for a person living with dementia stated "[the person] is unable to communicate appropriately." This had not been explored further and there was no guidance for staff on how to communicate with the person in ways that did not involve speech. Some people who were living with dementia had care plans that gave staff information about how to respond when they became confused. There was a lack of guidance for staff to enable them to communicate effectively with people living with dementia and to plan to meet their social and occupation needs. People who were nursed in bed were at particular risk of social isolation because of this. One person's relative said "[my relative] gets bored. There is not much to do."

We recommend that the review the care plans for people living with dementia to ensure they are provided with opportunities for meaningful activities taking into account relevant good practice guidance.

An activities coordinator was employed in the home five days per week. They had good sources of information and resources available to them. They had arranged a weekly programme of activities for people to take part in if they wished. This included religious services, exercise sessions, nail care, bingo, quizzes and a visit from a "Pets as therapy" dog. The activities coordinator also spent time with people on a 1-1 basis in their rooms. Activities they had carried out with people on a 1-1 basis included using picture cards of items of past household equipment, for example a mangle or old iron to prompt memories and conversation. One person was given a sewing box by the Activity Coordinator and was planning to sew on a button which was loose. People were positive about the activities and enjoyed the time the activities coordinator spent with them. However, the activities coordinator was only able to spend a limited amount of time with each person and outside of this time there was little stimulation for those nursed in their bedrooms.

Two people had bird feeders outside their window for which they ordered the nuts and seeds. Some people had a daily paper or a weekly magazine.

The service had a complaints procedure for people to follow should they wish to make a complaint; This was displayed in the entrance hall, but was not very visible. The complaints procedure was in small print and had not been produced in other formats to make it easier for people to

Requires improvement

Is the service responsive?

see, read and understand. **We recommended that the complaints procedure be reviewed to ensure it is in a format that meets the needs of people using the service.**

People told us that they were confident to make a complaint if they needed to and knew who they could speak to. One person gave us an example where they had complained about an agency member of staff and this had been responded to quickly.

Requires improvement

Is the service well-led?

Our findings

Westbank is required to have a registered manager. This is a condition of registration for Westbank. There was no registered manager for the service. The newly appointed manager had not yet applied for registration with the Commission. We will monitor this to ensure we receive an application and will take further action where necessary.

The management team had a clear vision and a set of values for the service that promoted person centred care, however these had not yet been fully embedded into the service and were not consistently delivered. Staff shortages, management changes and inconsistent leadership meant that staff were not always effectively supervised in their roles to ensure care was delivered in a way that reflected the values of the service.

Some people told us they had met the new manager, others had not yet. One person said, "He's a nice man." Staff said they liked working in the service. They said they had met the new manager and felt they were approachable, however staff told us that there had been a lot of changes within the service recently that had left staff feeling unsupported. Staff told us that they did not feel they were working effectively as a team. We saw that a lack of team work and leadership led to a delay in people receiving their meals and poor mealtime experiences for some people.

In the absence of a registered manager the area manager and a registered manager from another of the organisation's homes had been overseeing the running of the service. It had been agreed this support would continue as part of the new manager's induction. There was a Clinical Lead who undertook the role of deputy manager.

Staff were confident to challenge poor practice and knew how to "blow the whistle" on poor care if they needed to. There was a whistle blowing policy in place to protect staff in these instances and staff felt confident to raise concerns if they needed to. The manager had recently commenced weekly meetings with staff. Records showed these had been used to discuss the skill mix of the staff team, activities and menus.

The management team had understood some of the shortfalls in the service and the challenges the service faced. A time determined action plan had been set for improvements and this was being monitored by the director of quality and governance and operational director manager on a weekly basis. It was clear from the action plan that improvements had been made, for example staff training had been booked and some had taken place. A full audit of the quality and safety of the service had been conducted by an external consulting agency and the results fed into the action plan. However, the provider had not identified that care was not being delivered consistently in a way that respected people.

Systems to regularly assess and monitor the quality of the service were in place, but these had not always been effective in identifying issues with the delivery of the vision and values for the service. The provider had not demonstrated that they drove innovation in the service. There were a high number of people living with dementia and communication difficulties and the provider had not used research and good practice guidance to influence practice or provide a suitable environment. Staff shortages meant that staff did not feel they had time to do more than the basic care tasks.

The new home manager was unaware that the call bell system could print out details to enable an audit of response times. The area manager provided a print out and said they would show the home manager how do to this for audit purposes.

The quality of the service was not effectively monitored by the registered provider to ensure people's needs were met and to ensure the vision and values of the service were delivered consistently. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

Record keeping was inconsistent. There were gaps in records about the delivery of care, including fluid charts and repositioning charts. This made it difficult for the registered provider to monitor that people were getting the care they needed. Some daily notes were illegible. Staff commented that they often omitted filling in records because the records were not to hand at the point of care.

Accurate records about the delivery of care were not maintained. This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person had not ensured that people were consistently treated with dignity and respect. Regulation 17(1)(a)(2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person had not ensured that care and treatment was provided only with the consent of the person or on behalf of that person in accordance with the mental capacity Act 2005. Regulation 18(1)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person had not ensured that systems and processes were operated effectively to monitor and improve the quality of care provided. Regulation 10 (1)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person had not ensured that accurate records in respect of people using the service were maintained. Regulation 20 (1)(a)**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet people's needs. Regulation 22**
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person had not ensured that staff had received appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they are employed to perform, including enabling them to undertake further relevant qualifications. Regulation 23(1)(a)**