Care Quality Commission

Coate Water Care Company (Church View Nursing Home) Limited

Westley Court Care Home

Inspection report

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Cookley
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Worcestershire
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Ratings

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

Overall summary

We inspected Westley Court on 25 February 2015. Westley Court provides nursing and personal care to a maximum of 33 people. At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that the provider did not always have sufficient numbers staff on duty at busier times to meet people's

Summary of findings

needs and keep them safe. We found that there were some areas for improvement around infection control, such as managing laundry more effectively and ensuring people's personal toiletries were appropriately stored.

We found that while the nursing staff had the skills and knowledge to meet people's needs, care staff's training was not effective in order for them to deliver appropriate care to people.

Improvements were needed to give people, relatives and staff opportunities to provide their opinion about the way the service was run.

We found that people were kept safe by staff who knew how to protect people from harm. People were cared for in a supportive way that did not restrict their freedom. People's medication was stored and managed in a way that kept people safe. People's medication was given at the correct times by staff who were trained to do so.

People had access to healthcare professionals and were supported to appointments, such as the doctors, physiotherapists and occupational therapists.

People we spoke with were complimentary about the food and their dining experience. Staff knew people's likes and dislikes and respected their wishes. We observed people received regular drinks and staff supported those who needed assistance.

People told us that all the staff were caring and respectful. Some people who lived at Westley Court were unable to tell us verbally if the staff were kind and caring however we observed that people were relaxed and calm in the home. People told us that they were listened to and were able to make day to day decisions about their care. Staff told us about a key worker system that was being put into place. This was to help involve people and relatives in the planning of their on-going care. We saw staff spoke kindly to people and maintained their dignity when providing assistance. People were supported to remain independent and received assistance when they needed it.

We found that the service was responsive towards people's care and social needs. Staff showed us how they used people's history and past experiences to develop activities that people enjoyed and that were personalised to their choice. Staff knew people's likes and dislikes and respected their wishes.

People and relatives told us they found staff and the registered manager approachable and told us they could raise any complaints or concerns should they need to. The provider had not received any complaints over a 12 month period.

We found the registered manager had systems in place to ensure that the quality of the care was monitored. Checks in areas such as medication and care planning were carried out and completed monthly. Where there were any actions following these checks they were followed up and improvements were made.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not always safe.

We found that there was not always enough staff on duty at busy periods to meet people's needs and keep them safe. We found some areas of infection control required improvements. We found that staff recognised signs of abuse and how to respond to any concerns correctly. People's medicines were stored and managed in a safe way.

Is the service effective?

Requires improvement

The service was not always effective.

People did not always receive the most appropriate care because training and support was not effective. People had access to health care professionals and were supported to attend doctor appointments. We found that people were supported with enough food and drink to keep them healthy.

Is the service caring?

Good

The service was caring.

Staff spent time with people in order to get to know them and their likes and dislikes. People's independence was supported and staff encouraged people to make their own decisions about their care. We found that people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their individual needs. People felt confident to raise a complaint should they need to.

Is the service well-led?

Requires improvement

The service was not always well-led.

We found that improvements were required to ensure people, relatives and staff had the opportunity to be listened to and involved in the developing and running of the service. There were procedures in place to monitor the quality of the service and where issues were identified there were action plans in place to address these.

Care Quality Commission

Westley 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.

The inspection took place on 25 February 2015 by two inspectors. The inspection was unannounced.

Before our inspection we looked at the notifications that the provider had sent us. Notifications are reports that the provider is required by law to send to us, to inform us about incidents that have happened at the service, such as an accident or a serious injury.

On the day of our inspection we spoke with five people who lived at the home and three relatives. We also spoke with eight care staff, one nurse, a visiting doctor, the activities co-ordinator, the cook, the registered manager and the operations manager. Not everyone who lived at Westley Court was able to communicate verbally with us. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed four people care records who lived at Westley Court. Pathway tracking is a method of looking at the experiences of care for a sample of people who used the service. This is done by following a person's route through the service provided to see if their needs were being met. We also looked at the provider’s audits, these included audits of medication, complaints, infection control, incidents and accidents and staff training.

Requires improvement

Is the service safe?

Our findings

We spoke with people about staffing levels in the home. Some people told us there were enough staff on duty to keep them safe and meet their needs. However, some people told us that sometimes they had to wait a long period of time before receiving help. One person told us, “Staff come when I ring my bell, but sometimes this can be quite a wait. I need to ring in plenty of time if I need the toilet. I have to keep bags near me in-case I feel sick, as I do not think they would get to me in time. I don’t think there are enough staff. I think staff would come quicker if they could”. Another person said, “Sometime I feel rushed, but I think their busy”.

