The Orders Of St. John Care Trust

OSJCT Westbury Court

Inspection report

Westbury Court
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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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 17 and 18 August 2015 and was unannounced.

The service predominantly cares for older people who have physical needs and those who live with dementia. It can accommodate up to 42 people and at the time of the inspection 40 people were living at Westbury Court.

The home had a registered manager registered with the Care Quality Commission however, they had recently resigned following a period of absence. 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. The care home was being supported by one of the provider's peripatetic managers. A new manager had been employed and was due to start on 1 September 2015.

Summary of findings

Prior to the inspection we had received information of concern which related to how people's care was delivered. This was looked at during this inspection and our findings are included in the full version of the report.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to: ensuring risks to people were sufficiently managed, adequate staff training and support, the process for obtaining people's consent and ensuring they were protected under current legislation. You can see what action we told the provider to take at the back of the full version of the report.

We also recommended that: the service seeks support and training for the management team about motivation and team building and the service seeks advice and guidance from a reputable source about the development of more robust quality assurance processes.

People were cared for by staff who were kind but did not always have time to be compassionate. There were enough staff to meet people's needs but not to deliver personalised care. Although some staff wanted to personalise people's care, others were resistive to this approach. As a result, people did not always receive care when they wanted it and their preferences were not always listened to or considered by the staff.

Whilst consent was sought appropriately for significant treatment decisions, this did not always happen for day to day care decisions. People's care plans were detailed but did not support a personalised approach to care. It was not evident that people or their representatives had been involved in planning care or reviewing it. Some staff worked hard to ensure people had activities to take part in but this was not supported by the whole staff team. People were particularly positive about the quality of the meals provided.

Staff received training but had not always received training in subjects they needed to be aware of to ensure people needs were appropriately met. For example, in dementia care, personalisation of care and the Mental Capacity Act 2005. Staff had not received regular supervision/support to ensure their training needs were adequately identified and they could develop their skills and awareness.

Whilst some risks that people faced were addressed, others, such as pressure ulcer management and keeping people safe from others who may be distressed, were not. This put people and staff at risk or harm. People lived in a service which had not been well-led for a period of time. Staff lacked leadership and guidance on what was expected of them. The provider's audits for monitoring the service provided had continued, but it was not clear if the resulting actions had been completed. There were opportunities for people to express their concerns or make a complaint and these had been investigated and addressed by the registered manager.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. People were not always protected against risks that may affect them. Environmental risks were monitored, identified and managed however.

Arrangements were in place to make sure people received their medicines appropriately and safely.

Staff knew how to report concerns related to abuse which helped to protect people from harm.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

Requires improvement 

Is the service effective?

The service was not always effective. People received care and treatment from staff who had not received adequate training and support.

People's consent had not been fully obtained for the care which had been recorded for people to receive. The Mental Capacity Act (2005) had not been fully adhered to.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Requires improvement 

Is the service caring?

The service was not always caring. People were cared for by staff who were kind but did not always have time to be compassionate.

People's preferences were not always considered or listened to. Staff were not adopting a personalised approach to care.

People's dignity and privacy was maintained.

Staff helped people maintain relationships with those they loved or who mattered to them.

Requires improvement 

Is the service responsive?

The service was not always responsive. People and their representatives had not been involved in planning their care or reviewing it.

Care plans were detailed but not always personalised and the care delivered was not always in line with these.

People had opportunities to socialise and partake in meaningful activities.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Requires improvement 

Summary of findings

Is the service well-led?

The service had not been well-led. Staff lacked guidance and leadership and this had resulted in a culture that did not always benefit people who used the service.

Some staff were aware of challenges the service faced but lacked management and overall support to address these.

People were not always protected against poor service. The quality monitoring system was not robust enough to ensure improvements to the service were made.

The provider valued feedback from people and regular resident's meetings were held were changes were made from people's suggestions.

People's care records were kept secure.

Requires improvement

OSJCT 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.

This inspection took place on 17 and 18 August 2015 and was unannounced. It was carried out by two inspectors.

Before the inspection we reviewed the information we held about the service. This included information about significant events reported to us by the provider. We gathered information from the local County Council who commission care from this service.

During the inspection we spoke with six people about their experience of the service and three relatives. We also gathered information about people's experiences in other ways. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 16 members of staff including two representatives of the provider. We reviewed the care records of seven people. These records included their care plans and risk assessments. We also inspected a selection of medicines administration records.

