Hampshire County Council

Westholme Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 21 and 26 November 2018

Westholme 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 provides nursing and personal care for up to 74 people, including people living with dementia. The home is located on the outskirts of Winchester town centre and is arranged into three units; residential, nursing and discharge to assessment. Each unit has communal areas, including dining rooms and lounges.

The discharge to assessment unit can accommodate 10 people who require a period of care and treatment on leaving hospital before moving back home or into another supported living setting. At the time of our inspection there were 69 people living in the home.

There was a registered manager in post who had overseen the management of the whole service for many years. 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 service had an open and friendly feel. People commented positively on the home and the care received.

The provider and registered manager had taken action to make improvements identified at the last inspection, ensuring the service provided to people was compliant with the Mental Capacity Act 2005 (MCA).

People were treated with kindness, respect and compassion. Staff respected people's privacy and promoted their dignity. People and relatives we spoke with told us staff were kind and caring. There were many positive interactions observed with staff showing compassion and understanding when supporting people.

Care staff and managers knew and cared about people who used the service.

Relatives and friends could visit whenever they and the person liked, although the service promoted a 'protected lunchtime' to enable people to concentrate on their main meal.

People and, where appropriate, their relatives were involved in regular care planning reviews.

Wherever possible, staff promoted people's independence.

Staff were attentive, noticing when people looked uncomfortable or upset. They were quick but discreet in

offering the care and support needed.

People received care and treatment that met their individual needs. Care was planned and delivered based on people's individually assessed needs and preferences. Assessments and care plans were reviewed and updated regularly, with the involvement of people and their relatives.

People were supported to eat and drink enough to maintain a balanced diet. They had a choice of meals and drinks. Special dietary needs and preferences were catered for. Where people needed assistance to eat or drink, staff helped them attentively and with sensitivity.

People's risk of malnutrition was monitored regularly. People were weighed at least monthly, or more frequently if there was concern about weight loss. Prompt action was taken to address weight loss.

People had access to healthcare services and were supported to manage their health.

People had access to activities that made their individual needs and helped them maintain community links.

Staff worked with GPs and district nurses to provide the support people needed at the end of their life, for example ensuring that strong pain-relieving medicines were in place.

People and staff told us there were enough staff to provide the care and support they needed.

Medicines were managed safely and people were administered the medicines prescribed by their GP. Medicines were stored securely.

Recruitment systems were robust and helped ensure only suitable staff were recruited.

Staff had the knowledge and skills needed to carry out their roles. They had access to the training they needed.

Information about people's individual risks was comprehensive and up to date.

People were protected from abuse and neglect. Staff understood their responsibilities in relation to safeguarding adults. They knew how to raise concerns about poor practice.

People's rights were protected because staff worked in accordance with the Mental Capacity Act 2005.

People were protected from the risks of cross infections.

The premises and equipment were kept clean and in good order. There was a team of maintenance staff and a regular maintenance programme.

There was a system for bringing about learning and improvement following accidents and incidents.

Complaints and concerns were taken seriously and used to improve the quality of care.

Quality assurance processes were in place to monitor the service's performance and drive improvement. There was a programme of monthly audits within the service, with additional snapshot audits by the service

manager who visited the service at least every four to six weeks to do quality/governance. The service manager also visited the service regularly to support the registered manager.

The service worked openly and cooperatively with other organisations to ensure people were safe and received the care and support they needed.

People's and relatives' ideas and wishes were actively sought for activities and there were periodic surveys carried out to seek improvement.

The inspection rating from the last inspection was clearly displayed on both sides of the building and on the provider's website.

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.

People were safeguarded from the risk of abuse. Staff had completed relevant training and understood their roles and responsibilities in relation to protecting people from the risk of harm.

Risks to people had been identified and actions were taken to ensure their safety. Plans were in place to ensure people received safe and appropriate care in an emergency.

People were supported by sufficient and suitably skilled staff to meet their needs safely.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

The provider had made improvements so that care delivery was in line with the MCA (2005).

Staff received good training and supervision of their work.

People enjoyed a varied and nutritious diet which reflected their preferences and dietary needs. People at risk of poor nutrition were supported and monitored to prevent risks to their health and wellbeing.

People were supported by staff to access health care services as required and their healthcare needs were met appropriately.

Is the service caring?

Good

The service was caring.

People were cared for by kind and compassionate staff who knew them well.