Staff who we spoke with told us that there were not always enough staff on duty to keep people safe and meet their needs at busy times. For example, a night shift would consist of one nurse and two carers to care for 29 people. As the home was split over two levels it meant that when staff provided personal care to people in their rooms there would not be any staff to answer call bells or to ensure people were safe in the communal rooms. One staff member said, “When you are in a person’s bedroom you cannot hear the call bells”. One staff member explained that due to the staffing levels at night, the day staff helped take people to bed. This meant that most people were in bed before eight o’clock in the evening. People told us that they did not mind this in the winter months, however in the summer months they preferred to stay up longer.

We spoke with the management team about some people’s concerns around waiting times for call bells to be answered. The registered manager and operations manager were not aware that this was the case. There was no system in place to check how long people were waiting for the calls to be answered. We also spoke about safe staffing levels at busier times. The registered manager explained that they had trialled a twilight shift, which meant there was an extra staff member to help at busier times when people went to bed. The registered manager told us that this worked well, however had not continued. We were told that the provider was reviewing staffing levels and had looked to reduce staffing levels further. This view was taken due to the number of people who lived in the home rather than the dependency levels of people who lived there.

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.

People who lived at Westley Court told us they felt safe. One person told us, “Yes, I feel safe”. Another person said, “I feel safe and cared for”. One relative we spoke with told us, “The staff are lovely, I think that [the person] is safe”. A visiting doctor told us that they had no concerns over people’s safety. We observed people in the home, how they interacted with staff and others who lived there. We found that people were calm and relaxed in the home and had a positive experience with staff and others who lived there.

Staff were able to tell us what they believed poor practice meant and examples of what they would immediately report to the management team. We found there were suitable arrangements to safeguard people against the risk of abuse, including reporting procedures and a ‘whistleblowing’ process. We saw that advice about how to report concerns was displayed and included contact details for the relevant local authority. The registered manager documented and investigated safeguarding incidents appropriately and had reported them to the local authority and the CQC where necessary.

People and relatives told us the home was well looked after and that any maintenance problems were dealt with promptly. However, we found that there were some areas that had not been managed in a safe way. For example, observation around the home and through staff raising concern to us, we found that an urn of hot water was accessible to all people who lived in the home. The registered manager had not assessed that this was safe and protected people, particularly those who may have a dementia related illness, from scalding. We spoke with the registered manager about this.

We looked at how the provider protected people by prevention of infection. We found areas within the home that required improvements. For example, we found that people’s laundry was not managed appropriately. We found dirty items next to clean items with no clear system in place. We found that clinical waste bins that were stored outside on the patio area were not securely locked. We also found that in the communal bathrooms people’s toiletries, hairdressing equipment and continence pads were stored without a system to identify individual items. This put people at risk of cross infection. We spoke with the

Requires improvement

Is the service safe?

registered manager about our findings. They told us that a recent infection control inspection highlighted that people's toiletries should not be stored in bathrooms without appropriate labelling. They advised that these concerns would be addressed promptly.

We looked at how the provider managed medicines at the service. We spoke with people who used the service and they told us there were never any concerns with their medicines. One person told us, "They bring medication, they come around [to rooms], always on time." Another person told us, "I get injections and all my medicines. I take a lot and I'd know if anything wasn't done". Staff told us that they had received training in safe handling of medicines and their competency was checked regularly. We saw training records that confirmed this. An audit of medicines found that medicine administration charts (MAR's) were used to record what medicines were given and when. This showed that risks had been reduced to ensure people received the right medicine at the right time by staff who were trained to do so.

There were suitable arrangements for the safe storage, management and disposal of medicines. These included procedures for giving medicines in accordance with the Mental Capacity Act (MCA) 2005 where people lacked capacity. Medicines were stored securely and where necessary, in a temperature monitored environment.

Requires improvement

Is the service effective?

Our findings

We found that care staff did not always have the knowledge and understanding about best practice for people's health conditions. We found that improvements were required. For example, we found that when care staff had learned that a person was diet controlled diabetic, they had stopped them from having their favourite food. This caused the person to become agitated. We spoke with care staff about the training they received. All care staff we spoke with told us that the training was not useful and that the training was paper based and not interactive. One staff member told us, "It doesn't work for me. I'm not learning, it's just not engaging".

