Laudcare Limited

Westbury Court

Inspection report

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Westbury Court provides accommodation which includes nursing and personal care for up to 60 older people, some of who are living with dementia. At the time of our visit 46 people were living in the service. The rooms were arranged over three floors .There were communal lounges and dining areas with satellite kitchens on the first and second floors and a central kitchen and laundry.

We carried out this inspection over two days on the 26 and 27 July 2016. At a previous inspection which took place in June 2015 we found the provider did not meet the legal requirements for person centred care. They had not designed care and treatment plans to include people's preferences and accurate information to ensure their needs were met. They wrote to us with an action plan of improvements that would be made. We found on this inspection the provider had not taken all the steps to make the necessary improvements in this area.

The registered manager had recently left the employment of the service. A new manager had been recruited and was in the process of submitting their application to become the 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.

People using the service, their relatives and staff did not always feel there were enough staff available to meet the needs of people especially on the weekends. Whilst we saw staffing rotas reflected the staffing levels identified by the dependency tool the service was consistently left short staffed at weekends due to staff absences.

Care plans did not contain all of the relevant information that staff required so they knew how to meet people's current needs. Risks to people's safety had not always been updated to reflect their changing needs and plans in place to minimise these risks sometimes lacked detail.

People were not always supported to have enough to eat and drink. Food and fluid charts were not always completed. People's nutritional needs were not always clearly documented in their care plans.

Medicines were given in a safe and caring way. Medicines were stored safely and securely. There were records of medicines administered to people and where they were not given the reason for this was recorded.

People were treated with kindness and compassion in their day-today-care. They received care from staff who knew them well. People and their relatives spoke positively about the care and support they or their relative received from staff. We observed staff treating people in a dignified manner ensuring their privacy was respected at all times.

The staff had received appropriate training to develop the skills and knowledge needed to provide people with the necessary care and support. We saw safe recruitment and selection processes were in place. Appropriate checks were undertaken before new staff members' commenced work. Whilst staff said they felt supported, formal supervision of staff had not consistently taken place.

The provider had quality assurance systems in place to audit all areas of the home to identify areas for improvement. However the audits had not identified the discrepancies noted in the safe medicines management daily checklist.

Incident and accident forms were completed where appropriate and detailed what actions and care had taken place. However, we saw in people's daily records that incidents had been recorded but had not all been entered into the electronic system due to staff not being able to access it. This meant there wasn't an accurate record of accidents and incidents that had occurred.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

This service was not always safe.

People using the service were not always supported by sufficient staff to meet their needs. People, their relatives and staff did not always feel there were enough staff available to meet the needs of people using the service, especially at weekends.

Where risks had been identified, the steps that staff needed to take to protect them from harm were not always clear and in some plans there was a lack of detail. Not all assessments had been regularly updated.

We saw safe recruitment and selection processes were in place. Appropriate checks were undertaken before new staff members' commenced work.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe.

Is the service effective?

Requires Improvement

This service was not always effective.

People were not always supported to have enough to eat and drink. Food and fluid charts were not always completed.

The staff had received appropriate training to develop the skills and knowledge needed to provide people with the necessary care and support

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Senior management and staff had a good understanding of supporting people to make decisions and choices.

People had access to healthcare services to maintain good health.

Is the service caring?

Good

This service was caring.

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect.

Staff told us people were encouraged to be as independent as possible. People were able to make their own choices and decisions about their daily care.

People's bedrooms were personalised and decorated to their taste.

Is the service responsive?

Requires Improvement

This service was not always responsive.

People's care records did not always provide staff with sufficient guidance needed to ensure people's care needs were met in their preferred way.

People were able to choose what activities they took part in and suggest other activities they would like to complete. The activities co-ordinator told us they tried to organise activities that included people's past interests and hobbies.

People and/or their relatives said they were able to speak with staff or the managers if they had any concerns or a complaint. However they weren't confident their concerns would be listened to and appropriate action taken.

Is the service well-led?

Requires Improvement

This service was not always well-led.

The provider had quality assurance systems in place to audit all areas of the home to identify areas for improvement. However the audits had not identified the discrepancies noted in the safe medicines management daily checklist.

We saw in people's daily records that incidents had been recorded but had not all been entered into the electronic system due to staff not being able to access it. This meant there wasn't an accurate record of accidents and incidents that had occurred.

