Bupa Care Homes (CFHCare) Limited

West Ridings Residential and Nursing Home

Inspection report

Off Lingwell Gate Lane
Lofthouse
Wakefield
West Yorkshire
WF3 3JX

Date of inspection visit:
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23 June 2016
30 June 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection on 21, 23 and 30 June 2016. The inspection was unannounced.

West Ridings Residential and Nursing Home is a multi-unit site providing care for up to a maximum of 180 people. The service has six units and provides care and support for people with nursing and residential needs including people who are living with dementia. On the day of our visit there were only five units open and 127 people living at the home.

The service did not have had a registered manager in post at the time of our inspection, although there was a manager who had been in post since August 2015 and whose application to register with the Care Quality Commission was in progress. 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.

Staff had a clear understanding of safeguarding and whistleblowing procedures.

Staff lacked knowledge of how to use equipment and individual risk assessments for people were not detailed enough to give staff clear instructions for moving and handling people safely. People were not sufficiently assessed for equipment and not all equipment was suitable for people's needs. This was a continued area of concern from previous inspections.

Accidents and incidents were recorded with some analysis, although there was limited feedback given to staff or opportunities to evaluate lessons learned.

Staffing levels were variable and at times, not sufficient to meet people's needs due to staff frequently being called from one unit to cover staff absence in another unit. The hostess role, where sufficiently deployed, was positive and supportive. Staff morale was variable and linked to staffing levels in the service.

Recruitment procedures were in place, but lacked rigour to ensure staff suitability was thoroughly determined. Where agency staff were used there were improvements in the suitability checks made. Ongoing suitability of staff was not checked thoroughly or consistently.

Infection control procedures were robustly in place and the organisation of systems to minimise the risk of infection was clear.

There was a new trainer who was enthusiastic about induction and ongoing training for staff. However, training around risk was not in place and some training was not specific enough for staff to be effective and work safely, such as moving and handling. Staff knowledge of mental capacity and deprivation of liberty was variable across the site, although training had been completed.

Staff were patient, kind and caring in their approach on the whole. People's privacy and dignity was respected and staff gave good explanations to people about their care and support.

Assessment of people's needs in care records lacked key detail around areas of risk, such as for equipment or support with moving and handling.

There was limited evidence of meaningful and personally engaging interesting activities that were in keeping with people's interests. The environment for those people living with dementia had improved since the last inspection.

Systems with which to monitor and evaluate the quality of the provision showed some improvements over recent inspections, although they were disjointed and lacked consistency across the service. There were weaknesses in communication, between the units, with the manager, and with the wider organisation. Where serious failings in the service had been previously identified around the management of risk, no action was taken to improve practice and prevent future harm to people.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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?

Inadequate

The service was not safe.

Equipment for people was not always suitable or available to meet their needs.

People used equipment they were not assessed for and staff lacked knowledge of how to safely use equipment.

Staffing levels were not consistently managed to ensure safe delivery of care.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff's competence was not routinely checked to ensure they had the necessary skills and knowledge, particularly with moving and handling.

There was mixed staff knowledge and recording around consent.

Most people enjoyed the meals and there were regular opportunities for people to have drinks. Special diets were known and managed well by staff.

Is the service caring?

Good

The service was caring.

There were many caring, kind and compassionate interactions with people throughout the majority of the service.

People's independence was promoted well.

Staff had due regard for people's cultural and spiritual needs.

Is the service responsive?

Inadequate

The service was not responsive.

Assessment of people's care lacked detail around key factors,

such as risk.

There were limited meaningful activities to meet people's social needs.

Complaints were not acknowledged, responded to or recorded adequately.

Is the service well-led?

Inadequate

The service was not well led.

There were missed opportunities to identify lessons to be learned from serious incidents (Kingsdale Unit) and to improve practice as a result of these.

Communication was not consistent across the site, from unit to unit, between staff and managers and with the provider.

Systems to monitor the quality of the provision lacked consistency and rigour.

West Ridings Residential and Nursing 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 21, 23 and 30 June 2016 and was unannounced.

The membership of the inspection team comprised eight adult social care inspectors, an enforcement inspector, a corporate inspector and an inspection manager.
Prior to the inspection we reviewed information from notifications, liaised with local partner agencies including the local authority and the Clinical Commissioning Group (CCG) We spoke with 35 people using the service, 10 of their relatives/friends, two visiting professionals and 16 staff. We carried out observations of people's care and reviewed 20 care records. We looked at documentation relating to the running of the home.

