

Mark Jonathan Gilbert and Luke William Gilbert

Westcliffe Manor

Inspection report

21 Westcliffe Road
Southport
Merseyside
PR8 2BL

Tel: 01704562630
Website: www.dovehavencarehomes.co.uk

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Ratings

Overall rating for this service

Requires Improvement ●

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

Summary of findings

Overall summary

This unannounced inspection of Westcliffe Manor took place on 2 November 2016.

Westcliffe Manor provides accommodation for people who require nursing care. This may be on a permanent basis or for respite. Westcliffe Manor is situated in a quiet residential area of Southport with good transport links to the town centre, the sea front and other local amenities. The accommodation comprises of twenty seven single rooms and three double rooms. Bedrooms are situated on three floors with lift access. There are gardens to the rear of the property and parking at the front.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we found breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 relating to care planning and the service's governance arrangements.

We looked at people's care documents. We found people's care planning lacked sufficient detail to help ensure their care needs were being effectively recorded, monitored and evaluated. Clinical monitoring records were not always completed which meant that an accurate evaluation of care needs could not be made.

The organisation had systems in place to monitor the safety and quality of the service. Systems included audits (checks) on how the service operated. We found on inspection that the provider did not always ensure effective systems and processes were in place to consistently assess, monitor and improve the safety and quality of the service. This was because the shortfalls we identified on inspection for of care planning and around the management of medicines given 'when required' (PRN) and management of people who wish to administer their own medicines had not been picked up by the current auditing arrangements.

We found medicines were safely administered to people and people told us they received their medicines on time. We found some inconsistencies of practice to support people with PRN medicines and for people who wished to administer their own medicines. The registered manager took swift action to rectify this.

People said they felt safe living at the home and were supported in a safe way by staff.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. An adult safeguarding policy and the local authority's safeguarding procedure was available for staff to access.

Staff sought people's consent before providing support or care. The home adhered to the principles of the

Mental Capacity Act (2005). Applications to deprive people of their liberty under the Mental Capacity Act (2005) had been submitted to the local authority.

Staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults.

Staff told us they felt appropriately trained and supported. Training records showed a programme of on-going training, supervision and appraisal.

People living at the home and staff told us that there were sufficient numbers of staff employed. The registered manager informed us that staffing was based on people's dependencies and subject to review as required. The staffing rotas showed a consistent staff team.

Risks to people's health and wellbeing had been assessed in accordance with people's needs.

Staff worked well with health and social care professionals to make sure people received the care and support they needed. Staff made referrals to healthcare professionals for advice and support at the appropriate time.

People's individual needs and preferences were known and respected by staff. People told us staff were kind, caring and respectful in their approach. We observed positive interaction between the staff and people they supported.

A varied social programme was available to people living at the home. People told us how much they enjoyed the trips out.

We received very good feedback from people living at the home regarding the meals; this included presentation, choice and quality of foods served. People told us the dining room experience was 'first rate'. People were offered a very good menu selection and enjoyed a glass of wine before lunch. People's nutritional needs and diets were catered for.

People we spoke with and their relatives told us that staff had the skills and approach needed to ensure people were receiving the care and support they needed. People told us they were invited to give feedback about the home through meetings and daily discussions with the staff.

A complaints procedure was available and people living at the home and relatives were aware of how to raise a concern in the home.

There was a maintenance programme and arrangements in place for checking the environment was safe. Health and safety audits were completed.

The home was decorated to a high standard. The communal areas provided plenty of comfortable seating and both the dining area and lounge were spacious to accommodate wheelchairs and hoists for moving people from one area to another.

The culture within the service was open and transparent. Staff and people living at the home were complimentary regarding the overall management and leadership. They said the home was 'well run' and the registered manager approachable.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it.

The registered manager was aware of their responsibility to notify us Care Quality Commission (CQC) of any notifiable incidents in the home.

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?

Good 

The service was safe.

Medicines were managed safely in the home. People told us they received their medicines on time.

Risk assessments had been undertaken to support people safely and in accordance with individual need.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

Safety checks of the environment and equipment were completed.