There were clear values that included treating people with dignity and respect and supporting people to remain independent. Staff told us they felt supported by the regional support manager and manager.

Westbury Court

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.

We carried out this inspection over two days on the 26 and 27 July 2016. The first day of the inspection was unannounced. This inspection was carried out by one inspector, a specialist nurse advisor 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 service. On the second day of our inspection a pharmacist inspector attended. During our last inspection in June 2015 we found the provider did not meet some of the legal requirements in the areas that we looked at.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with 14 people who use the service and nine relatives about their views on the quality of the care and support being provided. During the two days of our inspection we observed the interactions between people using the service and staff. We used the Short Observational Framework for Inspection (SOFI). We used this to help us see what people's experiences were. The tool allowed us to spend time observing what was going on in the service and helped us to record whether people had positive experiences.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included 12 care and support plans and daily records, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the regional support manager, manager, deputy manager, two registered nurses, eleven care staff, and two activity co-ordinators. We spoke with housekeeping staff and staff from the catering department.

Requires Improvement

Is the service safe?

Our findings

People were not always supported by sufficient staff to meet their needs. All of the staff we spoke with said there were not sufficient numbers of staff on duty at weekends and they felt this compromised people's safety. One member of staff said "It's unsafe and very stressful when we don't have enough care staff" and "The danger with being short staffed for example, is that people could fall in their rooms because we don't have enough staff to help them come down to the lounge where we can keep an eye on them". Another member of staff said "I don't think residents are safe at weekends. Care is compromised because there is not enough staff". Another member of staff told us "We normally have four carers and a nurse during the week but come the weekend it can be two carers and a nurse all day. We are not finishing getting people up until 12 – 12.15pm". Other comments included "Staffing is tight especially at weekends. You can't blame the management when staff are phoning in sick", and "Sometimes people may not be able to get up when they want as we have to prioritise people's care needs. You cannot leave someone wet or soiled. It would be nice to have enough staff to support people when they wanted".

Relatives we spoke with told us they did not feel that staffing levels were appropriate at weekends. One relative told us how on 9 July 2016 staff who had previously worked a waking night shift stayed on until midday although they should have finished their shift at 8am. They said the staff members had stayed on longer to support people to have their care needs met due to staff members phoning in sick. They told us that the midmorning drinks trolley rarely happened on a weekend due to staff shortages and recently it didn't happen as they had ran out of milk. Another relative told us that due to staff shortages they had recently helped with the morning tea trolley to ensure people got a drink and they had assisted somebody with their lunchtime meal as there was only one carer available to support people.

We spoke with the regional support manager and manager who explained how they used a dependency tool to ensure appropriate staff were deployed at all times. They explained the dependency tool was based on information from the old care plan format. They were in the process of adapting the dependency tool to be compliant with the format of the new care plans. We saw staffing rotas reflected the staffing levels identified by the dependency tool. However whilst the management team had increased staffing levels during the past three months there was still a deficit of staff who were available to work on weekends. The regional manager and manager were currently addressing this with staff and by recruiting, but there still remained an issue with staff absences on a weekend and them not being able to source cover, especially at short notice.

We looked at staffing rotas for the 23 July 2016 which showed that five staff plus two nurses had been on duty that day for the whole of the service. On the ground floor there were usually four staff members allocated but on this day the rota showed only one member of care staff was available.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the care plans we looked at contained risk assessments for people. There were risk assessments for falls, mobility, malnutrition, skin integrity and choking for example. However, not all of these had been

reviewed regularly, and where the risks for people using the service had increased, it was not always easy to access this information. This was partly because the service was in the process of changing to a new care plan format and partly because the reviews had not always taken place when they should have. For example in one person's care plan dated December 2015 it identified them as being at low risk of falling and fully mobile. However we observed this person required the use of the hoist and staff told us this person's mobility was "variable". Another care plan completed in June 2016 stated that the person's mobility was variable and they needed to use the hoist. The person's moving and handling risk assessment had not been updated to reflect this person was no longer at low risk of falling and required the use of a hoist.