We reviewed the recruitment files of seven staff and the staff training record. We also gathered information about support (supervision) sessions provided for staff. We reviewed a selection of records relating to the management of the service. These included a selection of audits and action plans. We also inspected records relating to the maintenance of the building, accidents and incidents and complaints. The service's registration certificate was on display as was the current employer's liability insurance certificate.

Requires improvement

Is the service safe?

Our findings

Risks were not always managed in a way that ensured people's safety. Prior to the inspection we had received information of concern that care was sometimes recorded as delivered when it had not been. In this case this related to checking that people had been repositioned to alleviate pressure on their skin. We found staff sometimes retrospectively recorded people's repositioning. We observed one member of staff doing this, trying to find out who had been repositioned, when and by whom. Staff were not always 100% sure whether this had taken place and in some cases this resulted in a record being made of what staff thought had taken place. This had the potential for staff to record that appropriate actions had been taken to manage people's risk when this may not have been the case. There is also the potential risk of people's records being inaccurate.

When people were initially identified as at risk of developing pressure ulcers specialised pressure relief equipment was provided. In one person's case they had refused this and records showed the staff continued to monitor their skin for pressure damage.

People's risks relating to falls and falling out of bed were identified and actions taken to manage these. People had been assessed and appropriate equipment put in place to reduce harm to people.

Risks relating to one person's behaviour which could be perceived as challenging had not been correctly identified and managed in a way that protected others from harm. Risk management strategies had previously been put in place to address behaviours that were being demonstrated at the time. However, this person had since had an altercation with another person. They were also exhibiting other behaviour that potentially put people at risk. On one day of the inspection a member of staff diverted potential harm away from a person at the time one of these behaviours was taking place. However, they were nearly hurt in the process. They had noticed this behaviour taking place before but it had not been properly discussed and assessed so there was no risk management strategy in place. We fed this back to the peripatetic manager who was unaware of the presenting behaviour. They told us they would ensure this was reviewed, assessed and any risks addressed.

Appropriate systems and actions were not always in place to ensure risks to people were prevented. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Comments from staff implied there were not enough staff on duty. One member of staff said, "I don't think there is enough staff, it's always go, go, go". Other staff told us it was difficult at times to get enough staff on duty and they said at times the home worked under its allocated number of staff. We were told that the provider determined the number of staff by taking in to consideration the number of people to be cared for, their level of dependency and the layout of the building. During the inspection we did not make any observations or gather any information that people had been put at risk because of a lack of staff. Further care staff were being recruited to make it easier to cover the needs of the home.

Information received prior to the inspection told us people were left unattended in the lounge area when they were unsettled and call bells were left ringing for long periods of time. One relative told us the lounge area was quite often unsupervised by staff after tea-time and into the early evening. This period of time was when staff took a break and when people were started to be helped to bed. They told us they and other visitors had needed to look for staff at times because people required help in the lounge. They told us the registered manager had addressed this a while ago by saying that a member of staff had to be present in the lounge at all times, but the relative said the practice had not lasted. During the inspection the lounge was supervised by staff at all times and this included the early evening. We were aware of call bells ringing continuously but the calls we timed were answered within two and five minutes. However, one person said, "You may wait five minutes for your bell to be answered or you may wait 20 minutes. It depends how busy they are". We fed our findings back to the peripatetic manager. We asked how staff responses to call bells were monitored and we were told the response times could be printed off and audited. However, the system for enabling this to be done had not been maintained so this was not possible at the time of the inspection.

Staff spoken with all demonstrated an understanding of how to safeguard people from abuse. They had received safeguarding training and knew who to report any concerns to, both within the company and to appropriate external

Requires improvement

Is the service safe?

agencies. Staff also knew how to whistle blow and share any concerns they had about other staff practices. The company had a safeguarding people policy and procedures which linked in with the County Council's wider safeguarding protocol.

People were protected from those who may be unsuitable to look after them because robust recruitment processes were in place. Staff recruitment files showed that appropriate checks on people had been carried out before they worked at Westbury Court.

People received their medicines safely. We saw medicines being administered and people were given appropriate help to take these. Staff ensured people took their medicines before signing relevant medicines records. The medicines were stored securely at all times and this included times when the staff administering medicines left the medicine trolley to help someone; the trolley was always locked. Arrangements were in place with a Pharmacy to ensure prescribed medicines were delivered when needed and medicine stock not needed was safely removed. All staff who administered medicines had been trained to do so.

