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

Summary of findings

Overall summary

This inspection took place on the 16, 17 and 18 May 2016 and was unannounced. The previous inspection of this service was on 24, 25 and 26 of November 2014 when we found one regulatory breach. Following the inspection, the provider wrote to us to say what they would do to meet these legal requirements. During this inspection we checked whether the provider had completed their action plan to address the concerns we had found. We found the provider had made the required improvements, however at this inspection we identified some other improvements were required.

Westholme Care Home provides nursing and personal care for up to 74 people, including those who are living with dementia. This included a discharge to assessment unit for up to 10 people. This unit is for people who require a period of care and treatment on leaving hospital prior to moving back home or into another supported living setting. At the time of our inspection there were 69 people living in the home.

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 home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Our inspection of November 2014 found people were not adequately protected against the risks associated with medicines. At this inspection we found improvements had been made. Appropriate arrangements were in place for the safe storage, disposal, administration and management of people's medicines.

The provider did not always follow the procedures to ensure people's rights were upheld in line with the Mental Capacity Act (MCA) 2005. It was not evident that best interest decisions were always carried out when people lacked the capacity to make their own decisions. The provider had identified this concern and was taking action to address this at the time of our inspection. Staff training in the MCA had been planned and the appropriate documents were being implemented to ensure the correct process was followed. Action was being taken to protect people from inappropriate or unlawful decision making but the provider required more time to fully implement and embed this in their practice.

People and their relatives told us that people were safely cared for in the home. Staff we spoke with demonstrated their understanding of how to safeguard people and report their concerns. People were protected from the risk of abuse.

People had risk assessments in place that detailed their individual areas of risk and how these should be managed to keep people safe. Staff were updated daily on people's changing needs to ensure they had the information they required to provide safe and appropriate care. Plans were in place to guide staff on how to

support people safely in an emergency situation such as a fire, loss of utilities or insufficient staffing available to meet people's needs.

There were sufficient levels of suitably skilled staff available to meet people's needs. Whilst there were some staff vacancies the provider had ensured staffing levels were maintained. Agency staff were checked for their suitability to work with people and as far as possible the same agency staff were used to provide continuity of care for people.

Staff completed an induction into their role to ensure they were competent to carry out their responsibilities. Staff were supported by managers through regular supervision and an annual appraisal. Staff completed a range of training to develop the skills and knowledge they needed to meet people's needs.

People were offered choice by staff in their day to day care and their decisions were respected by staff. Staff were knowledgeable about people's preferences and acted to ensure these were met.

People and their relatives told us the food was good. We saw that a varied and nutritious menu was offered and the catering staff were aware of people's likes, dislikes and food safety needs. People received assistance with eating when this was required and people at risk of poor nutrition were monitored to ensure the risk was minimised.

People's healthcare needs were attended to promptly and people were seen by a range of healthcare professionals as required. A multi-disciplinary team worked together to support people in the discharge to assessment unit to enable them to move back home or into other supported living settings. Healthcare professionals we spoke with told us people received safe and appropriate care.

People received care and support from staff who knew them well and were caring, and compassionate in their approach. The relationships between staff and people receiving support demonstrated dignity and respect. People's decisions for their end of life care were known and respected to ensure people at the end of their life received appropriate and person-centred care.
Person-centred care means that people receive care which is individualised and focuses upon their needs and wishes.

People's care plans were person-centred and included their preferences for how their care should be delivered. Care plans were regularly reviewed and updated with people's changing needs to ensure they remained current and appropriate. People and their relatives told us that the care provided at Westholme was responsive to people's needs.

A range of activities was available for people to participate in if they chose to do so. People's activity and social needs were met by activity coordinators, staff and volunteers.

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

Staff were supported to review and learn from incidents. As a result of incident reviews improvements were made to the safety and quality of the care people received. The registered manager and other managers supported staff to understand what was expected of them in their role and to be accountable for their performance and the quality of care people received.

Quality assurance systems were in place to monitor aspects of the quality of service being delivered and the running of the home. Audits were effective in addressing the shortfalls identified and appropriate action was taken in a timely manner to ensure these shortfalls were addressed. People and their relatives spoke positively about the management and leadership in the home. Feedback from staff, people and their relatives was used to drive improvements in the quality of the service provided.