People were given choices and made decisions about their care

and these were respected by staff.

People's privacy and dignity were respected by staff.

Is the service responsive?

Good

The service was responsive.

People's care and treatment plans were person centred and reflected their preferences and decisions.

People's activity and social needs were met through a range of group based and individual activities provided by a team of activity coordinators, staff and volunteers.

A system was in place for people to raise their complaints and concerns and these were acted on.

People were supported to make decisions about their preferences for end of life care and these were respected by staff. People received the support they needed.

Is the service well-led?

Good

The service was well-led.

The registered manager and provider had clear expectations of high standards that was communicated with staff. Staff were supported to understand their responsibilities and to be accountable for their actions to provide a good quality service for the people.

There were processes in place to enable the provider and registered manager to monitor and audit the service and make improvements. Information from incident reviews, people, their relatives and staff was used to drive continuous improvement to the service.

There was a positive open and inclusive culture in the home. People, their relatives and staff spoke positively about the management and leadership of the service.

Westholme Care Home

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 was unannounced and took place on 21 and 26 November 2018. On the first day, the inspection team comprised two inspectors and a specialist nurse advisor. On the second day the inspection was concluded by the lead inspector.

Before the inspection we reviewed information we held about the service. This included statutory notifications of significant events such as safeguarding adults investigations, and a 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 obtained feedback from two local authority commissioning and safeguarding adults staff and a health professional who knew of or had contact with the service.

During the inspection we met the majority of people who received a service and spoke with 12 people in more depth about their experience of living at the home. Because some people were living with dementia and could not tell us about their experiences, 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 also made general observations of interactions between staff and people whilst carrying out the inspection. We spoke with, six relatives who were visiting the service at the time of the inspection. We also spoke with 10 members of staff, including healthcare assistants, nursing staff, an activities coordinator and staff who worked in the discharge to assessment unit. The registered manager and also the service manager.

We reviewed six people's care records in depth as well as samples from other care plans, medicines administration records for two units, and records relating to how the service was managed. These included

five staff recruitment files, maintenance records, incident reports, training records and audits.

Good

Is the service safe?

Our findings

No one expressed any concerns about their safety with people and their relatives very satisfied with the service provided. A relative told us, "I have been so pleased with what they have done; I have had no concerns or complaints whatsoever". A person living at the home told us, "I am very well looked after; on the whole, this is a very good place". Another person said, "I can't think of anything negative to say; it really is a home from home". These were representative of other comments people made.

The registered manager had made the home as safe for people as possible. Records showed that staff had completed training in safeguarding and staff had access to policies and procedures for guidance should this be needed. There was clear guidance available for people and staff to follow if they needed to contact the local safeguarding team. The staff demonstrated a good understanding of safeguarding people, being able to identify the types of abuse as well as any possible signs of abuse. They also knew how to report any concerns they may have. The registered manager had notified the local authority and CQC of any safeguarding concerns or incidents. They had also taken appropriate action when incidents had occurred to protect people and reduce the risk of repeated occurrences.

The registered manager had ensured there were safe and effective systems in place to manage risks. Senior staff had carried out risk assessments for the safe delivery of people's care. These included assessments for risks such as falls, moving and handling, nutrition, and pressure area care. Risks had been identified and care plans developed from these assessments giving staff clear guidance on how to support people as safely as possible. Where people had particular risks associated in meeting their nursing or care and support needs, specific risk assessments were in place. An example being the use of bed rails. A risk assessment was in place because of the risks of entrapment or of people climbing over the top and injuring themselves. An example of specific risk management was in respect of people who were at risk of choking because of swallowing difficulties. There people had been assessed as being at such risk, a referral had been made to the Speech and language therapy team, who had in turn developed individual care plans. Some of these people had been prescribed drink thickener and these products were stored safely as they could pose a risk to people if ingested.

The premises were maintained safely. The registered manager showed us up to date service and maintenance certificates and records relating to fire, electric, gas, water systems, lifts and hoists. A full water system check including legionella testing had been completed, which showed the premises were free from legionella. Legionella is a water borne bacteria that can be harmful to people's health.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. People's support needs in the event of an emergency evacuation had been individually assessed. Their support needs were described in a Personal Emergency Evacuation Plan (PEEP) which enabled staff and emergency services to identify their needs in an emergency.