Where risks had been identified, the steps that staff needed to take to protect them from harm were not always clear and in some plans there was a lack of detail. For example, one person's plan whose agitation sometimes led them to be verbally and physically aggressive, did not give clear guidance or information on what staff should do to keep themselves, the person and other people using the service safe. There wasn't a care plan in place that focussed on what staff should do to support this situation; instead the situation was mentioned briefly within three other care plans relating to medication, social interaction and communication. This meant that staff who were unfamiliar with the person would not be able to easily access information on how best to support the person. Other plans contained clearer guidance for staff and the process of how the risks had been assessed were clear and easy to understand. For example, one person had been assessed as having a high risk of falling. An assessment for the use of bedrails had been completed, but staff had identified less restrictive measures that could be used to keep the person safe. These included a floor bed and crash mats. The plan clearly detailed that although bed rails were currently being used, this was a short term measure and that a floor bed had been ordered by the home.

There was enough equipment available for staff to use to keep people safe. The equipment was clean and in good working order. Two people using the service were waiting for "long" beds to be delivered due to their height.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were given in a safe and caring way. People were asked if they needed any 'when required' medicines such as pain killers. We spoke with four people who told us that they received their medicines regularly and when they needed them. Medicines were administered by nurses and trained staff. There was no-one who looked after their own medicines at the time of our inspection. However there were policies and procedures in place so people could do this if they wished, after it had been assessed as safe for them.

There were records of medicines administered to people and where they were not given, the reason for this was recorded. This helped to show that people received their medicines correctly as prescribed. There were separate charts and body maps for recording the use of creams or other external items. Some people were prescribed medicine that needed additional monitoring and regular blood tests. Staff kept the results of the most recent blood test and the current dose with the administration records. This meant that staff were able to ensure they always gave the correct dose.

There were agreements in place for staff to give people their medicines covertly. This meant staff could disguise the medicines in food or drink to make sure people took them. Safeguards were in place to protect people and make sure this was in their best interest. One person was having their medicines given in this way, crushed into a food supplement drink, however there was no record that this had been checked with the pharmacy as being suitable for these medicines. Staff phoned the pharmacy during the inspection to seek clarification. Clear policies and procedures were available to guide staff in the safe management of

medicines, and information was available for staff and residents.

There was an audit trail of medicines received into the home and those sent for destruction. This helped to show how medicines were managed in the home. Managers completed regular audits of medicines management in the home, and staff had daily medicines check sheets to complete, which should have picked up any medicines recording issues. However we saw that two of these sheets were full and had not been completed for several days. We checked 16 people's medicine charts, and found issues with five people's charts that had not been picked up by staff who had completed the checklist. Three people's charts had entries where it was not always recorded how much had been given when a variable dose had been prescribed, and there were some hand-written entries on three people's charts which had not been checked and double-signed. This was not in line with the home's medicines policy.

Medicines were stored safely and securely. There were suitable arrangements for storing and recording medicines needing extra security. Weekly checks were made of these medicines. However checks had not been completed since 11 June 2016. We found two entries in the register for medicines which were no longer present in the home. Staff told us that these had been destroyed but there were no records available to confirm this.

People were protected against the risks of potential abuse. Policies were in place in relation to safeguarding and whistleblowing procedures which guided staff on any action that needed to be taken. Records showed staff had received training in safeguarding adults. This was also part of new staff member's essential training during induction. Staff were aware of their responsibilities and they were able to describe to us the different types of abuse and what might indicate that abuse was taking place. For example one staff member said they would observe people for changes in their body language or if they became anxious around certain staff. They told us "I know about whistleblowing. I wouldn't hesitate to report anything it's the right thing to do". All the staff we spoke with had a good understanding of the correct reporting procedure. Staff said they felt supported to raise their concerns and were confident the registered manager and deputy would take any action required. Comments from staff included "I have not seen anything that concerned me. If I did I would report it to a senior or manager straight away" and "We are the voice for some of the residents living here. I would speak with the staff first if I saw any poor practice. I would report it to the manager but I have no concerns".

People told us they felt safe living at Westbury Court. Comments included "I certainly do feel safe. We have very caring staff", "Yes I feel safe. If I call they answer pretty quickly but nobody has a chance to talk, they are all so rushed" and "Yes I feel safe anything worrying me, I can talk to staff". One relative told us "I do feel people are safe and secure here. They are able to walk around but not wander off".