Inadequate

Is the service safe?

Our findings

People mostly said they felt safe, although some people did not. One person said:" I feel safe living here, I just ask for help, if I'm polite they always respond". Another person said "Yes I do feel safe alright here". One person said: "I think my safety is important and I hope staff think so too. I can't think of a time I don't feel safe". Another person said: "I'm as safe as I would be anywhere". One person on the Swaledale unit said they did not always feel safe and told us: "They are amateurish with the hoist". Another person on the Airedale unit said they felt unsafe when being hoisted. Relatives we spoke with said their family members were safe at West Ridings. One relative said: "My [family member] is safe. Staff struggle with [my family member] and a relative spoke with the manager as they were worried about not enough staff". Another relative said: "This is the first place [they have] been where I feel I can go on holiday and I have peace of mind [they are] safe".

Staff had a clear understanding of safeguarding and whistleblowing procedures and gave examples of what would cause concern and what action they would take. We saw whistleblowing information displayed within the home for staff to see. We heard the management team encouraged staff to use the 'speak up' initiative if they had any concerns. Many staff we spoke with said they would not hesitate to bring concerns to managers, but not all staff said they would be comfortable to use the whistleblowing procedures if they had concerns about a colleague's practice. Staff understood procedures to follow for emergency evacuation and we saw their personal emergency evacuation plans (PEEPS) identified people's level of mobility with a traffic light colour code.

The manager told us: "I think people are safe. They're a lot safer than they were". They said there were no problems with health and safety in the home. However, our findings at this inspection showed the manager's evaluation was not accurate as we identified continuing concerns.

Unit managers we spoke with were able to identify some of the risks specific to their unit. One said that theirs were around areas of falls and challenging behaviour but then struggled to inform us of other areas. Another manager was able to identify their top four risks: falls, weight loss, infections and pressure ulcers. The clinical services manager was not able to tell us what the main risks were in the service, however, they were new in their role. Senior care staff were not all aware of how to complete risk assessments and did not know who did assessments for people to use hoists or slings. Senior staff told us people were not individually assessed to use bath chairs, wheelchairs or shower chairs and we saw no assessments of care records for these.

Staff lacked knowledge of how to use equipment and individual risk assessments for people were not detailed enough to give staff clear instructions for moving and handling people safely. People were not sufficiently assessed for equipment they used and not all equipment was suitable for people's needs. For example, all wheelchairs and commode chairs were a standard size, even though there were some people in the home that required larger equipment. We saw a commode chair for one person that appeared too small for their size and there was evidence the arm support was bent out of place and loose. We asked the residential service manager to take this equipment out of use as it was not safe or a suitable size for the person. When we returned on a different day we saw the broken commode chair had been replaced with

another commode chair, but in the same size. We were told by senior staff Bupa did not provide specialist seating for people. One person on the Calderdale unit sat in a specialist chair but we were told this was not specifically assessed for the person.

Risks to people and equipment for people's needs was not always known by staff. For example, we observed a handover on the Airedale unit in which staff said they thought a newly admitted person "might need a rota-stand, or it could be a hoist, we're not sure". We observed both pieces of equipment were used to support the person, but there was no assessment of the person's needs or abilities to use equipment. This meant staff lacked knowledge of the equipment required or the safe process for ensuring the person was moved and handled in line with their needs.

