Ferrolake Limited

Westport Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Westport Care Centre on 13 November 2018. This was an unannounced inspection.

At the last inspection which took place on 9 and 10 May 2016, the service was rated Good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Westport Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Westport Care Centre is a residential care home and provides personal care and dementia care for 42 older people. The home is a large detached building and the accommodation is set out over four floors.

There was a registered manager at the service. 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 received positive feedback from people and their relatives about the caring and friendly attitude of staff. Staff demonstrated that they knew people well and understood their preferences and how they wanted to be cared for. Feedback about the registered manager was also positive, with relatives telling us they would not hesitate to approach her if they wanted to discuss anything. The registered manager had an open-door policy where people felt able to come and speak with her if they wanted to.

There were robust recruitment procedures in place and newly employed staff received a through induction to the service. Staff training was up to date and this was achieved through refresher training that was offered on a regular basis. Staff told us they felt supported and were able to provide feedback through supervisions and feedback surveys.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received appropriate support in relation to their medicines and general health care needs. Care plans supported this practice.

The service was proactive in responding to complaints or any incidents and accidents. Learning took place following these which demonstrated the providers' commitment to improving.

The provider worked collaboratively with external stakeholders to provide joined up care to people.

Further information is in the detailed findings below.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Westport Care Centre

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 comprehensive inspection took place on 13 November 2018. The inspection was carried out by one inspector and an expert by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this inspection, their area of expertise was residential care.

Before the inspection, we reviewed the information we held about the service. This included notifications sent to us by the provider and other information we held on our database about the service. Statutory notifications include information about important events which the provider is required to send us by law. We used this information to plan the inspection.

During the inspection we spoke with five people using the service and four relatives. We spoke with six staff, including the registered manager, team leaders and healthcare assistants. We also spoke with two visiting health and social care professionals on the day of the inspection. We contacted 16 other professionals after the inspection to hear their feedback; we received a response from five of them.

We reviewed a range of documents and records including; five care records for people who used the service, four staff records, as well as other records related to the management of the service such as complaints and audits.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe living at the home. Comments included, "Makes my life easier, I know [my relative] is being looked after." Staff demonstrated a good understanding of safeguarding and how they would protect people from harm and who they would contact if they had concerns. Notifications submitted to the CQC demonstrated that the provider worked with relevant stakeholders when concerns were raised to keep people safe.

There were enough staff on duty to meet people's needs. The team leader said that during the day there were two team leaders and five healthcare assistants on shift, with one team leader and two healthcare assistants covering the ground and first floors and one team leader and three healthcare assistants covering the second and third floors. During the inspection we observed there to be sufficient staff employed to meet people's needs.

Staff files showed that appropriate recruitment practices were being followed. Staff files contained people's application forms which included their employment history and evidence of identity and proof of address. Disclosure and Barring Service (DBS) checks were also in place. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

The provider used standard monitoring tools to assess risks to people. These risk assessment tools included the abbey pain scale, Waterlow for assessing the risk of pressure sores, Falls Risk Assessment Scale for the Elderly (FRASE) for assessing risk of falls, Malnutrition Universal Screening Tool (MUST) for assessing risk of malnutrition and general dependency level using the BARTHEL score. There were tools available for staff to assess risk in relation to oral health, dementia dependency, moving and handling and continence. Risks were reviewed monthly and any areas of high risk had an associated care plan for managing the risk.

Safe medicines practice was in place which helped to ensure that people received their medicines as prescribed. The team leaders were responsible for medicines administering and training records showed they were assessed as being competent to do so. We observed a member of staff administering medicines during the inspection and they did this well. Medicines were checked against medicines charts and medicines profiles to ensure they were being given to the right person at the right time. The staff member asked people for their consent before giving them and took their time explaining what the medicines were for when one person asked them. Medicine charts were signed after people had been observed taking them. Medicine profiles included people's photo, details of their GP and any allergies. Information charts had details of medicines, what it looked like and dosage instructions. Liquids and medicines with limited shelf life were labelled with the date of opening. Some people were on controlled drugs, the controlled drugs register was correct.

The provider maintained an accurate record of all the incident and accidents that had occurred. Staff demonstrated a good awareness of the providers reporting procedures if any incidents and accidents took place. This was in line with the accident reporting and investigation policy that we saw. The provider took appropriate action in response to any incidents that occurred. For example, completing body maps,

informing relevant people such as family members, the local authority and the CQC.

The housekeeper and maintenance engineer were responsible for carrying out regular tests on call bells, wheelchair inspections, fire drills, emergency lighting and fire call point checks. Safety certificates for gas and electrical safety were seen.