New staff were required to complete an induction programme, this involved manual handling training and paper based learning. We spoke with a new care staff member who confirmed this happened and said, "You get a book on how to do your job". We found that new staff members worked alongside staff before they worked alone. However we found that new care staff, some with no experience in a health care role, were not assessed for their level of competence before they began working alone. They did not receive one to one discussions with a senior person or were asked if they felt ready to work alone. We also found that new care staff did not have direct access to people's care records or had not read them. A new care staff told us that they would learn about people's needs by speaking to them. However, this was not always possible as some people cared for lived with dementia.

People who lived at Westley Court told us they thought the staff knew them well and were confident when they supported them. One person said, "They are very good, they look after me very well". A visiting doctor told us that staff were knowledgeable about people's care needs and ensured appropriate health care professionals were sought. A relative who we spoke with said, "Generally no concerns, the care is good".

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). The MCA ensures that the human rights of people who may lack mental capacity to make particular decisions are protected. We spoke with staff about their understanding; we found that the nurse on duty had good awareness however all the care staff we spoke with did not understand the implications of the MCA or DoLS and how this affected their practice. We saw that people's capacity was considered when consent was needed or when risk assessments were carried out. We saw that where decisions were made on people's behalf, best interest meetings had been held in line with the requirements of the MCA. These decisions included matters relating to medicines and people's finances.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. At the time of our inspection five applications had been submitted in line with the provider's policies and procedures and approved. The nursing staff who we spoke with knew who had a DoLS what this meant to the individual person; however the care staff who we spoke with did not have this understanding. We spoke with the registered manager about care staff understanding around MCA and DoLS. They told us that MCA and DoLS training was in place and they had plans in place to ensure all care staff had completed this

People told us they enjoyed the food at the home. One person told us, "The food is good". Another person told us, "The food is excellent". One relative told us, "The food is lovely". We observed lunch time at the home and this was a positive experience for people. The table was laid with cutlery and napkins and people chose where they wanted to sit. We saw people chatting and with each other and staff. People were offered a choice of food and were given time to enjoy their food with staff ensuring that they were happy with their meals. Staff knew who required assistance and provided this at a pace which suited the person.

People were offered hot and cold drinks throughout the day. We observed staff support and encourage people to drink. Staff did not rush people and took their time to assist people to enjoy their drink. Staff we spoke with knew who required support to maintain a healthy fluid intake. However we found that where people required their fluid intake to be recorded and measured, records were not always completed. Therefore, those at risk of de-hydration could not be assured that they had drunk sufficient amount of fluid to keep them healthy. The registered manager told us that this had been explained to staff before and they would discuss this with staff again.

People we spoke with told us they had access to health care professionals when they needed to and that visits were arranged in a timely manner when they requested. One person we spoke with said, "I've seen the doctor when

Is the service effective?

I needed to”. A relative told us, “I was going to take [the person] to the dentist as we're working together (with the service)”. We saw in care records that people were visited by psychiatrists and a GP and attended routine appointments such as the dentist and chiropodists.

Good

Is the service caring?

Our findings

People we spoke with told us they felt cared for by the staff. One person told us, “The staff are wonderful, can’t fault them”. Another person said, “They are very good, they look after me very well”. Another person said, “I get on very well with the staff, they are very good”. A relative told us, “The staff are lovely, [the person] is very well and healthy”. We spoke with care staff about people they cared for. We found that care staff knew people well, their likes and dislikes. We observed that staff were caring towards people who lived there and provided support and encouragement in the activities that they did. We observed that when one person became agitated staff spoke to them kindly and calmly. They spent time with the person until they were settled and ensured that they were happy and calm.

We asked people if staff encouraged them to do things for themselves and make their own decisions about their care. People told us that they were able to make day to day decisions about things which were important to them, for example, what they wanted to wear that day. All people and relatives we spoke with told us that they had been involved prior to moving into the home, however had not been involved in the on-going reviews of their care and had not seen any documentation. We spoke with staff about how they involved people in the planning of their care. Staff were able to tell us about a key worker system that was being put in place, this ensured each person had a named member of staff to discuss the support and treatment they preferred. We saw from people’s care records that care reviews were carried out, however there was no evidence to demonstrate that people or their relatives were involved. We spoke with the registered manager and operations manager regarding people and relatives comments about the lack of continued involvement. It was discussed that people’s care records were on a computer system and they felt this was the barrier to people being involved in the reviewing of their care. It was recognised by management that this needed to be reconsidered so that people had better access to being involved in decisions about their care and support. However, with the key worker system being implemented this would help to involve people and their relatives in being more involved.