We saw safe recruitment and selection processes were in place. We looked at the files for five of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had also been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

People were not always supported to have enough to eat and drink. Some people required their food and fluid intake to be monitored because they had been assessed as being at risk of malnutrition. However, the recording of this documentation was inconsistent. For example, not all of the food monitoring charts had been completed in full. The type of required diet, for example normal, soft or textured, had not always been filled in, and one person's charts for the previous days contained conflicting information. For one day the chart stated the person was on a 'Normal diet' and for another day it stated 'Normal soft'. Staff had documented the food the person had eaten, and this included 'All pureed food' and 'Pureed potatoes, cauli and beef'. When we looked at this person's care plan, their nutritional plan stated they should have a 'Normal diet'. When we spoke to staff about this person, one member of staff said the person was on a normal diet and a member of kitchen staff said "We were told they were finding it hard to chew". However, there was no reference within the care plan to this. This meant it was difficult for staff to know the person's dietary requirements. On the second day of the inspection a referral to the speech and language therapist was made and the care plan was amended to reflect the person's needs.

When care plans indicated that people should have their fluid intake monitored the associated documentation was of poor quality. The charts we looked at did not demonstrate that people were being given enough to drink, and there was no evidence that people's total fluid intake was monitored. Although staff said the charts were "Meant to be checked twice a day", there was nothing to confirm if this happened. Several of the charts we looked at indicated that people's fluid intake was very poor, particularly as the weather had been warm. For example, one person's chart had a documented fluid intake of 475 mls on 20/07/2016, 650 mls on 21/07/2016, 680 mls on 22/07/2016 and 310 mls on 23/07/2016. In their care plan it was documented that they should drink 'At least 2 litres of fluid per day". Another person's care plan stated 'On food and fluid chart as does not spontaneously eat or drink, therefore at risk of dehydration'. This person's chart showed a fluid intake of 340 mls on 21/07/2016, 630 mls on 22/07/2016, 300 mls on 23/07/2016, 300 mls on 24/07/2016, 535 mls on 25/07/2016 and by 16.00hrs on 26/07/206 the chart showed they had drunk 60 mls. This meant that for at least six days the person's fluid intake was exceptionally poor. However, there was nothing documented anywhere to indicate that staff had recognised this or escalated it. On 24/07/2016, staff had documented in the daily records 'Had a good food and fluid intake' which contradicted the information on the fluid chart. Although staff had documented 'OBR' (offered but refused), this had not been documented hourly throughout the day. This meant it appeared that although staff had offered a drink, they had not returned frequently enough to try again despite the care plan stating the person needed 'Lots of encouragement'.

Another person had a urinary tract infection and a catheter in situ. Their care plan stated '1500 -2000 mls input per day due to catheter'. A good fluid intake helps to maintain the quality of a catheter and also aids the treatment of an infection. However, the fluid chart for this person showed they had received 850 mls on 23/07/2016, 570 mls on 24/07/2016, 1130 mls on 25/07/2016 and 10 mls on 26/07/2016.

Records indicated that people were at risk of not having enough to drink. In addition we observed people sitting in the lounges without a drink to hand. There were also no drinks available in communal areas for

people to help themselves if they were able to, although there were water jugs in people's rooms. One person who was sitting in the dining area asked us if they could have a drink of water. We asked one of the housekeeping staff if the water in the satellite kitchen was drinkable. They confirmed it was best not to use this water. There were no jugs of water available in the dining area for us to be able to give this person a drink. As there was no care staff to hand we sought permission from the person to enter their room to fetch their water jug in order to give them a drink. This was also the same for people sitting in the communal lounge. There were no drinks present and no jugs of drink for people to access. Again we sought permission from another person to enter their room and bring them their drink.

One member of staff told us "People are left with drinks in their room but there is not always enough time to give support to those people who need assistance". Another staff member said "If we are fully staffed then we have enough time to give people drinks. People don't get as much as they should in-between meals".

People had access to specialist advice and support in relation to nutrition. Care plans showed that people had been referred for swallowing assessments. However, when risks such as choking had been identified, the care plans did not detail how staff should manage this risk.

People's weights were monitored, although not always as frequently as their plans stated. For example, one person's plan stated they should be weighed weekly, but there was no weight recorded after 06/05/2016. In another person's plan it was documented that they should be weighed monthly, but there was no recorded weight for May. We were told that the weighing scales were broken and that a new battery had been ordered but had not yet arrived.