During the inspection there were enough staff on duty to provide care and support to people living in the home.

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Requires Improvement 

The service was not always effective.

Care plans did not always provide information to inform staff about people's support needs. This placed people at risk of receiving unsafe care.

Staff worked well with health and social care professionals to make sure people received the care and support they needed.

Staff were trained to ensure that they had the appropriate skills and knowledge to meet people's needs.

People told us the staff had a good understanding of their care needs.

Staff sought the consent of people before providing care and support. The home followed the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to

make their own decisions.

People told us they liked the food and were able to choose what they wanted to eat from a varied menu.

Is the service caring?

Good ●

The service was caring.

People's individual needs and preferences were respected by staff.

People at the home told us they were listened to and their views taken into account when deciding how to spend their day.

People told us staff were kind, caring and respectful in their approach. We observed positive interaction between the staff and people they supported.

Is the service responsive?

Good ●

The service was responsive.

A varied programme of recreational activities was available for people living at the home to participate in.

The staff that we spoke with demonstrated that they knew people in sufficient detail to identify their preferences and choices. People and relatives told us they were consulted around day to day decisions and their care.

A process for managing complaints was in place. People we spoke with knew how to raise a concern or make a complaint.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

Systems and processes were not always effective to consistently assess, monitor and improve the safety and quality of the service.

The service had a registered manager. Feedback from people, relatives and staff was complimentary regarding the registered manager's leadership and management of the home.

Staff told us there was an open and transparent culture in the home. Staff were aware of the whistle blowing policy and said they would not hesitate to use it.

People living in the home told us they were able to share their views and were able to provide feedback about the service.

Westcliffe Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of two adult social care inspectors.

Before our inspection we reviewed the information we held about the home. This included the Provider Information Return (PIR). A PIR 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 also looked at the notifications and other intelligence the Care Quality Commission had received about the home. We contacted the commissioners of the service to see if they had any updates about the home.

During the inspection we spoke with five people who were living at the home. We also spoke with four relatives and a total of seven staff, including a regional manager, the registered manager, nurses, care staff and ancillary staff. Following the inspection we contacted a health care professional to obtain their views about the service.

We looked at the care records for four people living at the home, three staff personnel files and records relevant to the quality monitoring of the service. We looked round the home, including people's bedrooms, the kitchen, bathrooms, dining area and lounge.

Is the service safe?

Our findings

We asked people what made them feel safe in the home. They told us, "There's staff looking after you", "The staff here are great. They (staff) do everything they can to help me", "There's always people around to help me". "I ring for help if I need something and the staff come really quickly". A relative said, "The staff always ensure my (family member's) safety." We made observations of people living at the home and they appeared relaxed and at ease in the company of the staff.

We looked at how staff were recruited and the processes undertaken to ensure staff were suitable to work with vulnerable people. We checked three staff files to evidence this. We found copies of appropriate applications and references and saw evidence that checks had been made to ensure staff were entitled to work in the UK and police checks that had been carried out. We found they had all received a clear Disclosure and Barring (DBS) check. This meant that staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults.

There were 23 people living in the home at the time of our inspection. There was the registered manager, a registered nurse and four other care staff on duty. There were ancillary staff such as, a chef, kitchen assistant/waitress, domestic and laundry cover. We saw that extra care staff were provided when needed, for example between 5pm and 10 pm to assist people with their meal and with personal care. The registered manager told us that agency staff were used for cover for trained staff, only for annual leave cover. They said there was very little absence from care staff and any additional cover was provided from the existing staff team. We looked at the staff rotas from September 2016 to October 2016 and found this to be the case. People's dependency assessments helped to assess the levels of staff needed and this was subject to review by the registered manager. They told us extra staff would be brought in to support people should more staff be needed.

We observed staff attending to people and supporting them with meals and drinks. People we spoke with said staff supported them well with their personal care needs and there was always staff about.

The care records we looked at showed that a range of risk assessments had been completed to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails. These assessments were reviewed each month to help ensure any change in people's needs was assessed to allow appropriate measures to be put in place.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training and this was ongoing. All of the staff we spoke with were clear about the need to report through any concerns they had. A recent safeguarding incident at Westcliffe Manor had been reported to the local authority in accordance with the agreed protocol. We the CQC (Care Quality Commission) had also been informed.