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 situation.

People were supported by sufficient and suitably skilled staff to meet their needs safely. The same agency staff were used to cover staff vacancies as far as possible to ensure continuity of care for people.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider did not always follow the relevant procedures to ensure people's rights were upheld in line with the MCA (2005). It was not evident that best interest decisions were always carried out when people lacked the capacity to make their own decisions. The provider was taking action to address this in order to protect people from inappropriate or unlawful decision making.

Staff received an induction into their role, on-going relevant training and supervision of their work. People received their care from staff that were appropriately supported in their role.

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 promptly.

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.

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 at this time.

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.

Is the service well-led?

Good

The service was well-led.

The registered manager communicated effectively with other managers and staff to monitor progress towards shared goals. Staff were supported to understand their responsibilities and to be accountable for their actions to provide a good quality service for the people they supported.

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.

This inspection took place on 16, 17 and 18 May 2016 and was unannounced. The inspection was conducted by an adult social care Inspector, a specialist advisor and an expert by experience. The specialist advisor was a registered mental health nurse with experience in the care of older people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who use this type of care service; on this occasion they had experience of family members living with dementia who had received residential care. The expert by experience spoke with people using the service and their relatives.

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We did not request a Provider Information Return (PIR) before our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We obtained this information during the inspection.

Prior to the inspection we spoke with a team manager from the community about the care people received at the service. During the inspection we spoke with a visiting GP and an occupational therapist about the service.

During the inspection we spoke with 10 people and eight people's relatives. Some people accommodated lived with dementia and could not speak with us. Therefore we used the Short Observational Framework for Inspection (SOFI) at lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, the deputy managers, the maintenance manager, an activities coordinator, a chef, the practice development nurse and five care and nursing staff.

We looked at 15 people's care plans and medicine administration records. Three staff recruitment files, staff

supervision and training records We also looked at the staff rotas for the dates 27 March to 14 May 2016, quality assurances audits, incident and accident reports, policies and procedures relating to the running of the service, maintenance records and quality control questionnaires.

Good

Is the service safe?

Our findings

Our inspection of November 2014 found people were not adequately protected against the risks associated with medicines because staff did not consistently follow safe practice around storing, administration and disposal of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection we found improvements had been made. Medicines on all units were stored safely and appropriately. Storage of equipment such as syringes and medicines were well organised. Clinical room doors were locked when not in use. Medicines awaiting disposal were stored in sealed containers and records were kept of the medicine, the reason for their disposal and signed by two staff as confirmation of their safe disposal. The registered manager had acted on the risk to people from medicines that should be used with caution and these had been reviewed by the GP and discontinued.

People who were prescribed medicines to be taken 'as required' had protocols in place to guide staff on their safe use. These protocols included the behaviours of people who may be unable to express themselves verbally so that staff could identify when a medicine was required. For example; some people were prescribed medicines to help calm them if they became agitated or presented behaviours that may challenge others. An assessment tool was in use to identify when a person who may not be able to clearly articulate their needs was in pain. This guided staff on when to give 'as required' medicines prescribed for pain relief and to identify when further treatment was required dependent on the severity and persistence of the pain the person experienced. There were safe medication management systems in place and people received their medicines when required.

People's medicine administration records (MAR's) included a photograph, their name date of birth, details of their GP, their medical condition and any allergies. These records are completed when people take their medicines and when the medicine is not taken record the reason why. We saw people's MAR's were completed accurately. We reviewed the MAR of a person prescribed a medicine which had a variable dose depending on the outcome of regular blood tests. Records showed the medicine was given at the correct dose as described on the blood test results. This was important to ensure the person received the correct level of the medicine to prevent serious risks to their health. People told us they were given their medicines on time and that staff observed to make sure they were successfully taken. We observed people being given their medicines and saw that staff followed the correct procedures to ensure peoples' medicines were managed and administered safely.