Environmental risks were identified and managed well. The maintenance team addressed the up keep of the building and carried out basic health and safety checks. This included checks relating to fire safety, water safety and the safety of equipment. Contracts were in place to ensure specialists serviced and maintained equipment and services such as the fire alarm system, electrical and gas supplies, lighting and mechanical lifting equipment, this included the passenger lift. The provider had an emergency contingency plan and was able to draw on support from its other services if needed.

Requires improvement

Is the service effective?

Our findings

Prior to the inspection we received information of concern which told us staff were not always provided with the training and support needed to meet people's needs. We found people were cared for by staff who had not been provided with sufficient training and support to meet people's individual needs. The provider did not have the systems in place to adequately identify staffs' individual training needs so they could provide a high standard of care. When we spoke with staff about training some staff thought it had been "excellent" and some felt they lacked training in specific areas of care. Two care staff told us they would like more training on caring for people living with dementia as they didn't feel fully equipped to support people with these specialist needs.

Staff sometimes demonstrated a lack of knowledge in some subjects which they needed to be aware of to ensure people's rights were protected. In particular there was a lack of confidence and knowledge around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The service's training record stated that 35 out of 53 care staff (excluding non-care staff) had not completed training on this subject. We spoke with two care staff who told us they had completed the training but found it difficult to relate to their work. The training record stated that several staff had received dementia training from the Alzheimer's Society and one member of staff had completed further training on the subject. However, 29 out of 53 care staff had received no training at all on dementia care.

Several staff confirmed they had not been provided with supervision/support sessions for some time. They said they would like to have these on a regular basis to be able to talk through where they felt they needed more support and training. We looked at a selection of support/supervision records; six staff had not received supervision since 2013. Three further staff had received supervision following observed poor performance but had not received supervision before this since 2012 and 2013. We asked the peripatetic manager to check the frequency of staffs' support/supervision sessions. They found staff had generally lacked this but that 26 staff had received one supervision session in 2015. There were 73 staff in total on the service's training record. There was no evidence of on-going staff competency checks so it had not been determined if staff had remained competent since their training.

Staff had not been provided with adequate training or support to ensure people's individual needs were appropriately met. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of staff had completed mandatory training, in subjects which the provider defined as necessary for their role. This included subjects such as safeguarding people from abuse, safe moving and handling practices and infection control. This training was updated on a regular basis although a few staff had not completed this. New staff were provided with the company's induction training. One member of staff felt their induction training had been "quite good" and two others told us the training had not prepared them for the job.

People's consent had not always been sought before delivering their every day care. We found care records for one person stating, "(name of person) voiced that she didn't want to get up and wasn't very happy but we got her up and she settled in the lounge". This record implies the person did not consent to the care the staff delivered and there was no mental capacity assessment to support the decision by staff to go against her wishes.

Despite there being people who lived with dementia and people who were very confused we did not find mental capacity assessments in place relating to people's care. One member of staff told us it was because everyone was able to give their consent for the care that was delivered. If there is any doubt that people are able to give informed consent, for example because they are living with dementia, the person's mental capacity should be assessed. There was no evidence that this process had taken place in relation to various aspects of people's care. Staff did not seem to understand the difference between someone agreeing to what they were being asked to do and giving informed and capacitated consent.

A senior member of staff told us people's consent was always sought before treatment was provided. For example, before administering medicines or attending to a wound and we observed this to be the case. Where a person had not been able to consent to a significant

Is the service effective?

decision, taking their tablets, and had refused these, the MCA had been adhered to. The person's mental capacity in relation to this had been assessed. Medicines in this case were administered covertly (hidden in food) to ensure they were taken. The decision to do this in the person's best interests had been taken by appropriate people, which included the person's GP. Records had been completed demonstrating that the correct process for decision making under the MCA had been followed. An application for an authorisation under DoLS had also been submitted to the local authority (the supervisory body). This was so the person could receive the care they required lawfully and in the least restrictive way.