Arrangements were in place for checking the environment to ensure it was safe. Health and safety audits

were completed on a regular basis. Examples of these were for the nurse call, water temperatures, safety checks for mattresses and window restrictors. Fire checks were carried out each week to help ensure doors, fire alarms, emergency lighting and firefighting equipment were in good working order. Wheelchairs, hoists and slings were checked each month to ensure they were working correctly. The home had a process in place to attend to repairs, to keep people who lived in the home safe and ensure the home was in a good condition. Any repairs that were discovered were reported to the maintenance person employed by the provider. We saw the general environment was safe.

A 'fire risk assessment' had been carried out. We saw personal emergency evacuation plans (PEEPs) were completed for the people resident in the home to help ensure effective evacuation of the home in case of an emergency. Copies of people's PEEPs were available in their bedrooms, the office and in a 'grab bag' kept at the front door. This made the information readily available for staff and the fire service when evacuating the building in an emergency.

We checked safety certificates for electrical safety, gas safety, legionella and kitchen hygiene and these were up to date. This showed good attention with regards to ensuring safety standards in the home.

We found the home to be clean and tidy. We visited people's bedrooms and communal living areas and bathrooms. Bathrooms and toilets were very clean and contained hand washing and drying materials. The providers employed domestic staff, who worked each day. Feedback about the cleanliness of the home was very positive from people and their relatives. Domestic staff completed cleaning checklists which showed the work they had carried out. We saw that these showed the house was cleaned throughout on a regularly basis. One staff told us that on Monday and Fridays 'deep cleans' were completed on bedrooms and communal living areas.

During this inspection, we looked to see if there were systems in place to ensure the proper and safe handling of medicines. We saw medicines were administered safely to people.

A medication policy was in place though this contained wording that was not appropriate to support staff with the safe management of medicines in a care home. We brought this to the attention of an area manager and a new medicine policy was put in place during our inspection. Staff who administered medicines had received medicine training and had undergone a competency assessment in March 2016 to ensure had the skills and knowledge to administer medicines safely to people.

We found medicines to be stored safely when not in use. Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. The temperature of the drug fridge was recorded daily. This helped to ensure the medicines stored in this fridge were safe to use.

Controlled drugs were stored appropriately and we saw records that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. We saw that a handwritten entry by a staff member for a controlled drug. This had not been countersigned by another member of staff to ensure accuracy of the record. We brought this to a member of staff's attention and they advised us they would action this.

People had a plan of care which set out their support needs for their medicines. We checked seven medicine administration records (MARs) and found staff had signed to say they had administered the medicines. We found records were clear and we were easily able to track whether people had had their medicines; this included the application for topical preparations (creams) which were applied appropriately.

We checked a number of medicines, including a controlled medicine and found the stock balances to be correct. People told us they received their medicines on time.

During the inspection we saw inconsistencies around supporting people who wished to self-administer their medicines. For a person who was administering eye drops there was a risk assessment in place to support them. For another person who was receiving respite care there was a lack of clarity around the medicines they were self-administering. We were told they were administering a painkiller but when staff discussed with the person concerned this was not the case, they were administering a topical cream 'when needed' as they did not need any painkillers. This had not been risk assessed by the staff or recorded on the person's MAR. The person concerned was however able to undertake this practice safely and staff took appropriate actions during the inspection to risk assess this.

With regard to the administration of 'as required' (PRN) medicines there was a lack of information to support staff when administering medicines such as Paracetamol. We did not however see any evidence of people not receiving their PRN medicines in safe way. Following the inspection the registered manager confirmed with us that PRN protocols were in place for people who were prescribed PRN medicines. These protocols describe when and how staff should administer PRN medicines.

Is the service effective?