People and their relatives told us staff supported people safely. A person said "Yes, I feel very safe here. There is sufficient staff to look after us. I'm happy when they're assisting me as they make you feel confident about them". A person's relative said "She seems happy so I believe that she feels quite safe". Staff we spoke with demonstrated their understanding of safeguarding and their responsibilities. A staff member told us how they had reported a concern and this had been acted on. Records confirmed that staff had completed training in safeguarding and staff had access to policies and procedures for guidance should this be needed. People were protected from the risk of abuse.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. For example; when people had been assessed as being at risk of pressure sores, care plans consistently informed staff how to prevent pressure sores developing. This was supplemented by information on pressure care which was displayed in the home. People who had been admitted to the home with a pressure sore were receiving appropriate treatment. We saw treatment plans were followed by staff and people were closely monitored to prevent any deterioration and assist healing.

A falls screening assessment was used to identify people at risk of falls. Factors that may influence a person's risk of falls were considered such as medicines, footwear, alcohol use, balance and mobility needs. This enabled staff to develop a care plan to address risks and help prevent people from falling. Where people had experienced a fall their needs were reviewed and further action taken to minimise the risk of a reoccurrence. For example; we saw that a person who had fallen had been assessed by an occupational therapist and actions such as; lowering their bed, leaving a light on at night, and a sensor mat to alert staff when the person sat up in bed had been taken to minimise their risks from falls. We observed staff supporting a person who had been identified at risk of falling. Staff were aware of their behaviour that preceded the risk of a fall. We observed staff identified this behaviour and assisted the person using a hoist to transfer them safely so they could rest in bed whilst further assessment was sought from their GP. A person told us "The staff make me feel very safe. I do feel content; they obviously know what they're doing. I'm slow in getting around, they help me sometimes and I know that they won't let me fall". People were protected against risks and action was taken to prevent the potential of harm.

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. This information was kept in an emergency grab bag at reception for prompt access. A deputy manager told us how staff practised evacuating people through verbal fire drills so that all staff were aware of what was required. Staff had also completed an evacuation with the Fire Brigade in March 2016 which staff described as "Really good". This had enabled staff to know the routes and the support required by each person to evacuate the location safely.

A business continuity plan was in place which described emergency scenarios such as; fire, lack of staff, loss of IT and utilities or medicines and the actions staff should take in the event of these incidents. This meant risks to people in an emergency had been considered and a plan was in place to support people safely in these situations.

People were supported by sufficient numbers of staff with the right skills and knowledge to meet their individual needs. The registered manager completed a staffing level assessment tool each month. This tool enabled them to calculate the numbers of staff required to meet people's needs safely. We looked at the staffing rotas for the period 27 March to 14 May 2016. Staffing levels were as described by the registered manager. People told us there were sufficient staff to meet their needs, one person said "I feel a lot safer here as the staff are always available should I need them. I'm not that mobile but they're quick to sort me out and they make me feel confident in them".

Vacancies for nursing and care staff were being recruited to. The provider used agency staff to cover vacant posts and wherever possible the same agency staff were used to provide continuity of care which was confirmed by staff and relatives. Staff usually worked in the same unit which meant people were supported by staff that knew them well. Care staff told us there were enough staff available and confirmed that additional staff were provided if people's needs changed.

Nursing staff were available day and night on each of the nursing units. The provider had introduced a new staff role of 'assistant practitioners'. These were senior care staff who were completing training in medicines management and some health related care tasks such as; catheter care and skin integrity care. Assistant practitioners were supervised in their work by healthcare staff. This meant more suitably trained staff were available to assist people with their needs.

The provider had completed some of the required recruitment checks to ensure the suitability of staff for employment during the recruitment processes. For example; staff records we reviewed did include a Disclosure and Barring check (DBS). The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. However, the provider had identified they had not carried out all the required checks. At the time of our inspection the provider was taking action to remedy this shortfall and mitigate the risk to people. Existing staff were being asked to provide a full employment history and confirmation of any gaps in employment where this was missing from their recruitment records. New staff were completing all the required checks prior to taking up their role to ensure they were of suitable character to support people safely.

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.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. New staff completed a comprehensive induction that included competency and knowledge checks as well as a period of shadowing more experienced staff to learn about people's needs prior to working alone. A person's relative said "Staff appear to be well trained so I feel that my Mum is in safe hands here". Another relative said "I believe that the staff are well trained. They certainly come over as such. I have every confidence in them".

The provider had identified the training required for each staff member's role to ensure staff had the appropriate knowledge and skills required to carry out their role effectively. Records showed that most staff had completed the training identified as mandatory by the provider. This 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. Required training was booked for staff who needed to complete it and the deputy managers were updating the tracker at the time of our inspection to ensure records reflected the completed training.