We talked to people about how their privacy and dignity was promoted by staff. One person explained how staff respected their privacy and that staff would wait outside their room to provide them the privacy they required. People told us that staff spoke kindly to them and in a respectful way. One person said, “Staff are compassionate. They treat me with dignity and respect my privacy”. People said that staff listened to what they had to say and spent the time to respond to any questions. One relative told us, “Care staff seem to be caring”. We observed people were assisted in a quiet and discreet way and care staff were professional at all times when assisting people to maintain their dignity. We saw how staff treated people with respect and addressed people in a courteous way. Visitors told us they were able to see their relative in private.

Good

Is the service responsive?

Our findings

People and their relatives told us that their preferences and choices were discussed in detail. This knowledge was reflected in people's social care activities and their records. People spoke about the activities co-ordinators who involved and encouraged them to explore their interests and hobbies. We observed times where staff would spend time with people individually. We saw that staff sat in a person's room, and spent time reading to them. One person we spoke with told us, "It's very much welcomed for someone to read to me, I do enjoy the company". Another person we spoke with told us, "There are activities going on every day and I enjoy them". We saw that one person enjoyed Disney characters, we saw that the staff had helped decorate and personalise the person's bedroom in the characters that they liked and had a collection of Disney films for them to watch. The activities co-ordinator told us that they ensured they spent time individually with people, especially those who were nursed in bed. People who we spoke with confirmed this happened and found these times invaluable. This demonstrated that staff actively encouraged people to follow their interests and maintain their social activities inside the home.

We spoke with staff regarding one person and a recent change to their medication. Care staff told us that they had reported to the nurse that the person was sleepy during the day and could not always stay awake through lunch. Staff told us that the person's GP was contacted and reviewed their medicines and made some changes. Care staff told us, that while this had only happened recently they found the person was responding better to the new change.

Every person we spoke with said that they felt confident enough to speak to staff or people in management if they had any concerns or complaints. One person said, "The manager is approachable and very nice, but I don't see much of them". Another person said, "There is no need for me to complain, I'm happy here". A relative said, "There are small things that I would want to discuss, but not enough for me to make a complaint". All of the staff we spoke with explained what they would do if someone made a complaint to them. One staff member told us, "If I could I would try and help, but if not I would go to the manager". The provider had not received any complaints since within the last 12 months. The provider had a complaints procedure in place, the information was clear and easy to understand and accessible to people.

Requires improvement

Is the service well-led?

Our findings

We looked at the way the provider encouraged an open culture to those who used the service. We found that improvements were needed to ensure all those who used the service felt included. People and relatives we spoke with said they did not see the manager very often. People who lived at the home told us that they did not have meetings, however did not express an interest to have one. People who lived there and relatives, also told us that they had not been asked their views about the service or the way in which it was run. One relative said, “We don’t have relative meetings, I think it would be good if we had one. I’m sure other relatives may have the same grumbles. We could probably get it all sorted out if we had a meeting”.

We spoke with staff about their opportunities. Care staff told us that some meetings had taken place, however their views were not always sought. One care staff member told us about some improvements that they would like to recommend, but felt they did not have the opportunity to do this. We spoke with the registered manager about the communication with relatives and staff. The registered manager told us that conversations happened regularly with relatives and staff and that they were available to talk with people. However, we found that the relatives and staff who we spoke with were not aware of the registered manager’s open door ethos.

It was clear that the registered manager had a good understanding about the people who lived in the home and the way the home was run. They had plans in place to gain further knowledge of people’s dependency levels and the skill mix of staff required to support people appropriately. We saw that the registered manager had plans in place to give extra responsibilities to staff and to enable them to make more decisions within their role. We spoke with staff who were aware that they were being provided with more responsibility, such as the key worker system and working as a lead role, such as infection control. Staff understood what was expected of them from the registered manager.

People we spoke with told us they had not had any accidents or incidents while they were at the home. We looked at how incidents and accidents were monitored that occurred in the service. Records showed that each incident was recorded in detail, describing the event and what action had been taken to ensure the person was safe. Accident forms had been reviewed so that emerging risks were anticipated identified and managed correctly.

The provider is required by law to notify CQC of serious incidents that have happened in the home. We found that the provider had notified us when there had been an incident. This showed they promoted an open culture and met the legal requirements.

The provider completed audits in areas such as staffing, training, care planning and medication. When a shortfall had been found action plans had been written and shortfalls were addressed and reviewed regularly. For example, we could see that a full review of medication had been undertaken. This review meant that improvements had been made in the way people’s medication was managed. This ensured people received medication in a safe and effective way. This showed that the provider had systems in place to assess and implement high quality care.

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 18 HSCA (RA) Regulations 2014 Staffing People who used the service were not always kept safe because there were not sufficient numbers of staff. Regulation 18 (1).