Staff told us slings were not all for single use and people sometimes shared these. We saw on the Airedale unit one sling was used for two people, one after the other.
One person on the Swaledale unit was being supported with equipment that was not suitable for their moving and handling needs and for which they had not been assessed. We were told they had used a pressure cushion that was intended for another person, but that one was ordered. The person said they had not been out of bed for several days as staff had attempted to hoist them with a sling that they felt unsafe in. We looked at their care record and found they were listed as needing a wheelchair, a special chair and a hoist, but there were no details of any assessments for these, or any instructions for staff to know how to handle the person safely. Staff we spoke with were not sure about the person's moving and handling or equipment needs. We spoke with the unit manager who said: "[Person] was using an extra wide chair in hospital. [They're] using an ordinary chair here. The unit manager said they had "no idea" who had assessed the person for the equipment. The manager told us a new sling had been ordered but it might take time to come because it was a specialist size. On the third day of the inspection, the manager told the inspector the sling had been delivered, but when we went to see the person, they and the unit manager were not aware of its delivery and there was no update to the person's care record or risk assessment for a new sling. The unit manager confirmed a new pressure cushion had arrived, but the person could not use this until the sling was available to get them out of bed. On the Wensleydale unit we noted one person had a new sling on order, but there was no assessment or information that the current sling being used was unsuitable. On the Wharfedale unit we saw the battery was flat in one hoist as it had not been put on charge and so staff shared one battery between two hoists.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 15 (1)(c)(d)(e) as equipment used to deliver care and treatment did not meet people's needs and was not properly used or maintained.

Risk assessments in care plans were not always accurately completed. For example, one person on the Calderdale unit was assessed as 'medium risk' of falls, yet we saw they walked precariously and frequently did not use the equipment they needed, such as their walking frame. Staff we spoke with said they thought the person was high risk, not medium risk. We saw a risk assessment for bedrails for one person on the Wensleydale unit. This stated the person was likely to fall out of bed in one section, yet said there were not likely to fall out of bed in another section. There was no rationale for the use of bedrails in the person's file.

We asked a member of staff to demonstrate how they would operate the bath hoist and how they might secure the lap strap. Staff demonstrated this for us but were not confident in their knowledge of how to ensure the equipment was used safely. The member of staff told us they had been shown by another member of staff and they were not aware of operating instructions, or whether people had been assessed to use this equipment. We asked another member of staff how they would know if a wheelchair lap-belt was fitted correctly. They replied: "I don't know". We observed mixed practice with moving and handling; we saw

staff supported people safely on many occasions, with clear explanations about the process so people felt safe. However, we also saw instances of precarious manoeuvres in which staff were not sure of the procedure to follow. For example, on the Airedale and Calderdale units we saw staff move people in slings which appeared ill-fitting. When we looked at the care records for these people we found limited information about clear assessments for the use of the slings. This was a continued area of concern from previous inspections. Following this inspection we asked the provider to send an action plan detailing how people had been thoroughly assessed individually for all the equipment they used, along with staff training plans to ensure the safe use of equipment.

The regional services manager told us accidents were more clearly recorded than at the previous inspection. Some incidents and accidents were recorded on the organisations electronic system, which prompted staff to alert CQC where necessary. However, the system did not prompt staff to alert safeguarding authorities and this was done at the manager's discretion. Accidents and incidents were recorded with some analysis, although there was limited feedback given to staff or opportunities to evaluate lessons learned. The home's Kingsdale Unit had closed in November 2015 within which we had identified concerns around serious injuries, yet there had been no lessons learned by management about these or measures put in place to avoid a recurrence of similar events. Furthermore, the last comprehensive inspection had highlighted breaches around this, yet insufficient action had been taken. We found there was significant potential for further serious incidents to occur because risks to people from the unsafe use of equipment had not been addressed, either by staff training or by accurate assessments of people's moving and handling needs. The new clinical services manager told us they thought the findings from the Kingsdale unit focused on care planning issues.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(a)(c)(b) as they were not assessing the risks or doing all that was reasonably practicable to mitigate risks to the health and safety of service users.

We saw and staff told us the hostess role, where sufficiently deployed, was positive and supportive and a helpful enhancement to the staff team and people's meal time experience. Staff morale was variable and linked to staffing levels in the service.

Staffing levels were variable and at times, not sufficient to meet people's needs due to staff being called from their unit to cover staff absence in another unit. Movement of care staff between units left staff on other units struggling to meet people's needs in a timely way. We observed a staff handover on the Airedale unit during which the senior staff was asked to redeploy a member of care staff to another unit. They told us: "This always happens, it will leave us short". Staff told us when this happened they tried to lessen the impact on people's care delivery, but this meant they sometimes could not take their breaks. Staff on Calderdale said being understaffed meant there was little time to be spent doing things people needed, such as going into the garden. We saw some communal areas were unattended for periods of time, particularly such as the lounges on the Airedale, Swaledale and Calderdale units. We looked at the staff rotas and the staff movement sheets which highlighted where members of staff had been asked to cover on other units. On the Calderdale unit we noted that out of 28 shifts, 21 of these were short staffed. Staff on the Airedale and Wharfedale units told us they were often called to cover staff shortages in other units and they felt this put people at risk. One member of staff said there had been 10 falls since 1 June 2016 and they felt that was 'down to short staffing'. Staff on the Swaledale unit told us there was a shortage of nurses: "In this home, we haven't got a lot of nurses. It should be two nurses [on the unit] but usually it's not." They gave us examples of when the unit had been short staffed.

