Alliance Care (Dales Homes) Limited

Westbury Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Westbury Court is a care home providing personal and nursing care to 60 people aged 65 and over. At the time of the inspection, there were 49 people using the service.

People's experience of using this service and what we found
The provider had made some improvements to the service. However, not all the requirements of the warning notice had been met. This was because the identification and management of risk had improved, but further action was required to ensure people's safety.

The manager had reviewed the admission criteria and some people, who showed distress behaviours, had been moved to more appropriate care settings. This minimised the risk of people experiencing harm.

Distress management plans had been developed but not all were accessible to staff. This did not ensure people received appropriate, consistent support when anxious. Staff were not sufficiently supporting a person who was declining care. The best way to support the person, was not detailed in their care plan.

People's risk of dehydration was not being safely managed. Records showed some people did not have enough to drink. The monitoring processes in place had not identified this. Staff were in the process of receiving nutrition and hydration training to give this area better focus and understanding.

Improvements had been made to the cleanliness of the environment. This included over-bed tables and skirting boards. However, some areas such the kitchenette on the first floor were not clean.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The last rating for this service was requires improvement (published 17 October 2019) when there were multiple breaches of regulations. Following the inspection, we served a warning notice on the provider. We required them to be compliant with Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 15 November 2019.

Why we inspected
This was a targeted inspection based on the warning notice we served on the provider following our last inspection in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC are conducting trials of targeted inspections to measure their effectiveness in services where we served a warning notice.

We undertook this targeted inspection to check they now met legal requirements for Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report only covers our findings in relation to the safe care and treatment in the service. The overall rating for

the service has not changed following this targeted inspection and remains requires improvement. This is because we have not assessed all areas of the key questions.

Follow up
Following the inspection, the provider sent us an action plan, which stated the work required, and by when, to improve the service. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Westbury Court on our website at www.cqc.org.uk.

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.

Details are in our safe findings below.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014. This was a targeted inspection. CQC are conducting trials of this type of inspection to follow up services where CQC have issued a warning notice.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Westbury Court 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.

The service had a manager, who started employment at the service shortly after the last inspection. They were in the process of registering with the Care Quality Commission to become the registered manager. It is a condition of the provider's registration that they have a registered manager at Westbury Court. Once registered, they and the provider would be legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with five members of staff including the manager, care staff and housekeeping staff. We reviewed three people's care records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. We have not changed the rating as we have not assessed all of this key question area. We will assess all of the key question at the next comprehensive inspection of the service.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that whilst some improvements had been made, the provider had not met all the requirements of the warning notice and were still in breach of the regulation.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. At this inspection, we found risks continued to not be managed safely.

- The management of risk did not always ensure people's safety. One person often declined assistance with their personal care and treatment of a wound, yet this was not well managed. There was no care plan in place to guide staff on the best way to support the person when they declined assistance. At 14:30, on the day of the inspection, the person had not been assisted to use the bathroom or receive assistance with their personal care. Their lunch had been delivered to them at 12:30 but remained untouched two hours later. Staff were aware the person needed assistance but were not clear how to give this.
- Distress management plans had been devised to promote safety, but they were not in place for each person who needed one. This did not ensure each person received appropriate support when anxious, thus increasing the risk of any behaviour escalating and potential harm.
- During the afternoon of the inspection, a person who was living with dementia, had taken another person's dessert. They were walking along the corridor using their fingers to scoop up the custard, which had gone cold. Taking other people's food increased the risk of an altercation, but staff had not identified the incident. The person was unable to tell staff if they were hungry, and their food monitoring record had not been completed. This increased the risk of the person not having enough to eat.
- Records did not show the risks of dehydration were safely managed. Some people had food and fluid charts, so staff could monitor their intake. However, all three records viewed were not fully completed and showed a range of gaps in recording. These shortfalls had not been identified and showed people's intake was not being effectively monitored. This increased people's risk of dehydration.
- Improvements had been made to the cleanliness of the environment. This included skirting boards and over-bed tables. However, there was debris on the surfaces and flooring in the kitchenette on the first floor. The kettle was dirty, and the tea, coffee and sugar canisters were stained and did not have lids. At 14:55, there remained food debris on the tables in the dining room.

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

2014.

● The manager had reviewed the admission criteria and some people who showed distressed behaviours, had been moved to more appropriate care settings. This had minimised the risk of behaviours escalating and people sustaining harm.
● A range of staff training had been arranged to enhance safety. Staff were in the process of completing training in nutrition and hydration. This had been arranged to develop understanding and heighten the focus of both areas.