Staff told us the training provided was of good quality. A care staff member told us how they had completed training in "Carer's in partnership". They said this was "Brilliant" and had enabled them to understand the impact on families of having a loved one come into a care home. The staff member said "It was a real eye opener. It helped me to know how to really go the extra mile to make people feel welcome". 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. The registered manager told us that relatives were invited to attend some training sessions such as support planning and skin care. This was in recognition that people's relatives contributed to their relatives care at the home. People were being supported by staff who had the opportunity to develop and maintain their skills and knowledge.

Staff told us they were supported in their role by their line managers. A line management and supervision structure was in place to ensure all staff had 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. Staff confirmed they had access to professionally recognised qualification training in health and social care. People were supported by staff who received support and professional development in their role.

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 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.

Not all staff had completed training in the MCA; however, staff we spoke with were aware of the principles of the MCA and the importance of supporting people to make their own decisions as far as they were able. Staff gave us examples of when people had refused care and how they waited until the person was ready to accept care or they adapted arrangements to meet the person's choice. For example; when a person did not want to eat at the dining table a table was brought to where they were sitting. A person who did not want to be assisted with their continence needs was encouraged to do so when they were standing and more likely to agree. We observed staff offering people choices about when they ate, what they ate, whether to participate in activities, whether to have a bath or shower and their clothing choices.

People's care plans included mental capacity assessments related to specific decisions about people's care and treatment when they were unable to make these themselves such as; taking monthly weights for people at risk of poor nutritional intake. Where people lacked the capacity to make decisions about their care plan this was underpinned by a best interests document. This described who else was involved in decisions about their care and to confirm the care plan had been developed in their best interests. We found the document had not always been fully completed to evidence people's best interests had been considered. This meant people could be at risk of inappropriate decision making.

Applications had been made to the supervisory body for a DoLS where people were identified as being deprived of their liberty. We noted the applications did not include details of the restrictions in place to support people safely. Some people were not free to leave without supervision, internal unit doors were locked, sensor mats were in use and 15 minute and hourly checks were completed for some people who might not be able to consent to these arrangements. A mental capacity assessment was completed to determine whether the person could agree to the conditions of their care and treatment. However, a best interest decision making process was not followed or recorded prior to submitting the application. This is a requirement of the MCA to ensure that any decision made on behalf of a person who lacks capacity is made in their best interests. This is important to ensure decisions made on behalf of people show who has been consulted about the decision and that the least restrictive options have been considered. The provider had identified this shortfall during their quality monitoring visit in April 2016 and was taking action to address this at the time of our inspection. The appropriate documents were available to staff to ensure the correct process was followed and this was being implemented. The deputy manager confirmed staff who had not completed training in the MCA were booked to attend this during the following month. This meant action was being taken to prevent people from being at risk of inappropriate or unlawful decision making. The provider needed more time to fully ensure these improvements had been implemented and embedded in their practice.

We found peoples nutritional needs were consistently met on all units. Staff showed a good understanding of people's support needs at mealtimes. 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 fork mashable due to swallowing difficulties received the correct consistency diet, and a person at high risk of choking was assisted by specified staff only. People at risk of poor nutrition were monitored by staff who completed food

and fluid charts to check people were eating and drinking sufficiently. We observed a person who was refusing their lunch; staff offered the person an alternative high calorie snack which they ate. The person's records confirmed they had been offered a food they particularly liked. Some people living with dementia can experience eating and drinking difficulties and be at risk of poor nutritional intake and weight loss. Staff described how they offered high calorie snacks and finger food such as sausage rolls and cheese to supplement the diet of people who did not always want to eat a meal. We observed staff offering food to people who did not want to sit and eat. 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. A person told us "The food here is very good. You can order almost to preference. Recently I said, Ooh, I'd like a fried breakfast sometime, the next day, I had a fried breakfast. I couldn't eat all of my lunch that day so they gave me a snack to tie me over. They make sure that I have enough to drink and they certainly do that with the food".

We observed people were frequently offered drinks and a person's relative said "They (staff) are always coming round with the drinks trolley". People at risk of poor hydration were monitored through a record of their fluid intake. We noted people's intake was totalled each day; however individualised daily fluid intake targets were not in place to enable staff to monitor whether the person's fluid intake was sufficient to prevent and reduce the risks from dehydration. This could place people at risk of poor hydration.