Our findings

People had a plan of care to identify care needs. A nursing care plan provides direction on the type of care an individual may need following their needs assessment. Care planning is important to ensure people get the care they need when they are at care home. Care plans covered areas such as, mobility, personal hygiene, falls prevention, diet and nutrition, privacy and dignity, constipation, personal hygiene, skin care, social care and care plans for medical conditions that require clinical intervention. For example, an indwelling catheter, pressure ulcer, or tube for enteral feeding. Enteral feeding refers to the delivery of a nutritionally balanced feed via a percutaneous endoscopic gastrostomy tube (PEG). The PEG is passed into a patient's stomach to provide a means of feeding when their oral intake is not adequate. We found care plans provided varying amounts of information about people's care needs.

Some care plans we saw described people's care though these were not always consistent or inclusive of all care needs. There was a risk therefore that the staff did not always have the information they needed to provide care and support to people in accordance with their individual need. Clinical care monitoring records were not always completed, which meant that an accurate evaluation of a person's health could not always be made.

For one person with a catheter, the plan of care lacked detail for catheter care. We saw the person required regular medical intervention for the catheter due to their condition but did not have a clinical care chart so that staff could record the person's urinary output. This is to ensure the urinary catheter is draining satisfactorily and for this person it was important as their catheter needed to be carefully monitored. We saw that there were no concerns with the catheter at this time. We reviewed a plan of care for a person who had a PEG feed. The requirement to rotate the PEG tube was not recorded on the person's plan of care. The person's care monitoring chart had a column for staff to sign when the PEG tube had been rotated. The care monitoring chart did not however consistently record the daily rotation of the PEG which is needed to decrease pressure on the skin and lessen the risk of infection. Staff advised us this was carried out daily as part of the person's PEG regime though appreciated there was a lack of evidence to support this health requirement. There were no concerns with the person's PEG tube at this time.

This is a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was information recorded around supporting people with restricted mobility and who were prone to developing sore skin due to pressure. This included the use of moving and handling equipment and pressure relieving aids such as, cushions and specialist mattresses. A person confirmed with us that the staff used the correct equipment to support them.

People told us they were happy with the standard of care and support they received and that staff were knowledgeable regarding their individual needs. People also spoke highly of the meals; this included presentation, choice and quality of foods served. People told us the dining room experience was 'first rate'.

People living at the home told us they received support to maintain their health and they could see a doctor when they wanted. A relative said, "The doctor is always called if needed." We saw people's care documents contained information about people's medical conditions, health care and medicines. We also saw people had access to a range of health care professionals, including GP, dietician, chiropody service and SALT (speech and language therapy) team. Appointments were arranged at the care home or within the community. Appointments were made with the involvement of the person and people told us staff accompanied them. A health care professional told us the staff arranged appointments at the appropriate time and the staff provided a good standard of care.

Throughout the day staff checked on people's wellbeing and comfort. Staff demonstrated knowledge of people's personal care, health and social needs and how they liked to be supported in order to meet their personal care and health needs. For people who needed support with communication staff were patient in their approach; they had a good awareness of non-verbal communication such as expressions, and posture. Care files showed evidence of communication with people and their families around care needs. A relative told us the communication was 'first class' and went to say, "If they (staff) are at all worried or (family member) needs a doctor, they let me know."

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). We found that the provider had followed the requirements in the DoLS and had submitted applications to the relevant supervisory body for authority to do so. We saw the applications for four people and saw the applications had been made appropriately with the rationale described.

We looked to see if the home was working within the principles of the Mental Capacity Act, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found requirements were being met and people who lacked capacity to make certain decisions were assessed appropriately. The example from the inspection was for a person who was at risk from falling out of bed. The person had been assessed as requiring bedrails to help ensure their safety. We saw the assessment had taken into account the issue of consent and the standard two stage mental capacity assessment had been used as part of the process evidencing good practice. We saw that the use of bedrails had been made in the person's best interest and had discussed this with the family member. The restrictive practice was endorsed by the DoLS Best Interest Assessor (BIA), in their report. A BIA is an independent assessor employed by the local authority.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) plans were in place for a number of people. These were completed appropriately following consultation with relevant parties.

We looked at the training and support in place for staff. Staff we spoke with told us they enjoyed their job. They said they felt supported to do their job and 'equipped' through relevant training courses they had attended. Staff said, "The 'manager is very supportive" and "We get good training and support from the manager and senior managers within the group."