We observed lunch during our inspection. The tables were laid in the dining room, and there was music on in the background. Some people ate in their own rooms but others came to the dining room. The food smelt pleasant and people were offered a choice; however the meal options were both meat based. Although we were told there were no vegetarians, people had to ask if they preferred a non-meat meal. People said the food was "Very tasty" and "Very nice". When people required assistance with their meals this was provided at a pace appropriate to them; however, we did observe a member of staff sitting between two people and giving one person a forkful of food before turning to the other person and doing the same for them. Although this was done in a nice way, they were chatting to both people and encouraging them to eat more, it was not person centred. As soon as another member of staff was available, they came to help.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Mostly people and their relatives spoke positively about the food. Comments included "I'm not a fussy eater. I have never not liked the choices on offer", "On the whole the food is quite good but I would like more fresh fruit. We had fresh fruit salad today but we don't usually get offered a choice of fresh fruit for desert" and "The new chef is brilliant. She bends over backwards to make sure residents eat. She will make something special for them if they don't like the choices on offer".

People had access to specialist diets when required for example pureed or fortified food. We spoke with the catering department. The role of head chef was currently being covered by the second chef who had been in this role for two weeks. They had information of all people's dietary requirements and allergies. This also included people's likes and dislikes. They explained that people had a choice of meals. They said if people did not like what was on the menu then they were able to request alternatives. On the first day of our inspection we observed one person who did not want the meals on the menu requesting fish and chips. Staff phoned the kitchen and this was prepared for the person.

Staff were complimentary about the covering head chef. They said previously not enough food was always available for people. Comments included "Portions are too small and there is never enough if people want seconds" and "There isn't enough choice. The portions are too small. They said things had improved with the covering head chef. On staff member said "The quantity and quality has improved". One relative told us "The food has improved 100% since the new chef has started". The kitchen was clean and tidy and had appropriate colour coded equipment and utensils to ensure that food was prepared in line with food safety guidance.

People had access to healthcare services to support them to maintain good health. Records in people's care plans showed visits from GP's, district nurses, tissue viability nurses, physiotherapists and chiropodists.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff said they had access to e-learning modules and regular refresher training as required. Core training required by the provider included the safeguarding of vulnerable adults, moving and handling of people and mental capacity act Some staff told us that the opportunity for further professional development had been lacking until recently. A Clinical Lead/Deputy Manager had been appointed in the past two months and they said they had spoken to the nursing staff about training needs. The nurses confirmed this, and said they were aware that training days were being planned on wound care, syringe drivers and venepuncture. Venepuncture is the puncture of a vein as part of a medical procedure. Typically to withdraw a blood sample or for an intravenous injection. New staff received an induction during which they also shadowed an experienced member of staff before working on their own. The staff we spoke with were positive about the training they received and felt it supported them to be able to carry out their duties effectively. Comments from care staff included "My induction covered what I needed. It gave me an overview" and "We get refresher training as needed. I recently went on a first aid course".

The provider's policy stated that staff should receive supervision sessions every eight weeks or six times per year. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meetings would also be an opportunity to discuss any difficulties or concerns staff had. Staff told us they received regular supervision. However, of the six staff files we looked at only one member of staff had been supervised during 2016. Two staff said that despite working in excess of six months, they had not had a meeting to officially sign off the end of their probation periods. None of the files contained appraisals and none of the staff said they been appraised during the last year. Despite this, all of the staff said they felt well supported by the new management team. They said "It feels much better now. There is much more support available" and "We are like a new team now, we can learn together because there is more support now".

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Consent to care was sought in line with legislation. All of the care plans contained mental capacity assessments and where necessary best interest decisions had been made in conjunction with people's relatives and the care team. The plans detailed which decisions people were able to make themselves. For

example "can choose own clothes" and "offer a shower or wash". We saw staff asking people for their permission prior to assisting them. For example "Would you like some help with that?" and "Can I help you?"

Staff had a good knowledge of the Mental Capacity Act 2005. Training in this subject had been undertaken by staff. During our inspection we observed staff supporting people to make decisions about their daily living and care. For example, people were supported to make choices about what they ate, what activities they wished to be involved in and where they wanted to spend their time. Comments from staff included "People should always be involved in daily choices. I speak with people to make sure they know what I am doing so they can say no" and "It's important to still include people in decision making. I always ask people about choices with food and clothes".