People's changing needs were monitored to make sure their health needs were responded to promptly. During our inspection we observed staff made prompt referrals to the GP and other healthcare professionals to assess people's needs when their behaviours had changed or they had concerns about their health. 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. Records showed people received treatment from a range of healthcare professionals such as; district nurses, chiropodists, speech and language therapists (SALT) and hospital clinics. We spoke with visiting healthcare professionals who confirmed referrals were made promptly and appropriately when required and that staff followed treatment plans to support people to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

People and their relatives consistently told us staff were caring and they were happy with the care they received. A person said "All of the staff are very very nice, they'll do anything for me day & night with their support I do have a good quality of life in here. They are very caring." A person's relative said "Oh yes, the staff are very caring. I'm very impressed at what they do and I'm always offered a cup of something". Other people's comments included; 'The staff are very good to me, they can't do enough; 'I chat & laugh with the staff, they're good fun to be with they're always smiling'.

Staff spoke about people in a caring way showing knowledge of their backgrounds and interests. Staff told us about people's families, their past employment, their interests and objects and routines that were important to them. For example a person's relative said "My Husband used to be a sailor so they talk to him about sailing frequently to try to generate a response." We observed interactions between staff and people which evidenced staff used this knowledge to engage in conversation with people. People's care was person centred and unhurried enabling staff to spend quality time with them and build positive relationships.

Staff showed kindness and compassion to people when they were distressed or unwell. For example; we saw a staff member holding the hand of a person to reassure them and encourage them to eat and drink following a period of ill health. A person who had refused personal care and was in their pyjamas and bare feet was spoken to reassuringly by a staff member who was then able to help them into warmer clothing and socks. Staff supported a person to move from an uncomfortable and potentially unsafe position in a calm and caring manner, checking with the person they had understood and agreed to being helped prior to assisting them to move. A person said "The staff are very good, very helpful & caring. "People were supported by caring and compassionate staff.

People's records included information about their personal circumstances and how they wished to be supported. This included their decisions about day to day care such as; dietary needs and preferences, their communication needs and what was important to the person such as; maintaining their relationships with family and friends and their spiritual needs. When people were unable to express their decisions and choices, relatives had contributed to their care plans by providing life histories and information about the person's preferences and dislikes. We observed people's decisions about their care were respected. For example; people were provided with support for their spiritual needs by staff and visiting clergy. One person's care plan reflected that she liked to listen to a reading from the bible and one member of staff discussed this care need with us and said staff often put on a projector in her room so that she could read verses from the Bible. People's dietary needs and choices were known and followed. A person's care records stated it was important for them to be able to walk about freely and we observed the person did this throughout our inspection.

When people refused care, staff respected their decisions and returned to check if people were happy to receive their care at a time they wanted. We noted that staff remained polite and courteous when a person became verbally abusive towards them. Staff had attempted to assist the person with their personal care but the person refused and their behaviour was challenging. Staff left the room and explained they would

return later to see if the person would accept care. People made decisions in respect of their care and treatment and these were respected by staff.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by other healthcare specialists. Services and equipment were provided as and when needed. People's care plans included information about their wishes, advance decisions and funeral arrangements. This included what was important to the person such as pain management and a 'light and airy' room and what they would not like such as noise and darkness. We saw the provider had received many written compliments about staff from people's relatives that included the care given to their relative at the end of their life. One person had expressed to staff ; "Thank you for your care and patience, they (person) had a gentle passing with such kindness shown".

A person's relative told us how their loved one was treated with "The utmost respect & dignity". We observed staff spoke to people using their name, or a preferred term. For example a person said "They're very sweet, one of them calls me "Auntie (name) I like that". Records showed that people's preferred terms of address were noted and this included when people preferred to be called by endearments such as 'darling'. Our observations confirmed staff treated people with dignity and respect.

Good

Is the service responsive?