The registered manager told us about the Dovehaven training academy which will provide bespoke accredited training for staff at the care home. They informed us a trainer had been allocated for their service. Records seen showed staff had completed training in 'mandatory' subjects such as health and safety, safeguarding of vulnerable adults, infection control, mental capacity act and deprivation of liberty safeguards, food hygiene, dementia care, diet and nutrition, person centred care and fire safety.

We saw that most of the care and ancillary staff had completed a recognised care qualification at level two or three through the Qualification and Credit Framework (QCF). The Qualifications and Credit Framework (QCF) is a new credit transfer system which has replaced the National Qualification Framework (NQF). It recognises qualifications and units by awarding credits.

Staff we spoke with told us they received induction, an appraisal and regular support through supervision. We looked at three staff personnel files. We saw that staff had received an appraisal in 2016 and had received regular supervision throughout the year. Supervisions are regular meetings between an employee and their manager to discuss any issues that may affect the staff member; this may include a discussion of on-going training needs.

The PIR told us about the staff induction and we reviewed this at the inspection. Most staff had completed the provider's own induction, as they had commenced work prior to the introduction of the 'Care Certificate' in 2015, which providers are now expected to use with new staff. Newly appointed care staff had not begun the 'Care Certificate'. The registered manager told us they were to meet with their training organisation in a few days to discuss the relevant staff completing the induction. The 'Care Certificate' is the government's recommended blue print for staff induction.

With regards to provision of meals, people appeared to receive adequate food and drinks throughout the day. Hot and cold drinks and biscuits were readily available, as people had free access to these amenities in the lounge. Staff also brought round plenty of hot and cold drinks and snacks mid-morning and afternoon. We saw a large bowl of fresh fruit was available and staff asked people if they would like them to prepare the fruit for them.

We saw that menus had been devised with the input of the people living at Westcliffe Manor. We saw that people's requests for different meals, for example Chinese food and pasta, had been accommodated. People were given a choice of a hot meat or fish meal at lunchtime, with a dessert. In the evening there was soup and a hot smaller meal and a dessert. For breakfast there was a varied choice, from cereals and fruit juice to a full English breakfast.

We spoke with the chef who was knowledgeable regarding any special diets people required. We were told that the menu was reviewed each week and meetings were held each week between the registered manager and the chef to discuss requirements. The chef met with people in the home each day after lunch for feedback regarding the meals; people told us they had regular contact with him and appreciated the 'work' that went into providing such nice meals.

The home was decorated to a high standard. The communal areas provided plenty of comfortable armchairs and both the dining area and lounge were spacious to accommodate wheelchairs and hoists for moving people from one area to another. The hoists were moved from these areas after use so as not to detract from the 'homely' feel which staff promoted. A small computer room was available and also a hairdressing salon on the first floor.

Is the service caring?

Our findings

We asked people living at the care home if they thought staff were kind, caring and treated them with respect. People's comments included, "The staff are lovely, very polite", "I find everyone so kind and helpful, they are kind here" and "If you ask for anything they really try hard to accommodate your wish." People said they were listened to and their views taken into account when deciding how to spend their day. One person said they liked to have their lunch in their room however the staff checked each day to see if they would prefer to come down stairs.

We saw staff being respectful in their approach, taking time to listen to people and respond appropriately. Staff used people's preferred term of address and when talking with people or supporting them with meals. Staff sat next to people at the correct height to maintain eye contact. When a person was anxious they provided a reassuring hug and there was plenty of laughter and chatter between everyone.

Staff told us that people's needs were discussed at daily handovers and these along with the care records provided them with the information they needed to look after people. Staff spoke warmly about people and it was evident from discussions that they knew people well and had a good understanding of how to respect people's rights and choices.

We saw that people and/or their relatives were involved with their plan of care and any decisions around health matters. A relative told us they had been fully involved from the initial assessment of their family member's care.

Relatives told us they visited at any time and were welcomed by the staff. We saw staff warmly welcoming visitors and light refreshments were offered. Relatives also had access to tea and coffee making facilities in the lounge and a family member was having lunch with their relative. They told us how much they enjoyed this event.