We saw on some occasions staff were not able to respond promptly to support people. On the Airedale unit

one person told us: "I've been waiting for the toilet for ages; they won't take me". Staff said: "We are coming as quickly as we can, we won't be long" after which we saw the person waited for 12 more minutes to be assisted.

People, relatives and staff consistently reported poor staffing, particularly in the Swaledale and Calderdale units. One person said: "If you ring the buzzer they say they're short staffed, they take a long time to answer". Another person said they had to wait 30 minutes to go to the toilet. One relative told us their family member had been incontinent because of staff being unavailable to support in a timely way. Another relative told us they were very unhappy with staffing levels. "There's just not enough of them, we have to do basic care tasks for our [family member], such as cleaning their nails. We observed in the '10 at 10' meetings that issues related to short staffing were discussed and manager highlighted the importance of consistency when using agency staff. Staff said they had been short staffed at the weekend on the Calderdale unit, but had not contacted the manager about this as it was sorted out internally. One member of staff said: "This weekend was absolutely horrendous. On Sunday there were three care workers and an agency nurse, one care worker went to hospital so there were two care workers and a nurse". One member of staff said: "Sometimes there's not enough of us. It makes me feel bad when I can't do everything for people". The manager said they always wanted to be informed of short staffing issues as they arose. One manager said they had sought support from the manager about the staffing issue on their unit and the manager had looked at whether hours could be offered over the contracted number to be able to ease the situation in the short term.

All of the above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18(1) as sufficient numbers of staff were not deployed to meet people's needs.

Recruitment procedures were in place, but these lacked rigour to ensure staff suitability was thoroughly determined. For example, for one newly appointed person, who we had seen working unsupervised in the service, there were two references but one of these did not contain sufficient information or assurance about the staff's suitability. The manager told us they had oversight of recruitment, but we saw robust checks had not been made. Where agency staff were used, we saw more detailed suitability checks been implemented since the last inspection, with information verified before agency staff worked in the home. Ongoing suitability of staff was not checked thoroughly or consistently. Although we saw evidence of some spot checks of staff practice, we saw these were not carried out with any consistency and did not extend to agency staff. The manager told us they used the same agency for continuity of staff and they sought assurances from the agency about suitability and training.

We looked at the systems in place for the receipt, storage and administration of medicines in the home. We saw that medicines in use and those in stock were stored safely and that temperatures of storage were clearly recorded. However, we noted refrigeration temperatures were not consistently recorded on the Calderdale unit. We saw the medication administration records (MAR) included specimen staff signatures and evidence staff had read and signed the medicines policy. However, we saw the 'as required' (PRN) protocol for some people was not available on the Calderdale unit, and for others was not legible and it was difficult to read the name of the person or the reason for their medicine. This also lacked detail and did not mention strategies that may be used prior to giving medicine. We noted on one person's care plan there was no mention of PRN medicines that may be used. We observed the member of staff who administered medicines on the Calderdale unit supported people to wipe their hands and ensured inhalers were wiped after use, but did not wash their own hands or use hand sanitiser between supporting each person.

Where people needed topical creams, there were not always charts available to record when or where these had been applied. We spoke with staff about this on the Calderdale unit and they told us they recorded

creams in daily notes, not on the MARS.

Staff supported people appropriately when they received their medicines and they were aware of when and how people liked to be supported with this. Staff asked people if they wanted to take their medicine and explained what it was for, checking whether people had any pain and whether they required pain relief. We saw staff patiently waited with people to check their medicine had been taken on most occasions. However, we found a tablet on a table for one person, who was meant to be monitored when taking medicine.