Our findings

People's care and treatment plans were personalised and reflected people's needs and choices. Information was included on how people preferred to be supported and what was important to them. An example of this was a person's care plan for their communication needs. This included how the person's communication was affected by their health conditions; the support they required from staff to enable them to communicate and how they would like staff to communicate with them. We saw staff communicated with this person as described in their care plan. People's abilities were included in their care plans so they could be supported to maintain their independence as far as possible. For example; a person's care plan included their abilities with personal care and the outcome they wished to achieve, which was; 'I like to look clean, shaved and tidy'. We spoke with this person's relative who confirmed "He is clean, shaved and smart and that is important to him". People received person-centred care in line with their assessed needs and preferences.

People and their relatives told us their needs were responded to by staff. People gave us examples that included staff responding to a person in an emergency situation. One person said "The staff responded very quickly by attending to me and calling the paramedics and a doctor. They sorted me out but I wouldn't go to hospital as I wanted to stay here. Once sorted, the staff couldn't do enough for me. I have used the call bell and it's always been responded to very quickly". Other comments included how staff had responded to people's dietary requirements, safety needs and their emotional needs. For example a person's relative said "When Mum gets upset, they're quick to sort her out and calm her down".

People had care plans in place that reflected their needs in relation to health issues such as; catheter management, diabetic monitoring and safe swallowing care plans. These showed the appropriate protocols were in place to monitor and manage the risks and wellbeing of people with these needs. Daily notes and monitoring information was recorded by staff to provide a continuous record of people's care and treatment in relation to their identified needs. Staff attended a verbal handover at each shift and a written handover summary of people's needs was available for each person by each unit. This provided information about people's daily needs, mobility and transfer requirements, allergies and diet. The handover records of people receiving nursing care also included an update on their night care and how their health needs were progressing including any actions taken. We saw staff carried copies of this information. This meant staff and agency staff had recorded information to refer to about people's needs should this be required so that people received appropriate care and treatment.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people received one to one staff support when this was required or preferred. There were two full time activity coordinators in post. An activity coordinator explained they divided their time between the units offering individual activity support in the mornings and group activities in the afternoon. During our inspection we observed the activity coordinators were constantly engaged with people. We noted that care staff also provided people with opportunities for stimulation and social activity. An activity co coordinator said "We work together as one big team with the care staff". The registered manager told us "I don't want to see

people sleeping in chairs, everyone (staff) must be involved in activities". We observed people participating in memory games, nail care, making scones, a garden party, ball games, a tea party, singing, skittles, bingo and knitting supported by staff and activity coordinators. Staff referred to peoples past experiences and interests to engage them in activities. This can be beneficial for people living with dementia who may remember past events more easily than the present. For example; we observed a staff member referring to a person's previous experience of cooking as they asked them to join in making scones. People were asked to identify significant past events from pictures and to discuss their memories of these. We observed people were engaged and enjoying the activities they participated in.

The environment had been adapted to meet the specialist needs of people living with dementia. For example; people's bedroom doors were personalised to make them more recognisable, with their name or personal items they recognised. Communal areas included stimuli such as pictures or objects to help people orientate themselves and create interest. An area of the home had been decorated as a pub so that people who enjoyed a pub environment could relax and eat there if they wished and a sweet shop was being built on the nursing unit. A person had wanted a golf course and this had been created in the garden. People living with dementia had access to resources and were cared for in an environment responsive to their needs.

The home had an active 'Friends of Westholme' group who were supporting activities in the home along with volunteers from a local college. The registered manager told us how their support had been invaluable in creating resources and opportunities for people. For example; volunteers supported people with activities such as gardening and outings as well as fundraising and making donations of items to improve the resources available for people in the home.

A person's relative commented that weekend activities could be improved. An activity coordinator told us they worked occasional weekends for special activities but care staff were usually responsible for activities during the weekend. One care staff member told us "We do our best but it is more difficult without the activity staff". The registered manager told us they had taken action to improve opportunities for activities at weekends. For example; a staff member in each unit was allocated to arrange activities at weekends and activity coordinators provided resources and ideas for these activities. The home now had a driver and the use of a mini-bus for trips out, we saw trips had been scheduled for some weekends.

Notable days were celebrated such as the Queens' birthday when a garden party was planned. A person said "On your birthday, you get cakes and goodies then the staff come into your room and sing to you". A relative said "On Valentine's Day the staff decorated one of the lounges & it was fabulous, out of this world. I felt very emotional".