For people who had no family or friends to represent them, local advocacy service details were available and placed on display during the inspection for people to access. The registered manager was aware of how to contact the agency if support was needed.

People told us the dining room experience was very good. The dining room tables were attractively laid for lunch and people were offered a red or white wine or a choice of cold drink prior to lunch being served. Waitress service was provided over lunch. Quiet music was played in the background and lunch was a very sociable occasion with plenty of chatter between people and the staff. A person commented on the 'lovely relaxing atmosphere' over lunch. Special occasions were celebrated and for Halloween 'spooky food' was served as part of the festivities. The registered manager said they had plenty of celebrations, "Any excuse for a party".

End of life care relates to the care provided for a patient anywhere within the last year of life, up to and including death. We saw an example of an individual plan of care of those thought likely to be dying and

information about how to support people who were receiving end of life care was recorded. Staff liaised with external health professionals to provide the support people needed at this time. We spoke with a person whose relative was being supported to receive end of life care. They said, "The care has been very good, we have been kept informed of all the decisions." Staff had a good understanding of how to manage, respect and follow people's choices for end of life care as their needs change. The PIR informed us that staff were attending a recognised course in end of life care. This we discussed on inspection and the registered manager said once the training was completed, a staff member would take the lead for overseeing palliative and end of life care.

Is the service responsive?

Our findings

The PIR recorded, 'activities are meaningful and life history work is undertaken so service users can be supported to remain in contact with people and activities to reduce the risk of isolation'. People had a personal care book; these contained varying amounts of detail. The purpose of these books was for staff to get to know people, for example, preferred routine, social interests and family background. We also saw some examples of how people's preferences were recorded in a plan of care. A person confirmed that staff followed their preference around positioning in bed and always checked to ensure their comfort. Details around this were recorded for staff to follow. We saw other examples of staff responding to people's preferred routine during our inspection.

Care records held information about how people would like their care given and assessments of people's needs, including specific assessments of areas such as health and mobility. We saw that care documents were subject to review; the reviews varied in detail though they provided an over view of the care given over a period of time. Named nurses were appointed and they were responsible for overseeing people's care and conducting care reviews. The staff that we spoke with demonstrated that they knew people in sufficient detail to identify their preferences and choices. People and relatives told us they were consulted around day to day decisions and their care. A person said, "The staff would not go ahead and do something without checking first."

People told us they were able to make choices. They said they could choose what meals they had, how they spent their time and when and when they got up in the morning or retired at night. The chef told us many people chose to have breakfast in their bedrooms and this wish was respected by the staff. People in the home made their meal choices each morning and a record was kept. The chef told us there was flexibility for people to have something not on the menu. This we saw during the inspection.

People informed us the staff 'went out of their way' to celebrate events such as, birthdays, Christmas and Halloween. The registered manager told us about an American themed buffet to celebrate 4 July, and a recent trip to Blackpool to see the lights and have fish and chips. People told us they really enjoyed this event. The Dovehaven group of homes had a minibus which was utilised for trips and this had included a visit to a local garden centre for coffee and cake. A person told us the outings were really good and, 'staff make sure everything runs smoothly'. There was no dedicated activities organiser however the 'handy person' visited two afternoons a week to offer a range of social activities 'in house'.

At the time of our visit people received the support they needed in a timely manner. When the call bell was activated staff responded promptly so that people received support when they needed it. A relative told us the staff were responsive and that their family member was not left waiting. One person told us, "Staff are excellent, they are there when you need them. I never have to wait long when I press the buzzer."

People living at the home that we spoke with were aware of how to make a complaint. Relatives told us they would speak with the registered manager if they had a concern and that they confidence in how their concern would be looked into. A copy of the complaints procedure was available in people's rooms. The

registered manager told us that usually there was a copy of the complaints policy in the main hall way however this was not displayed. This was rectified at the inspection. We reviewed a complaint received and appropriate actions had been taken in a timely manner.