People were kept safe from harm through robust infection control procedures. The home was clean and free from malodours, this included people's bedrooms, communal lounges and the kitchen. There was a housekeeping team that were responsible for maintaining standards of cleanliness. Infection control audits were completed which helped to ensure that infection control practices were robust. The kitchen had received a food hygiene rating of five in March 2017 which is the highest that can be achieved.

Good

Is the service effective?

Our findings

Staff told us they were happy with the training provision on offer and they were confident in carrying out their duties. All staff were trained to a minimum level two in national vocational qualifications. The registered manager told us that new employees who did not have a relevant qualification in health and social care were supported to complete the Care Certificate. The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new support workers.

The provider maintained a matrix to monitor staff training. This showed that all staff received regular refresher training in topics that the provider considered mandatory such as safeguarding, emergency first aid, dementia awareness, Mental Capacity Act 2005 (MCA) and moving and handling. The pharmacy carried out yearly refresher training for all staff.

Staff received supervision and staff files showed these took place on a regular basis. Supervision sessions allowed for discussions to take place regarding any issues/concerns and training opportunities.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

There was evidence in the care records that people were involved in planning their care. Care plans included the views of people using the service. Mental capacity assessments were completed when there were doubts about a person's capacity to understand decisions related to their care and treatment. Best interest decisions were taken with the involvement of family members/friends and professionals. People had 'do not resuscitate' forms in place which documented that correct procedures were followed in relation to consent.

People that were subject to DoLS were clearly identified and their authorisations were in place. The care plan system was set up to alert staff when they when expiring. People that were not under any restrictions were seen leaving the service freely.

A healthcare professional said, "I would definitely say my service users' needs are met and in fact

expectations have been exceeded. They do go the extra mile to ensure their residents are happy and settled. Support needs are documented, and I am regularly kept informed of changes in needs." Care records contained evidence of input from health care professionals in relation to people's care. They also included people's medical history and any health concerns. Staff told us that district nurses and occupational therapists came to the service to provide nursing and health care, typically for people at risk of pressure sores, malnutrition or falls. The registered manager said that people were under the care of one GP practice who carried out visits to the service if required. Similarly, an optician visited yearly. Details of visits from health professionals were recorded in care records. The provider was using a tool to identify early signs of health deterioration called the 'Significant 7'. It allowed staff to identify deterioration earlier, resulting in people receiving care at the home and avoiding admission to hospital.

People and their relatives told us they were satisfied with the quality of food available in the home. Pre-prepared meals were ordered into the service and heated on site. Breakfast was prepared in-house. The menu was varied and reflected people's preferences. Culturally and religiously sensitive food was available. The kitchen team were made aware of allergen information and people with diabetes so that appropriate food could be prepared.

People were involved in decisions about the environment. They were given the choice in choosing the colour scheme for the bedrooms which had their photo and name card on them. Rooms were personalised to people's individual tastes. There were arrangements to ensure people had access to appropriate private and communal space. The ground floor lounge area had easy access to a paved and well maintained outside area that was laid in a stimulating way. A "Guest Room" was being furnished on the first floor for family to stay over.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were caring and friendly. Comments included, "Always friendly here," "When the cleaners go and clean the room they always speak with [my relative] which is nice, sometimes it's the small things that make all the difference." A healthcare professional said, "The staff are always so friendly and helpful and they know their residents very well, I get good feedback and I never feel I am struggling to get the information I need from them."

We observed some really nice incidents of caring behaviour between healthcare assistants and people which was genuine. We observed caring interaction at mealtimes. Staff asked people in the lounge how they were and one said, "Would you like me to get you a tea or a coffee and have a drink with you?" when the person said yes, the staff member returned with drinks and had a chat with the person.

Lunch was a very calm experience with people being spoken to several times and not only to enquire about food options. There was gentle encouragement and offers to support people who were reluctant to eat. One person who ate independently asked a staff member to help them cut up their food which they did so.

People were cared for in a manner that demonstrated a real understanding and empathy. There was a memory board for people who had passed away so they wouldn't be forgotten. One person who had a wish on their bucket list to go to a football match got a VIP hospitality suite at a recent match which they enjoyed immensely.

Care records contained person centred information about people, about their background such as important people in their lives, places that were important to them and their occupations/hobbies. They also detailed people's preferences about how they liked to be supported and the way they wanted their personal care to be delivered, such as the time they liked to wake up and any nuances in relation to their daily routine such as preferences in terms of personal care.

The provider had started a new initiative where they created video diaries called 'life stories', these were short videos of people's lives, with background music chosen by them. They included videos of sentimental places and experiences from people's lives which put together made a wonderful collection of memories for people to look over with other people in the service and their families too.

People were asked for their views about their care plans and their thoughts were recorded about what they wanted their care to look like. Their opinion was also sought through residents' meetings and feedback surveys.