In some cases people's consent had not been correctly obtained. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the food and that they had lots of choice. One person said, "I like the food very much". Another person said, "The food is really good. I personally enjoy a cooked breakfast and they are excellent here". This person's cooked breakfast had been cooked while they waited and was freshly served. Another person enjoyed a boiled egg and others a mixture of cereals, toast and porridge. We observed the breakfast assistant ask several people if they had had enough to eat. We observed three meals and at each people were given the support they needed to eat and drink. The cook said, "They can have what they want". The cook was aware of who was losing weight, who was on a particular diet and who needed extra encouragement with their food. They told us food was fortified with extra calories where needed by adding butter, cream and dried powder milk. They told us picture cards were sometimes used to help people make a choice about what they wanted to eat. This helped people who found an image easier to process than words.

People's nutritional risks were identified, monitored and managed. People's weights were recorded and the Malnutrition Universal Screening Tool (MUST) was used by staff to help determine what actions to take regarding people's nutritional risks. One person's nutritional risk assessment and MUST were recording a gradual loss of weight. The last review of the person's care plan reflected this and the problem had been discussed with their GP. For the time being staff had been directed to continue trying to encourage the person to eat. Another person had a poor swallow reflex and their care plan stated they required a thickener in all drinks. We observed this being done each time the person was given a drink.

People's care records showed they had access to health care professionals such as their GP. The GP services were available to visit and review people each week. One person's infection had not resolved itself. The immediate problem was addressed by the nurse on duty and they reviewed this with the GP on the same day and different antibiotics were prescribed. The service accessed the out of hours GP service when needed. Staff also worked closely with community nurses, mental health nurses, tissue viability nurses, speech and language therapists, physiotherapists and occupational therapists in order for people's health needs to be addressed. People had access to a private chiropodist every six to eight weeks and anyone with diabetes had access to the NHS Podiatry service. NHS optical and dental services were accessible when needed. Where people needed continence aids (such as pads) the GP made a referral to the continence advisory service and an assessment of need was carried out. An allocation of continence pads was then provided.

Staff were also able to call on advice and support from the provider's own team of Admiral Nurses. These are specialist dementia nurses who give practical and emotional support to a person with dementia, the staff and family members. Their support is tailored to the person's individual needs and challenges. This had been done in the case of one person.

Requires improvement

Is the service caring?

Our findings

People were treated with kindness, but sometimes, when the staff were busy, compassion was not always demonstrated. For example, one person's calling out was ignored by several staff who were busy serving tea. One member of staff said, "They always call out". Another member of staff explained to us that the person often called out but they responded by repositioning the person so they could see other people. They also said, "I'll sit with you for a while". Whilst they were with the person the calling out stopped and when the member of staff left to do something else they called out again. This member of staff showed the person that they mattered; they listened to them and gave them comfort. Other staff demonstrated caring in the way they helped people eat their food and during other interactions

People's needs were met but not always in the way they would prefer. For example, one person had two main preferences and when these were met they made a difference to the person's comfort and well-being. One of these was to have a table alongside them in order to be able to place things within easy reach. On the first day of the inspection the table was not present and it came to our attention because the person had nowhere to put their mug of tea. The tea had started to spill on their lap blanket and we were concerned it may tip into their lap. We drew a staff member's attention to this and despite it being obvious that the person could not hold the weight of a full mug they told us the person liked to hold the mug. There was no further action taken by staff to make this person's life easier by putting a table alongside them. We reviewed the person's care plan which stated that a table should be placed alongside them. We found there were physical health reasons why the person could not successfully hold on to a full mug of tea, which necessitated a table to be placed one particular side of them. The person's relative had raised this issue many times with the staff and in the end it had been added to the person's care plan for staff clarification. The need for this had clearly still not been effectively communicated. On the day of the inspection this showed an immediate lack of care about the person's well-being. It also demonstrated a lack of compassion for the person's predicament which they could not alter. On the second day the table was in place because the relative was visiting and they had organised this. People were not always being listened to in a way that showed or made them feel they mattered.

One person told us they thought "the place" was "really good" however, they also told us it was not until the day they were going home that they learnt there was an upstairs lounge which was quiet and where activities took place. They said "this was a shame" because they would have preferred this and would have joined in some of the activities. This person had not had information, which would have made a difference to their stay, explained to them. However, they said "I would certainly come back and I will use the upstairs lounge next time".

People's care was not personalised so people's individual choices or preferences were not always identified or met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they were informed of any significant events, such as a fall or ill health. They also confirmed they were able to visit when they wanted to and they were made welcome by the staff.

We observed staff maintaining people's privacy and dignity. For example, personal care was delivered behind closed doors and when people were mechanically hoisted into a chair; their dignity was maintained with a blanket placed over their laps.