The registered manager had a system in place to record and review any incidents and accidents that took place. Incidents were periodically reviewed to make sure there were no trends where action could be taken

to prevent a recurrence. Accident and incident monitoring was overseen by the service manager as part of learning and making the service safer for people.

The registered manager had developed a business continuity plan for emergency scenarios such as; fire, lack of staff, loss of IT and utilities or medicines. It also provided guidance and actions staff should take in the event of these situations.

Staff were delegated to work in one of the individual units and staffing levels set in each unit, determined on people's needs. The discharge to assessment unit had a separate multi-disciplinary team dedicated to people's planned discharge to other accommodation. People and staff we spoke with all felt there were sufficient care staff employed on each of the units to meet their needs. They told us that if they rang their call bell, staff responded in reasonable time and staff were always available if they needed general advice or assistance. The registered manager told us they kept staffing levels under review and could be increased if there was a change in need.

There were robust systems for the recruitment of staff and the required recruitment checks had been completed, as well as the required records being in place. These included, a Disclosure and Barring check (DBS which helps prevent the employment of staff who may be unsuitable to work with people who use care services), a full employment history with confirmation of any gaps in employment, references and a health declaration. Where agency staff were used the provider kept records provided by the agency to confirm they had completed the required employment checks and were suitable for their role. The provider checked nurses had current registration with the Nursing and Midwifery Council (NMC) which confirmed their fitness to practice safely.

The home was clean with systems for managing infection control. One member of staff was delegated as an infection control lead. All staff were trained in infection prevention and there were robust monitoring systems in place. Staff wore their personnel protective equipment when it was appropriate to do so. Records showed infection audits were done weekly on Wednesdays. On Saturdays it was cleaning audits for catheters leg bags, glucometers, and dressings. Cleaning schedules for clinic rooms were maintained as well as for the whole building. The service was clean, tidy and free of malodours. When people suffered from chest and MRSA infections audits were accurately recorded.

Staff were observed using PPE as required. Hand Alcohol gels were available as well as hand washing facilities where appropriate.

There were safe systems in place for the administration and management of medicines. Medicines were recorded on receipt, when they were administered and when any were returned to the pharmacy. On the first day of the inspection we found the recording for administration of topical creams was inadequate as there were many gaps in the recording for when creams should have been applied. This meant it was not possible to verify whether people had had their creams applied as directed by their GP. When we returned on the second day, the registered manager had taken appropriate action. They had made changes in procedure, putting cream application records within people's rooms so that they were more readily available to the care staff who assisted with people's personal care. They had also put in more rigorous auditing with senior staff checking at the end of the day that people's creams had been applied as directed.

Staff received regular training and competency checks to make sure medicines were administered safely. People told us they were satisfied with the way staff managed their medicines. Medicines administration records, (MAR), contained information about people's allergies and had a recent photograph of the person. Medicines administration records were complete and contained the required information where doses were

not given. Some medicines were prescribed to be given 'when required', and protocols were available to guide staff on when it would be appropriate to give doses of these medicines for each person.

There were suitable arrangements for storing medicines. Storage temperatures were monitored in the medicines refrigerators to make sure that medicines would be safe and effective. Fridge temperatures were recorded regularly and staff had guidance on what to do in the event of the fridge temperatures being outside of the recommended levels. Staff were knowledgeable on safe storage practice.

Staff followed the home's own policy regarding the safe management of medicine that require additional controls. Staff always undertook stock checks as stated in their own home policy. Medicines, which required additional controls due to their potential for abuse, were stored safely and securely. Records relating to them were accurate. We noted two nurses checked the stock weekly.

The last pharmacist audit for medication for the service was on the 26/02/2018 with nothing adverse. The service implemented weekly medication audits following a safeguarding concern about a person who was discharged to another service with inadequate medication supplies. The deputy manager said this had been learning from mistakes experience, hence implementation of a new action plan on medication audits in addition to the monthly audit.

Good

Is the service effective?

Our findings

A pre-admission assessment of each person's needs had been carried out before people moved into the home. This procedure made sure the home only admitted people whose needs they could meet. On moving into the home, more in-depth assessments were recorded in people's care files. These had then been used to develop a care plan that reflected people's care needs. There was evidence within people's care records that people had been involved and consulted in their care, support and treatment. No one we spoke with was dissatisfied with the way their care was managed. A relative told us, "There's nowhere I have seen where I would prefer my Mum to be". People living at the home made comments such as, "I am very well looked after; I have no complaints at all", and, "Everything has been good and I have been very pleased with the way things have gone".