Infection control procedures and prevention measures were robustly in place and the housekeeping manager had a good understanding of the risks and how to minimise the spread of infection. For example, we saw there was swift action when one person was identified as having a known infection on admission. We found odours throughout the home were kept to a minimum, which was an improvement since the last inspection, although on the Calderdale unit we noted strong odour of urine on day two of the inspection. There were good stocks of personal protective equipment (PPE) and we saw staff used this appropriately. The housekeeping manager was confident in their systems and we saw communication with staff was clear and reliable. Staff we spoke with said they had a clear understanding of what was expected of them regarding infection prevention and control and they had confidence in the way the housekeeping manager ensured standards of cleanliness and hygiene in the home.

Requires Improvement

Is the service effective?

Our findings

People and relatives mostly said they thought staff were skilled at their job. One person said: "Of course they know what they're doing, I expect they know their job". Another person said: "It's to be hoped they know what they're doing. I don't have any concerns about it, they seem to do the job right enough". Another person said: "Yes they know what I like. I don't know how they remember all our names but they do". One person said: "The carers are amazing, I like it here, they look after me so well and they have so many people to look after". One relative said: "Staff are so good with my [family member] and they know how to care for them". Another relative told us they understood what was involved in caring for people professionally and felt staff were competent, although too few in number and too many changes of staff, which affected continuity of care. Another relative said they thought the staff were well trained and they knew the triggers that upset their family member, such as the word 'wheelchair'. They told us staff were 'very good'.

There was a new trainer who was enthusiastic about induction and ongoing training for staff. Staff received induction and training in a range of topics and the trainer was enthusiastic about ensuring thorough delivery of training to all staff, going forward. However, training around risk was not in place and some training was not specific enough for staff to be effective and work safely, such as moving and handling. For example, there were gaps between the training staff received and the procedures they needed to follow for each individual. Moving and handling training directed staff to individual care plans for specific methods on how to use equipment, yet care plans did not identify how they should support people. We asked the trainer whether the training for moving and handling was sufficient. They told us they taught thorough techniques and would expect staff to be able to apply the techniques learned as long as they had individual moving and handling instructions in the care plan for each person's needs.

Staff said they enjoyed training delivered by the new trainer. One member of staff said: "Very good training, I like [trainer's training] [they] answer my questions. Another member of staff said they felt the classroom based training they had received was more helpful and thorough than computer based training they had with a previous employer.

Ongoing suitability of staff was not checked thoroughly or consistently. Although we saw evidence of some unannounced spot checks of staff practice, we saw these were not carried out with any consistency and did not extend to agency staff. The manager told us they used the same agency for continuity of staff and they sought assurances from the agency about suitability and training. Staff's competence in moving and handling was not assessed routinely.

Most staff reported feeling more supported than in previous times, had regular supervision and all were aware of an open door policy with the general manager. We spoke with one member of staff who said they were being supported to be a senior care worker with extra training and competency reviews. This had not yet been completed but they said that the organisation had been 'really responsive' in offering training to them. They told us: "I started my NVQ three weeks ago. This was initiated a couple of weeks after I had asked about it as a possibility". They said they had a development plan which they were working to which had been agreed and they received regular support in the form of supervision sessions which lasted for 20

minutes. This member of staff told us that they felt that they had a lot of support from management and though new to their unit felt that they had the manager's support. One of the unit managers said they met with the managers for supervision every six weeks and their development review had taken place six months ago. Another unit manager said the support had improved: "It's better now but was really up and down before, I didn't really feel I could discuss things with them previously but now I can".

Group supervisions were deployed as method of improving staff awareness and practice around certain hot topics. For example, a recent night visit conducted as a spot check had found that patio doors were being kept open which staff were not always present to monitor. This was raised as an incident by the manager and group supervision took place to ensure that learning was embedded around this issue. We saw records of these sessions which were conducted by the manager and also the unit managers as appropriate. Staff signed documentation to say that they had attended these. However, we noted that the information on these forms was sparse and did not clearly highlight what actions were being taken to make improvement.

Communication systems across the site were not consistent and there were no opportunities for staff to come together or contribute to the running of the home. Staff morale was variable and linked to staffing levels in the service.