Although deprivation of liberty authorisation's had been sought for some people, it was not clear within the plans what the status of these were. For example, one plan contained an application dated 08/06/2015 and another plan contained an application dated 01/07/2015. Both plans contained letters acknowledging receipt of the applications but there was nothing to show whether the requests for assessments had been followed up. Where DoLS applications were in place we discussed with the regional support manager and manager about regularly reviewing these to ensure what was in place remained the least restrictive option.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about staff. One relative told us "The staff are excellent. There just aren't enough of them. I won't have a bad word said against them". Another relative told us "The staff are all good. They work hard and do their job". Comments from people using the service included "The caring is exceptionally good", "Staff are very good, Brilliant. There just aren't enough of them" and "I'm happy with the care. It's very good".

All of the staff we spoke with and observed treated people with kindness and compassion. There was a pleasant and friendly atmosphere throughout the building. Staff said they enjoyed their jobs. Comments included "This is such a lovely place to work (when we have enough staff)", "I want to make sure that people here get the care they deserve. I really want to get things right for people" and "Being able to interact with people is what care is all about. I feel blessed to be able to do my job".

People were treated with kindness and compassion in their day-today care. We observed and spoke with one member of staff who showed real concern for one person who had become unwell the previous evening. They were discussing the person's condition with a visiting health professional and spoke about their concerns regarding the person's distress and how this could be resolved. When they spoke with us, they clearly knew the person well and wanted the person to feel calm and safe. They had also spoken with the person's GP and based on their advice the GP subsequently prescribed some medicine to relieve the anxiety. The same member of staff then drove to the pharmacy to collect the medicine so that the treatment could be started as soon as possible.

We observed staff supporting one person from their bedroom to attend the bathroom. The person was walking with the support of a frame but was having difficulty in getting going. The staff member gently encouraged them to take some steps saying "Count as you walk. You might find it easier". A member of staff said they knew that one person enjoyed singing, and so when assisting them with their breakfast that day they had sung songs with them.

Staff showed concern for people's wellbeing in a caring and meaningful way. People looked comfortable in the presence of staff and did not hesitate to seek assistance and support when required. We observed staff supporting one person who had become tearful. Staff took the time to offer them reassurance and check that everything was alright with them. They held the person's hand who responded with a smile.

We observed one person who was being transferred from their armchair to a wheelchair in the communal lounge. They expressed some anxiety. Staff took the time to offer reassurance about what was happening and offered comfort by holding the person's had during the transfer. They explained to the person they would be able to come back to the communal lounge as soon as they were "Ready again".

The relationships between staff and people receiving support demonstrated dignity and respect at all times. During a mealtime observation, we saw sociable interactions between people and the staff who were supporting them. For example one staff member who was supporting a person with their lunch had a

conversation which included discussing the activities available after lunch and about the changeable weather. During the lunchtime meal we observed staff supporting people at a pace which was appropriate to them. One person was undecided about what they would like for lunch. The staff member offered the person a little bit of each meal so they could taste them and make their choice. However, the person did not like either meal and an alternative meal of their choice was then sought.

Staff were aware of the importance in respecting people's rights to privacy and dignity. People were addressed by staff using their preferred names and staff knocked on people's doors before entering their rooms. When people received personal care, staff ensured this was done behind closed doors. One member of staff told us "I always tell people what I am doing and offer reassurance. I let them know they are safe". Another member of staff said "It's important to understand people. Care here is good. Staff do care". Staff told us they would ensure people were always covered whilst intimate care was taking place and they would talk with them about what was happening.

People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included such items as books, ornaments and photographs. People told us they could spend time in their room if they did not want to join other people in the communal areas.

Staff were committed to ensure, where required, people were supported with end of life care. One person using the service was receiving palliative care. We overheard two members of staff discussing how they would speak to the person together in order to fully understand their wishes in relation to their end of life care. One said "I want to make sure that everyone gets the end of life care they deserve; it's so important to get it right". We looked at the person's plan and their wishes in relation to who they wanted to visit them were clear and detailed. The person had only arrived at the service the day prior to our inspection, so although the plan wasn't completed in full, there was enough detail to ensure the person's preferences were met. One member of staff said "You can't rush an end of life care plan; we need to really get to know the person first so it might take a couple of days".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection which took place on 09 June 2015 the provider was not meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the registered person had not designed care and treatment plans to include people's preferences and accurate information to ensure their needs were met. The provider wrote to us with a plan of what actions they would take to make the necessary improvements. We found during this inspection that the provider had not undertaken some the necessary improvements required to fully meet people's needs.