People using the service and their relatives were encouraged to provide feedback to the organisation through informal and formal routes. This included the provision of surveys. We saw a food survey which had been sent out to people in August 2016; 22 people completed this survey and 100% rated the food as good/very good. Requests for snacks and different foods has since been implemented. Satisfaction surveys completed earlier this year reported favourably regarding the service and the standard of care. People's comments included, "I feel very safe", "Visitors always made to feel welcome" and "All the staff are very good." The results from the surveys were displayed along with actions taken to inform people living at the home.

Is the service well-led?

Our findings

We looked at the quality assurance systems and processes to monitor how the service was operating and to drive forward improvements. A range of audits and checks were undertaken to help assure the service; these were completed by the registered manager and regional manager. Areas included medicines, infection control, incidents, kitchen standards, thickening agents in drinks (used for people who may have difficulty swallowing), nutrition, care file audits, equipment and environment checks.

We found on inspection that the provider did not always ensure effective systems and processes were in place to consistently assess, monitor and improve the safety and quality of the service. This was because the shortfalls we identified on inspection for care planning and medicine practices had not been picked up by the current auditing arrangements.

This was a breach of Regulation 17(1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities

A registered manager was in post and available to support the inspection process. The PIR recorded, that the service tries to deliver, 'a well led service giving all service users individualised care as well as operating an open door policy listening to all service users and their families/significant others'. Feedback from staff, people who lived at the home and relatives was positive regarding the management and leadership of the home. They spoke well of the registered manager and said they were approachable. Relatives commented on the good communication that existed in the home. A relative who were visiting the home (following a stay by their family member) spoke highly of the care and attention their family member had received. A person living at the home said, "The home is well run, we see the matron (registered manager) each day."

The manager responded positively to our feedback and following our inspection advised us of the actions they had or were in the process of taking to improve care planning and evaluation, the management of PRN medicines and management of people who wished to administer their own medicines.

Talking with the registered manager and staff demonstrated a focus on maximising people's quality of life and treating people with respect. The registered manager told us they appreciated that 'nothing is as good as being in your own home but that the ethos of the service was to try and make Westcliffe Manor, 'the next best thing'. A person told us that the staff tried in all ways to make everyone feel at home. Likewise a person who completed a satisfaction survey said the staff provided, "First class attention."

There was a management structure in place. The registered manager was supported by a deputy manager, a regional manager and the provider. We saw the registered manager talking with people throughout the day and checking to make sure they were being cared for appropriately.

The registered manager informed us that on a three monthly basis they met with other managers within the Dovehaven group of homes to discuss the services they manage and to share ways of improving the service and areas of good practice.

The PIR recorded that, 'staff are actively encouraged to bring concerns suggestions and ideas for future development to the fore for general discussion'. Staff told us staff meetings took place and that they felt involved and supported in their job role. They said communication was good and everyone worked well as a team. Staff we spoke with enthusiasm about the people they supported and their job roles. Staff said they were aware of the whistle blowing process and would not hesitate to report any concerns or poor practice. We saw that an open and transparent culture was promoted within the home.

At provider level a 'mum's test' was carried out to help evaluate the service provision to provide assurance that the service 'was suitable for your relative'. This review included talking with people at the home and checking the standard and appearance of the environment. Comments received were positive.

As part of monitoring infection control, an external infection audit by a local community health team had been completed and the home in 2015 and the service achieved 92.62% overall for infection control standards. Infection control leads were appointed in the home to help monitor the control of infection.

Various approaches were in place to seek feedback about the service. This included satisfaction surveys and meetings with people living at the home and relatives on an informal and formal basis. a residents' meeting has been planned to discuss the forthcoming Christmas festivities. The registered manager told us about the actions they had taken in response to surveys around the provision of more choice of meals and social activities.

The registered manager was aware of their responsibility to notify the Care Quality Commission (CQC) of any notifiable incidents in the home. Our records confirmed this.

Staff had access to a number of policies and procedures around safe working and following best practice.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People's care planning lacked sufficient detail to help ensure their health and care needs were being met. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The service's governance arrangements were not always effective to consistently assess, monitor and improve the safety and quality of the service. Regulation 17 (1) (2) (a) (b)