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).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We found staff had variable understanding of mental capacity and how decisions might be made in someone's best interest if they lacked capacity. Some staff understood the legislation and how it impacted upon people's care. However staff did not all understand Deprivation of Liberty Safeguards. Staff told us they would actively prevent people from leaving the home if they wished to as staff did not think it was safe for people to leave unaccompanied. The manager told us DoLS assessments and applications were in progress; each unit kept records of DoLS but there was no central record for the whole site, and information regarding DoLS was not routinely shared with the organisation.

We found there was some evidence of best interests meetings although this was not consistent across the site. Staff knowledge of mental capacity and deprivation of liberty was variable, although training had been completed. One member of senior staff told us they assessed capacity but said they had not had any training to do this.

Staff were all clear that people needed to be given choices, but some staff were unable to tell us how they would know if a person lacked capacity and what to do and staff focused on people's ability to communicate, rather than their mental capacity. Care documentation showed mixed recording in whether

people lacked capacity to make individual decisions. For example, one person's care plan said 'advanced dementia' yet the mental capacity assessment was ticked 'no'. One person's care record showed 'cannot make decisions about care planning process', yet stated the person did not require an assessment of their mental capacity. The record showed the person could make verbal consent in one section, yet in another it stated 'unable to express verbally'. In another care record we looked at it stated there was a permanent impairment of the mind and the person was 'unable to make a decision' yet there was no reference to specific decisions. In one person's care record it was stated they were unable to make any decisions and 'staff to make decisions about what to wear for [them]', yet in another section it stated the person was to choose their own clothes. Another care record stated a person had 'full' mental capacity, then stated deprivation of liberty was required. Another part of the plan stated 'is unable to voice any wishes', yet stated 'is able to communicate his/her decision', but there was no information about how the person communicated. In the 'consent to access care documentation' section the form was ticked to show the person gave consent, even though this was only applicable where a person had capacity. Consent was not consistently sought. For example, one person on the Airedale unit had not given consent for the use of bedrails, yet the care record showed they had capacity to do so.

The provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff lacked knowledge about the principles and codes associated with the Mental Capacity Act.

The majority of people we spoke with reported they enjoyed the food. One person said: "The food is perfect, fantastic". Another person said: "The meals are just how I like them". Another person said: "The meals here are always nice, I look forward to them". One person announced "Delicious" as they began to eat their meal. Another person said: "The food is mostly good. Even if you go to a restaurant, sometimes there are things you don't like. It's really good". However, many people on the Wharfedale unit did not like the food and we saw many plates were returned with uneaten food at lunchtime. One person we spoke with said: "We are well looked after; the food is rubbish though, everything turns out like stew". People were supported to eat and drink and choices were offered, with alternatives for people if they did not like their choice on most units, although there was less choice offered on the Calderdale unit and in some units, food was already plated up for people. We saw there were frequent opportunities for people to have drinks, particularly in the warm weather during the inspection and small bottles with lids and straws were used to encourage people to drink water. Some people chose to have alcoholic drinks which staff brought for them.

Food and fluid charts for some people were not completed consistently, although some were completed in full. One person who was receiving end of life care, did not have a fluid chart in place and staff could not give assurances as to how they would meet the person's needs or identify if they were dehydrated. Where people required special diets these were managed well, details were clearly available and documented in care plans. Staff support and equipment needed for people to eat and drink was consistently given and staff we spoke with understood people's nutrition and hydration needs. Speech and language therapy (SALT) had been involved in people's swallowing assessments and dietician referrals had been made where necessary. Staff were aware of which people needed to have thickened fluids and practice was observed to be in line with people's swallowing care needs, the details of which were precisely recorded in care records. We saw one hostess was very motivated in their work and knew people's dietary needs. Staff on one unit told us the hostess was not always available and this put additional pressure on them to meet people's needs.

Staff communicated with one another about people's dietary needs much of the time, but this was not consistent. For example one person could not have boiled sweets and staff checked with each other beforehand. Yet another person was given a cooked breakfast by a member of staff who did not check with other staff the person had already eaten. Fresh fruit was available within people's reach. Staff encouraged

people to eat and were observant when some people began to wander away or look sleepy, so speeded up the service of the meal.

We saw a noticeable improvement from the last inspection in the environment for people, particularly for people living with dementia in the Wensleydale unit and further improvements were ongoing, with a much more homely feel to the units than on previous inspections. Staff praised the improvements to the environment, such as the new décor and different doors to people's rooms. The manager of housekeeping, laundry and infection control showed us photographs of before and after the improvements to help illustrate the work that had been done.