Since our last inspection the service had been updating the information held in people's care plans. They had introduced a new format for recording people's care and support needs. The new style plans were easier to navigate than the old style ones, but changing everyone's plans was still a work in progress.

The care plans we looked at did not evidence that people or those acting on their behalf had been involved in the planning process. There was no detail within the plans to indicate what level of independence people wanted to either maintain or aim for. Although there were sections within the plans for people's choices and preferences to be noted, this was not filled in for nine of the twelve care plans we looked at. There was also no details recorded in relation to people's past lives prior to moving into Westbury Court; for example, people's previous occupation, where they had been born and lived throughout their lives. One member of staff told us "People forget their past lives. There's no information in care plans on people's life history. Something in common to talk about makes people feel important".

Care plans were not person centred. For example, one person's care plan stated that the expected outcome was 'For X to receive her medication as prescribed in a way she likes'. The care plan did not contain any detail of how the person wished to receive their medicine. For example, with a drink. Another section of the care plan stated 'Requires assistance of 1 or 2 carers depending on mood' but did not detail what 'Mood' would need the support need the support of two staff members. Although we did see some plans where there was an element of person centeredness, for example, 'Likes to wear perfume and makeup'. However this was not consistent throughout individual plans and some plans contained no person centred information at all.

Care plans did not always contain accurate and up to date information. One person's care plan noted they did not like vegetables in their nutritional plan yet we observed the person eating the vegetables on offer during their lunchtime meal. The staff member explained what was available for lunch and at no point did the person say they didn't want or dislike vegetables. Another person's care plan stated "She often forgets its meal time and will walk the corridor". However the care plan had not been updated to reflect this person was now in a wheelchair and no longer mobile. We observed one person who had experienced some anxiety and had not been cooperative with having their personal care needs attended to. When we spoke with staff about how they would best support this person during times of anxiety they informed us the person liked staff to 'Sing the ABC song' to them. When we looked on the person's care plan this information was not recorded.

Another person's care plan stated the person was allergic to mushrooms, tomato and shellfish in the introduction. The admissions assessment did not contain this information and we could not find this information in their nutritional plan. We checked in the kitchen and the chef had noted this person was not to eat these foods. It was unclear how this information had been obtained.

We looked at two plans for people who had wound care needs. The plans contained photographs that were clear and the dimensions of wounds had been documented. The progress of the wound was easy to follow and the dressing plans were clear. However, because not all of the plans had been reviewed or updated, it was not clear if staff were providing care in accordance with people's current needs. For example, in one person's plan it was documented that staff should put a collar and cuff support on the person to protect their shoulder. The plan had last been updated on 06/05/2016. During both days of the inspection, the person was not wearing a collar and cuff. When we asked staff about this they said the person often refused, but this was not documented in either the care plan or in the daily records. This meant that person was not receiving care in accordance with their plan.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive care that was responsive to their individual needs. Although the staff on duty knew people well, they were not always able to respond to people's needs in a timely manner, especially on weekends when staff shortages were experienced. Staff said although they wanted to, they said they did not have time to sit and talk with people and that care was sometimes rushed. For example, in one person's daily review notes a member of staff had documented "Stayed in bed all day due to being very short staffed". Another member of staff said "On some days we might not get people out of bed until after lunch". Another member of staff said "We have to prioritise who receives care first sometimes. If two people want to get up at the same time and one person is soiled then we will always support the person who needs personal care first". Whilst this was the appropriate thing to do it did mean people would have to wait and not be able to get up at their preferred time.

The provider employed two activities co-ordinators who were responsible for ensuring people could access a range of activities. People were able to choose what activities they took part in and suggest other activities they would like to complete. Activities provided included baking, music and arts and crafts. The activities also followed the 'Oomph' approach which believes that older people should still have access to physical activities and be stimulated. Part of this approach involves encouraging people to stay active through music and movement. On the day of our inspection only one person chose to take part in this activity. We observed the person was involved in the session by choosing the music they wanted to listen to and the props to go with the movement.

The activities co-ordinator told us they tried to organise activities that included people's past interests and hobbies by asking what they wanted to do. For example, they were in the process of organising a Norwegian themed activity as some of the people living in the home had previously visited there. They were holding a Norwegian day which would include photos and traditional food for people to try. Staff spoke positively about the activities co-ordinators. They said they would offer people 1:1 time before starting the group activities. They said they felt the activities were organised to "Suit people's needs".