Information about advocacy services was present in the reception area. One relative told us they visited on a regular basis to ensure their relative was getting the care they needed and so they could speak up on their behalf if they needed to.

Requires improvement

Is the service responsive?

Our findings

Prior to our inspection we received information of concern that staff were not delivering care in a personalised way. For example, making people get up and go to bed when they did not want to. We were also told that only those that could ask were taken to the toilet and others were left to be incontinent. We were told people were not getting their baths. When we asked people how they felt staff responded to their needs they said, "You cannot beat the place, the staff are wonderful", "The staff are very good" and "They do everything for me. I couldn't ask for more".

Some staff told us a culture of resistance had developed against personalised care and working outside of the routines. They told us this had happened because there was not a strong leader to challenge it. They said people were, at times, being provided with care when it best suited the staff. Some staff told us they found this way of working very difficult and if they suggested a more personalised approach, they were ignored by more senior care staff. Comments made by people supported the fact that their care was not always provided in accordance with their choice or preference. There were examples of where people felt they needed to fall in line with what the staff suggested. For example, one person said they were recently woken and asked if they wanted a wash at 6:30am. They said they had not really wanted this but agreed because they said, "Otherwise you have to take your chances; you may get washed at 9am or 11am". When we spoke about this with staff one said, "You are expected to get 15 people up and out of bed by 10 am. This means that sometimes people are asked to get up when they don't want to". This demonstrated a lack of personalised care and a lack of respect for people's individual choices and control.

Care plans outlined people's needs and how these would be met. They were often detailed but did not always show that people or their representatives had been involved in the planning or reviewing of their care. Each person's personal hygiene care plan, for example, stated they were to be provided with a bath/shower once a week. This seemed to be what staff would do rather than what the person's preference may be. For two people there was no record of a bath or shower having been given for three weeks and no recorded refusals. Staff were unable to confirm if these people had been bathed or had refused. Care was not therefore in line with these people's relevant care plans and the reasons for it not being could not be explained. We did, however, observe other areas of care that were in line with people's care plans.

People and their representatives were not fully engaged in the process of ensuring people's care was designed around their individual preferences and needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person confirmed they were able to set their own routine and lead their life the way they wanted to. They told us some staff were better at accepting this than others. They said they were quite able to verbally tell these staff what they wanted to do and what they did not want to do.

We observed staff helping people to the toilet although one situation did cause us concern. One person, fully reliant on staff for all their needs, pressed their call bell to be taken to the toilet. A member of staff cancelled the call bell and told them they were busy but someone would help them when they were available. The person's visitor told the member of staff not to cancel the bell as there may be other staff able to help. This person was helped to the toilet seven minutes later when other staff were free. The cancelling of a call bell, before staff are ready to meet a person's needs, potentially puts people at risk of not having their needs quickly responded to. One recorded complaint was around a person's needs in this area being ignored by staff. Action to address this had been taken following this complaint.

We found care staff carried out their work in a task driven way, moving from one task to another with little time to spend with people in-between. There was however an activities co-ordinator who provided people with opportunities for conversation, social activities and going out. This was provided in one to one sessions or in small groups. The activities co-ordinator had worked hard to improve people's quality of life through meaningful and enjoyable activities. We saw two people being taken out for some fresh air on one day of the inspection. A small group of people also enjoyed some cooking. One other member of staff had organised a cooking session where pancakes had been cooked. They told us people had really enjoyed taking part and they had enjoyed organising it. Staff told us not all of the staff understood the value of the activities and this sometimes caused friction between the staff. Staff told us a strong leader was needed to further support and promote meaningful activities.

Requires improvement

Is the service responsive?

The complaints procedure was in reception for guidance. One person told us they would be able to speak to a specific member of staff if they had a complaint. Another person said, “I have had no complaints yet but I would speak with (member of staff’s name) if I had any”.

Complaints were recorded electronically. There were four complaints recorded from 2014 and 2015. There was evidence of a robust and appropriate response with actions taken and improvements made as a result.

Requires improvement

Is the service well-led?

Our findings

The home had a manager registered with the Care Quality Commission however, they had recently resigned following a period of absence. There was also no deputy manager in post. A new manager had been appointed and was due to start in September 2015. The provider was currently recruiting for a deputy manager. Until the new manager started, the day to day management of the home was being supported by regular contact and visits from the provider's peripatetic manager and managers from another home run by the provider. The peripatetic manager confirmed that once the new manager had started, she would be responsible for their induction. She would also be in place to support them as the deputy manager until this position was filled.