Referrals to other health professionals were evident, such as GP, memory clinic, optician and chiropodist. We received positive feedback from visiting nurses who reported the staff worked closely in partnership with them to meet people's needs. They told us: "Communication with staff is very good, makes it easier for us".

Good

Is the service caring?

Our findings

Most people said staff were caring. One person said: "I love it here, I'm very happy" and another person said: "Carers are lovely, very helpful". Another person said: "The staff are very good. Oh they do look after me". Another person said: "The staff are all very good. Well, you get the odd growler, don't you, you know what I mean, but they're all ok". The person did not want to tell us anything to clarify their remark and stated "I like it here, they ask what you want to eat, you get to choose. I like my room, look I can watch the birds fluttering, I like that". One person said: "The staff are not always nice, they treat you as if you're a nobody. They have an attitude problem. I was made to feel like an imbecile".

Relatives we spoke with said they thought staff were caring. One relative told us: "I can't speak highly enough of the place, nothing is too much trouble, they really care. [My family member] is always clean and well fed. When the weather is nice they sit out with big hats on. They [staff] have so much to deal with here - you can see - but the staff are brilliant".

Staff engagement was warm, kind and caring in the majority of our observations throughout the service. Staff used humour appropriately with people and joined in with friendly banter, which people enjoyed. For example, one member of staff said to a person: "Do you want your vodka, no, orange juice?" which made the person smile. Another member of staff commented on a person's hair and said "Not a bad haircut there", and it was evident people were relaxed in this conversation. Staff spoke with sensitivity and made positive comments to people, such as "Are you ready to get up? Did you have a nice sleep?" "Your hair looks nice" and "You look beautiful today". Care records detailed people's personal preferences around dignity. For example, one person's record stated '[Person] always likes to look smart with coordinated clothes'.

A community nurse we spoke with told us staff were caring. They said they had seen staff behave in a caring manner towards people, when they did not know anyone was watching.

Only in the very minority of occasions we noticed one member of staff did not engage positively with people; this was on the Swaledale unit. The member of staff did not respond when one person tried to attract their attention, but completed care records instead. When another person tried to interact with this member of staff, they rolled their eyes and walked away. Staff sometimes spoke about people in their presence on this unit, instead of addressing people directly. We discussed this during feedback with the management team as it was a clear contrast to the quality of interaction we had observed during the whole inspection.

One person we noticed on Calderdale had a t-shirt on back to front with blood stains on it, which did not promote their dignity. We asked staff who said: "That's from their arm, they pick at their dressing"

Staff were otherwise respectful of people's dignity and promoted their need for privacy.
Staff told us they promoted people's dignity through a range of different ways, such as covering their legs with a blanket when hoisting, making sure doors were closed for privacy, ensuring people had clean clothes and brushed hair. One member of staff said: "You want to treat people how you'd want to be treated".

We saw when staff spoke with people they knew their backgrounds. For example when one person's visitors left, a member of staff asked the person: "Did you used to work with those gentlemen at the printers?" We found staff were aware of people's cultural needs. The unit manager on Airedale spoke about the importance of faith in person centred care. They illustrated a clear example to us of how they ensured the spiritual and cultural needs of people were met. The unit manager said understanding people's customs, rituals and beliefs can make their whole demeanour change with positive effect. This was observed and documented clearly in the person's care plan.

People's choice and individual needs were supported. For example, a male staff member had moved to work on a unit so that one person could have a male care worker to support with personal care. We spoke with the male worker concerned and they confirmed that the move had occurred to support this person's needs. Staff had an understanding of people's spiritual needs and made effort to support this aspect of their care. For example, staff knew it was important for one person to wear their rosary beads and this was noted on their care plan.

We saw staff involved people with explanations and information about their care and support. Staff supported people at an appropriate pace and care tasks were not rushed. People's independence was maintained as much as possible, although where people did not have access to the appropriate equipment for their needs, this was not possible. One member of staff on the Wensleydale unit told us: "We encourage people to be independent, what they can do for themselves we get them to do, encourage people to walk to the table. We supervise rather than do for".

The residential services manager said "Care of staff is really brilliant here and the carers are really passionate about what they do". One member of staff said: "I absolutely love my job".