Some people chose to remain in their rooms rather than go to the lounge and others who were being cared for in bed were unable to go to the lounge. As a consequence, there was a risk that these people could become socially isolated. When activities were not taking place, people in the lounges had no interaction. In one person's plan staff had documented "Refuses daily to come out of room to take part in activities,

despite constant reassurance. Will continuously call using the call bell or bang on the table for attention". However, there was no guidance for staff on how they should reassure the person, or how they could ensure they did not become isolated. In another person's plan it was documented "Sleeps better if gets some stimulation during the day", but there was nothing documented to inform staff what kind of stimulation the person preferred; for example did they enjoy music, talking, watching TV or listening to the radio.

There was a procedure in place which outlined how the provider would respond to complaints. We looked at the complaints file and saw that complaints had been dealt with in line with the provider's procedure. People we spoke with and their relatives told us they were able to raise their concerns. However some relatives told us whilst they felt able to raise their concerns they did not feel currently listened to.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to regularly assess and monitor the quality of the service. Various audits were carried out by the management team to assure themselves of the quality and safety of the service people received. These audits were based on CQC's five domains and included care planning, training, infection control and health and safety. Whenever necessary, action plans were put in place to address the improvements needed. We saw a whole home audit had been undertaken in May 2016. Whilst the whole home audit had recognised some of the areas for improvement we had identified, the audits had not picked up the discrepancies noted in the medicines management checklist in the safe domain.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Incident and accident forms were completed where appropriate and detailed what actions and care had taken place. However, we saw in people's daily records that incidents had been recorded but had not all been entered into the electronic system due to staff not being able to access it. This meant there wasn't an accurate record of accidents and incidents that had occurred. This could also mean auditing of accidents and incidents to identify trends could be a challenge if the correct information was not in the system. We spoke with the regional support manager and manager who agreed to look into this.

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

Staff members' training was monitored by the manager to make sure their knowledge and skills were up to date. There was a training record of when staff had received training and when they should receive refresher training. Staff told us they received the correct training to assist them to carry out their roles.

There currently was not a registered manager employed by the service. A new manager had been employed by the provider and was currently in the process of submitting their application to become the registered manager. The new manager was currently being supported by a regional support manager who had been covering the management responsibilities since the previous manager had left in April 2016. The manager understood their responsibilities and the requirement to notify us of important events that affected the service.

The new manager told us they wanted to be "Visible to staff" and have an "Open door culture". They said they wanted to "Lead by example" and not "Just sit in the office". During our inspection we observed the manager supporting staff with a lady who had entered another person's room and required encouragement to come out.

Staff had been provided with cards that highlighted the five values of the provider. These included 'Do it from the heart' and 'Make every moment matter'. Staff demonstrated a good understanding of what the service was trying to achieve for people. Comments included "It's about giving people a safe service", "Involving people in daily choices" and "Supporting people with maintaining their independence". Staff said they felt well supported and listened to by the new management team. However, one member of staff said

that the values of the organisation only applied to residents. They said they felt that the provider did not value its staff.

Staff were supported to question the practice of other staff members. Staff had access to the company's Whistleblowing policy and procedure. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. All the staff confirmed they understood how they could share concerns about the care people received. Staff knew and understood what was expected of their roles and responsibilities.

People and their relatives were invited to share their views of the service. Relative and residents meetings took place throughout the year. This was an opportunity for people and their relatives to discuss and concerns they had and make suggestions for improving the service. A suggestion box was available in the reception area inviting people and their relatives to make comments about the service.

Comments relating to management included "Both the manager and deputy are around and approachable", "The manager does pop in some times" and "Dealing with the management is pleasant enough when you can get hold of them, but they are difficult to get hold of".

The service had appropriate arrangements in place for managing emergencies. There was a contingency plan in place which contained information about what to do should an unexpected event occur. For example, a flood or loss of utilities. There were arrangements in place for staff to be able to seek out of hours management support should they require it.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care We found that the registered person had not designed care and treatment plans to include people's preferences and accurate information to ensure their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments associated with people's safety had not always been reviewed and update. Information on how best to support people was not always clear and detailed. People were not always supported to have enough to eat and drink. Documentation relating to the monitoring of food and fluid intake was not consistently recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Auditing systems in place were not always effective with identifying gaps in monitoring.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff available to meet the needs of people using the service, especially at weekends.