People were cared for by staff who had been effectively trained and received on going refresher training when this was needed. Staff told us that they were up to date with training and could also elect to do to more in-depth training as the local authority had good training resources. A member of staff told us, "The training I was given has been second to none and it included shadowing other staff and I learnt such a lot". New staff confirmed that they had undertaken a comprehensive induction and staff new to care undertook the Care Certificate. This is a set of standards introduced by Skills for Care for people new to the industry. Training records showed training was well-organised and that staff were trained in core subjects. These included training in subjects such as; safeguarding, moving and positioning, infection control and food hygiene. The provider monitored the completion of staff training through a tracker system that enabled them to identify when training required completion or updating. Nursing and assistant practitioner staff were supported by the provider's practice development nurse who carried out competency assessments to ensure clinical staff had the skills and knowledge required for their role and whether further training was required. Relatives had been invited to attend some training sessions, such as support planning and skin care, in recognition that people's relative's contributed to their relatives care at the home.

We discussed equality, diversity and human rights with staff and the registered manager. Staff had a good understanding about treating people as individuals and ensuring they were given choice and their preferences respected. People's assessments detailed all aspects of their needs including characteristics identified under the Equality Act. This made sure the service was able to meet their care, health and support and cultural needs and provide them with individualised care.

Staff told us they were very supported and received regular supervisions and annual appraisals. There was a line management and supervision structure in place with all staff having a named supervisor who met with them every six weeks to provide one to one supervision. Staff were also observed in practice against quality standards to check they were delivering safe and effective care. The provider had a system in place for the annual appraisal of staff performance. This included the provider and staff identifying goals for their professional development and monitoring progress towards these.

At the last inspection we found that some improvements were needed in respect of complying with the Mental Capacity Act 2005 (MCA). This 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.

At the last inspection we found that not all staff had completed training in the MCA. At this inspection, all staff had received this training and so they were knowledgeable about the requirements of this legislation. At the last inspection we also found that although a mental capacity assessment had been carried out in appropriate situations, the form had not always been fully completed to evidence people's best interest had been considered. At this inspection we found mental capacity forms had been completed fully and so recorded the best interest decision and who had been consulted in formulating the decision.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest 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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had good systems in place to ensure applications had been made to the supervisory body for a DoLS where people were identified as being deprived of their liberty. At the time of this inspection, no conditions had been attached to any of the DoLS granted by the local authority.

People's nutritional needs were met on all units with staff having good understanding of people's support needs at mealtimes. The home had appointed nutrition and hydration champions in the staff team to take a lead in these areas. At lunchtime we observed people who required assistance or prompting with eating were appropriately supported by staff. Where people had identified risks related to their diet these were managed safely. For example, people who required the consistency of their food to be pureed or cut up because of swallowing difficulties received the correct consistency diet. Records we reviewed showed some people who had been at risk of malnutrition had been supported to gain weight.

Food was well presented and people and their relatives were very complimentary about the food served. People confirmed they were given a choice of what to eat and where they ate and that sufficient food was provided for their needs.

Records showed that people's health needs were responded to appropriately with referrals to healthcare professionals such as district nurses, chiropodists, speech and language therapists (SALT) and hospital clinics. In the discharge to assessment unit, there were meetings with the GP, occupational therapist, physiotherapist, care managers and nurses to review and discuss people's needs in relation to their care and treatment whilst in the home and their needs on discharge from the home.

Good

Is the service caring?

Our findings

People and relatives all said the staff team were caring and compassionate. A relative told us, "All of the staff are so approachable and they can't do enough for people"; whilst another said, "She is always nicely presented and looks well-cared for when I visit". Comments from people who lived at the home included, "I have been very satisfied with what all the staff have done for me; they are so nice", and "No problems at all, they have been wonderful".

Throughout the inspection we observed interactions between staff and people. Staff responded to people and were very caring, with staff seeming to have a genuine interest in the wellbeing of people. They checked with people and asked how they were feeling if they looked distressed or in need of something.

All the staff said there was good leadership from the line management structure and there was always a senior member of staff to seek advice and support from.

People who could tell us, said they were involved in making decisions about their care and treatment. Everyone we spoke with also told us the staff were aware of the importance in respecting their right to privacy and dignity. We saw that the staff referred to people by their preferred form of address and spoke courteously to people. We observed that when personal care was being given, this was done behind closed doors.