The provider had a complaints procedure and this was displayed in the home. We reviewed the complaints received since our last inspection. Records showed complaints received had been responded to in line with the provider's procedure. People and their relatives told us that when they had raised a concern these had been dealt with promptly. No one we spoke to had raised a formal complaint but people said they felt confident complaints would be dealt with appropriately. For example a person said "I haven't complained but, if I did, I feel that the Management would respond quickly". And another person said "We do have the odd problem but it gets sorted straight away". A person's relative said "I haven't complained but believe that a complaint would be responded to with sympathy". A system was in place for people to raise their complaints and concerns and they were acted on.

Good

Is the service well-led?

Our findings

People and their relatives told us they thought the home was well managed. One relative said "This is a brilliant home which I definitely feel is well managed". Other people commented on the "Well trained, professional and motivated staff" which they attributed to good leadership. Staff we spoke with said they were well supported by managers. One staff member said "The registered manager (name) is fantastic, we are well-supported she listens to everyone and is a good manager. Another staff member said "I definitely feel part of a team this one (home) is so good managers fully support you".

The registered manager promoted a positive culture within the home. Minutes of meetings held with people's relatives and staff showed their contributions were acknowledged and encouraged. Staff told us they were able to question practice and raise any concerns they had and these were listened to. Weekly management team meetings were held to ensure communication between the registered manager and other managers was effective and to monitor progress towards shared goals. We attended a managers meeting and observed managers discussing; complaints, staffing requirements, staff training, progress on identified improvements such as recruitment practices and people's individual care and treatment needs.

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. For example; we saw evidence that where a staff member had not met the level of competency required in an aspect of care delivery they had been supported to refresh their knowledge and skills until they met the required level of competency.

The provider had recently carried out a staff survey. We reviewed the results of this survey and saw the majority of staff consistently reported positive relationships with managers and felt they were well supported in their role. The registered manager had fed back the results of the staff survey to staff at the general staff meeting on 27 April 2016 and confirmed the feedback would be used to make improvements. Minutes of the meeting showed that staff were invited to contribute towards improvements in the home and had raised suggestions which were acted on. This included; equipment such as an extra hoist and resources for people such as; toiletry boxes and items people may like to use such as handbags and phones.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. People and their relatives were asked for their views and experiences of the home using annual satisfaction surveys carried out by activity coordinators. We reviewed the feedback from the survey carried out in July 2015 which had been analysed. People and their relatives had mostly commented positively on the home, the attitude of staff, the food and activities. The registered manager told us as a result of the survey they had increased management support in the home at weekends in response to the feedback. The home held quarterly relatives meetings to enable people's relatives to give more regular feedback and monitor progress towards planned improvements. A person's relative said "The meetings are open, frank and informal and we are listened to by the registered manager and deputy

manager, the registered manager is doing a really good job – a real step change".

'Duty of candour' forms part of a regulation which states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. We saw where notifiable safety incidents had occurred the registered manager had acted in accordance with the regulation.

Information from incidents was used to make improvements to the service people received. For example; a critical incident review had been held to evaluate the care a person had received prior to a hospital admission. A critical incident review is held to understand how and why an incident occurred that resulted in harm or potential harm to a person. The review considered whether improvements could be made to the service people received in the home. As a result of this review the registered manager had ensured that all staff were made aware of the incident and had been involved in a review of the findings. New staff completed a review of the incident at induction. The analysis of this incident had resulted in improvements to practice and to people's care and safety. New tools had been introduced to provide a prompt assessment of people when they were unwell and to prompt staff actions. Guidance was included to support staff when communicating with other professionals about people's needs so that critical information was given to ensure the appropriate actions were taken. This meant information from investigations was used to drive improvements across the service.

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 by the provider, the registered manager, maintenance and management staff. These included observational audits such as a 'manager's walk the floor report' to check on staffing, residents' concerns, the environment, activities, monitoring records and nutrition and catering. Other audits 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. Actions were signed when completed. A medicines audit completed in May 2016 identified gaps in the recording of people's medicines. We saw the registered manager had taken prompt action to address this. Staff had been informed of the results of the audit and were required to have a further competency check with the deputy nursing manager. Weekly audits had been put in place and staff were required to confirm they had read and understood the medication policy. The registered manager acted on shortfalls identified through the quality assurance system to improve the quality of service people received.