On-going communication and contact between the provider and the home was also maintained through regular visits from the regional senior management team.

There were mixed views from staff about the culture, leadership and the support they had received to do their jobs. Some staff told us they had had limited contact with the current registered manager and that they felt demotivated from the lack of teamwork. One member of staff said, "I don't know who I would go to if I had a concern". Others said they were happy with the level of support they had received. Some newer staff expressed feeling uncomfortable about giving feedback or ideas for improvements; stating they didn't feel listened to or part of the team. However, newer staff did have more structured support and confirmed that they had received recent one to one supervision.

Staff felt one of the key challenges the home faced was the ability to provide personalised care when people's needs were often complex and required intensive support. A member of staff said, "We need to work out how best to do this, each person deserves care that is person centred". Some staff felt better team work and a more flexible approach to the way care was given would help. It was evident that there had been a lack of leadership.

There was some evidence that staff could and did contribute to the improvement of the service. For example, a member of staff said she had expressed concerns about the abilities of some staff in their moving and handling techniques. This was fed back to the care leaders who put actions in place to improve staff competency in this area. Staff meetings did take place although staff told us they were not as frequent as they would like.

There were quality assurance audits in place however, some of these processes lacked a robust way to evidence the achievement of compliance. Therefore the effectiveness of the audit process itself was limited. For example, a sample of care plans were audited on a monthly basis, these outlined compliance in key areas and produced action plans for improvements; however, there was no indication if or how these actions had been completed. An infection control audit undertaken in May 2015 again identified actions for improvements, but there was a lack of recorded evidence of completion. Finally a pharmacy audit undertaken in February 2015 gave no indication that the necessary actions had been completed satisfactorily. For example, there was an action that a protocol was needed for the administration of covert medicines. Whilst a protocol was seen as part of the inspection there was no indication on the audit itself around who was responsible for the action and when it had been done.

Quality monitoring was also carried out by a representative of the regional senior management team. These were a programme of unannounced visits, sometimes outside of normal visit times, such as night time. A monthly management report was produced which showed progress made against improvements identified.

The accidents and incidents were audited by the provider's representatives to ensure appropriate agencies had been informed. An incident involving a person being hit had been reported to the local authority's safeguarding team by the registered manager. However, because of the way it had been recorded, the Care Quality Commission (CQC) had not been notified of the incident. This omission is unusual for this provider and one of the provider's representatives told us they would adjust their auditing to ensure accidents and incidents were being logged correctly at Westbury Court. The representative also confirmed that accidents and incidents within Westbury Court would be audited more thoroughly, in the absence of the registered manager, to ensure appropriate actions were taken following these.

Requires improvement

Is the service well-led?

People and relatives did say that they would feel comfortable making known any concerns or worries they may have. They were all aware of the current management situation but said that they knew who to speak with in the team if needed.

The provider valued people's feedback. Regular resident meetings were held. These meetings included people's relatives or people that were important to them. Minutes of the most recent meeting evidenced that feedback was listened to and changes made as a result. For example, some people had expressed an interest in a regular 'knitting and nattering' session and this was taken on board and offered every Thursday. Another person told us about her feedback during one of these meetings where she said she didn't think there was enough fruit around the home. She confirmed that more fruit was then made available as a result.

People were also able to express their views through satisfaction surveys. The survey could be completed electronically, handed in to staff or sent in by post. The peripatetic manager informed us that the information from the survey was collated centrally and the results shared with the home every three months. This was a new process and therefore no results were available at the time of this inspection. The last resident survey seen was completed in June 2014 where the home was rated by people as good or excellent in most areas.

People's care records were kept secure and records relating to the running of the service were generally maintained. The service's registration certificate was on display as was the current employer's liability insurance certificate.

We recommend that the service seek support and training for the management team about motivation and team building.

We recommend that the service seek advice and guidance from a reputable source about the development of more robust quality assurance processes.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Not all that was reasonable and practicable had been carried out to protect service users from risks. Regulation 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not received appropriate support, training, professional development, supervision and appraisal needed to enable them to deliver service users' care safely and appropriately. Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care was delivered without service users' consent. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care delivered to service users was not always appropriate and did not reflect their preferences. People were not always given appropriate information to help them make choices. Regulation 9 (1) (3) (b) and (g)