Good

Is the service responsive?

Our findings

People were involved in planning, managing and making decisions about their end of life care. They contributed to advance care plans, this is a process of discussion about future care between a person and the provider. There were also end of life care plans which had details of people's last wishes, whether they were for resuscitation and their preferences in relation to their death.

Since the last inspection, the provider had achieved accreditation with the Gold Standards Framework (GSF). The National Gold Standards Framework (GSF) Centre in End of Life Care is the UK's leading provider of training in end of life care for generalist frontline staff. GSF is a systematic, evidence-based approach to optimising care for all patients approaching the end of life, delivered by generalist frontline care providers. They run training programmes that help to support people approaching the end of life in any setting.

People who were on end of life care were supported by the provider in collaboration with the local hospice and palliative care team.

People had care plans in place which reflected their individual needs. All risk assessments were done within 48 hours of a person moving in and their care plans were built up over a period of time whilst people's needs were understood. A basic care plan was completed in seven days. There was an electronic care planning system in place which helped to ensure that all the care planning documentation was up to date, alerts were given when reviews were due or risk assessments needed to be updated. It also gave a visual alert for those people that were on end of life or those under authorised Deprivation of Liberty Safeguards.

Care plans focussed on people's support needs and included their abilities and needs, how the support plan could improve their life and how staff could support them. People told us, "They do have some activities and sometimes I participate," "I sometimes like to play Bingo when I am not busy" and "I don't go outside, but if I want to go out I tell them." There was a thriving activities programme in place. This included Namaste care for people living with dementia, staff were trained in delivering Namaste care. Namaste care offers simple and practical ways for direct care staff to provide holistic end-of-life care for people with advanced dementia. There was an ex-servicemen's club which people attended monthly, a Pilates programme and regular visits to a local farm. On the day of our inspection, we saw staff taking the lead in doing activities for people and it was evident they were comfortable doing so and engaged with people well.

People and their relatives told us they were confident that they would be listened to if they raised any concerns or complaints. A 'how to make complaints' poster was on display in the reception area. All complaints that had been received were documented in a folder and included the provider's response and other supporting documents. Records showed that the provider investigated all complaints, for example speaking with staff and liaising with complainants and other relevant people where required. Complaints were resolved within timescales according to the complaints procedure.

Good

Is the service well-led?

Our findings

People using the service and their relatives told us the service was well-led. They knew who the registered manager was and said she always made herself available if they wanted to speak with her. The registered manager was experienced and was a visible presence in the home. Comments included, "[Registered manager] has been out of this world," and "Absolutely fantastic."

The service was open to working with external stakeholders to improve the service provision and the experience for people using the service. Staff had worked with a University and participated in a project to manage agitation and quality of life. The senior staff attended monthly Multi-Disciplinary Team (MDT) meetings involving the GP, social workers, district nurses, psychiatrists and other professionals to discuss the provision of care. A healthcare professional said, "I found the staff to be very helpful and the resident's records were up to date."

Staff said they worked with the community occupational therapist (OT) and a team called the falls project group to undertake falls assessments for those people who were at high risk of falls and followed any recommendations they gave. This was done to try and reduce the number of falls. Any falls within the home were analysed, identifying the person and the times they had fallen to help identify the triggers. Monthly meetings were held with the OT, we saw minutes of these where they discussed training, early warning signs of health deterioration, recent falls and the personalisation of Zimmer frames. The OT was also involved in dementia care mapping and carried out observations as part of this. We saw evidence that due to this work, the number of falls within the service had reduced since 2016 for some people. A staff member said, "Now we are being proactive and do more monitoring of people at risk of falls to try and prevent them from occurring."

There was evidence the service was proactive in achieving better outcomes for people. There was a culture of 'lessons learnt' following any incidents/accidents, complaints, safeguarding and other reports. A lessons learnt template was completed after each instance, where staff went over what went well, what didn't go well, what could be learned and what improvements could be made to help reduce the likelihood of recurrences.

There was a focus on monitoring quality through regular audits which covered a number of areas. These included internal and external medicines audits. A sample of five care plans were audited every month to check whether they were up to date. Catering audits helped to ensure that infection control practices, health and safety practice and record keeping was all up to standard. Other audits included, housekeeping, maintenance, mealtime experience and weekend audits. There was an overarching action plan which brought together any action points from the various audits that were completed.

Regular meetings were held for people, relatives and staff and feedback surveys were completed so that their views could be heard. People talked about menu provision, activities and any concerns. Any feedback received was acted upon. The feedback surveys carried out for people and their relatives focussed on the care and activities provision, hotel services and the home. The staff survey focussed on job satisfaction,

training, reward and recognition, teamwork and customer focus. Feedback from both surveys was positive.