People told us their families and friends could visit at any time with staff being very welcoming. Relatives also confirmed this telling us that they were always kept informed of any changes.

Within people's care plans there was information relating to people's life history, their interests, people and things that were important to them and their preferred routines. Staff were knowledgeable about people and aware of the information within care plans.

Good

Is the service responsive?

Our findings

Each person had a personalised care plan that reflected their individual needs. For example, one person's care plan detailed, "I like my curtains open in the middle so that I can tell whether it is day or night". Care plans we looked at were up to date and had been updated when people's needs changed or reviewed each month. On the first day of the inspection we identified that some care plans for specific health conditions could be improved by providing more information for staff on how to meet needs. By our return for the second day of the inspection, the registered manager had reviewed the plans and updated them.

The registered manager was aware of when relatives had lasting powers of attorney for welfare and when they should consult with relatives about people's care. Monitoring charts, to validate the care staff had provided, were also up to date and well-recorded. The registered manager had put systems in place that ensured people had enough to drink. Where concerns about fluid intake were identified, there was a system to record what a person had drunk and these were monitored daily. People's air mattresses were checked to make sure that the setting corresponded with the person's weight and where people needed regular checks or repositioning, these had been undertaken and recorded.

We found that where people who had wounds, these had been dressed in line with their wound management plan. Staff monitored the healing of wounds, recording progress that included the use of photographs. Referrals had been made to the Tissue Viability nurse for people with more serious or complex wounds appropriately.

Information had been gained from people or their relatives about people's life history and interests. This was then used to provide a personal approach to each individual and in the planning of activities. One of the activities coordinators told us that in the mornings they focused on one to one activities; with an emphasis on people who spent time on their own in their bedrooms. For example, one person, who stayed in their room and who did not like TV and radio, was found to have an interest in nature and wildlife. Their bed was positioned near the window and bird feeders placed outside the window so that the person could watch the birds coming to feed. In the afternoons the emphasis was on providing communal and group activities. On the first day of the inspection, a group of volunteers from a local bank had come into the home to assist in putting up decorations for Christmas.

The service met the Accessible Information Standard, which became law in 2016 to make sure people with a disability or sensory loss are given information in a way they can understand. People's communication needs and sensory impairments were detailed within people's care plans.

The service sought to support people nearing end of life to have a comfortable and dignified death by consulting people about end of life wishes. The home had attained the highest accreditation for the National Gold Standards Framework Centre in End of Life Care, a platinum award. The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling frontline staff to provide a high standard of care for people nearing the end of life. This clearly demonstrated the emphasis the service provided in meeting people's end of life needs.

Clear information about how to make a complaint was available for people. The complaints log showed the registered manager responded to and investigated complaints thoroughly.

Good

Is the service well-led?

Our findings

The service had an open and friendly feel. People commented positively on the atmosphere, for example, an agency member of staff, who had experience of working in many different services, told us, "It is a good home, one I like working at. Things are very organised". Another member of staff told us, "There is excellent team working here". A relative told us, "The manager is so on the ball and is so approachable". People living at the home all felt the home was well-managed with good leadership.

People and their relatives were involved with developments at the service in a meaningful way. For example, a 'Friends of Westholme' group was established, made up of relatives who assisted with activities like a monthly film club. Residents' and staff meeting clearly showed that everyone was involved in planning menus and other activities. The home had made links with the local community, for example, the activities coordinators had engaged with a local school who provided volunteers to come into the home to assist with some activities with people.

There were clear standards and expectations communicated through the management system. Staff were supported to understand their responsibilities and were held accountable for their actions. Regular team meetings were held with all staff and records evidenced the registered manager provided guidance to staff on meeting their responsibilities and the regulatory requirements. Procedures were in place to manage staff performance and action was taken to support staff to achieve improvements when this was required.

Periodic surveys of people using the service, relatives, staff and health and social care professionals were carried out. Results of these were analysed and action plan put in place for any improvements that had been identified.

Information from incidents was used to make improvements to the service people received.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. There were a range of regular audits carried out by the provider, the registered manager, maintenance and management staff. These included, medicines management and staff competence in medicines, care plans, accidents and incidents, falls and health and safety audits. Action plans were developed from audits to identify the actions required, who was responsible and the time frame within which to ensure completion.

The registered manager had notified us of any incidents or situations that were required to be reported.