Care plans illustrated end of life care was mostly discussed. Advocacy was available to people where this was needed and people had an IMCA where there was no family to support them.

Inadequate

Is the service responsive?

Our findings

Some people told us care was responsive to their needs, although other people did not. One person said: "I have everything I ask for, the staff are lovely and they say it's no trouble if I need them". Another person said: "They come if I press my buzzer, but it can take a while though. I know they're busy". Another person said: "I get a bit fed up, there's not a lot to do and if I've read my paper, that's that." One relative said: There's nothing for people to do, they are not stimulated"

Care records were person centred and completed in most cases. These included personal preferences, such as 'likes Guinness with main meal' and 'has daily paper delivered'. We saw there were regular reviews of care records and people had been involved in discussions about their care. However, assessment of people's needs lacked key detail around areas of risk, such as for equipment or support with moving and handling. Some detail within care records was conflicting. Records to show when people were repositioned were in place. Where people had capacity not all records were signed by them.

Senior staff at 10 at 10 meetings discussed the 'resident of the day' initiative to ensure the care plans and records of each person were reviewed monthly. Staff on each unit reviewed one person's care documentation each day. We were informed that people's family usually contributed to these reviews over the telephone, though there was no set structure for this. Managers we spoke with did not always ensure that family were involved with these reviews of the documentation. The residential service manager said "There is not a structure for a formal review, if the family want to be involved this is done through resident of the day". However we found on the second day of inspection feedback from the 10 at 10 meeting highlighted as an action point that all staff completing the resident of the day should ensure that relatives were invited to be part of the review of the care planning.

Key workers were knowledgeable about the needs of the people they supported, although we saw when staff wrote daily notes this was not always for the person they were key worker for. Where particular care needs were highlighted, there was evidence of responsive action taken. For example, one person was identified as being at high risk of depression and staff had arranged for the person's dog to be brought in to visit. The care record stated this improved person's moods and showed evidence the depression scale score improved.

Staff were responsive to people's everyday needs. For example, staff brought someone's glasses, a tissue for one person to wipe their nose and extra cushions to ensure people were seated comfortably.

Call bells were in place and we saw these were answered promptly. Staff we spoke with told us they were aware of the importance of making sure people could summon help, and if they were unable to use call bells staff made frequent checks. However, we heard two members of staff speaking in front of two other people, about a person who pressed their call bell a lot. One member of staff said "Oh I bet you can guess who's buzzing" and the other member of staff said: "I think [person] just does it out of habit now".

Resident involvement meetings were organised by the manager and there was evidence families were

involved in the discussions when Kingsdale unit closed. The manager told us that person centred care was her area of expertise and said: "As a leader that is how I demonstrate good practice." Staff we spoke with said they tried to deliver personalised care. One unit manager said person centred care was delivered "as far as is possible with what they've got" but said staffing levels sometimes affected the quality of care delivery.

There was limited evidence of meaningful and personally engaging activities that were in keeping with people's interests. Some people had little to do, others enjoyed group activities. We spoke with a new activities staff member who was completing training and had not yet started work in the home and they were enthusiastic about their forthcoming involvement. The environment for those people living with a diagnosis of dementia had improved since the last inspection. The manager told us there was room for improvement with individualised activities.

On the Swaledale unit we saw two people had not moved from the same chair all day and were not assisted with continence needs. Both of these people's care plans said they should be assisted to reposition four-hourly due to high risk of pressure damage. We checked at three points in the day and staff confirmed the people had not been moved from their seats. On the Airedale unit we saw some people were reading and doing puzzles but many were just staring at each other with little else to do. One person, newly admitted to the Airedale unit appeared to not know what was happening and there was little reassurance from staff as staff did not have time to sit and chat with people. On Calderdale, we saw people were seated to the table in wheelchairs for long periods.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9(1) because people who used the service did not receive person centred care and treatment that met their needs and reflected their personal preferences.

On the Wharfedale unit we saw a game of bingo in the lounge. Most people joined in and won snacks as prizes, with lots of chat and banter throughout the game. We heard the activity coordinator asked people for feedback on a recent armchair exercise session. In the Calderdale unit there was hand massage available to some people and we heard music was on throughout the day. Some people sat passively. We heard one person screamed out and we asked staff about this. Staff told us this was the person's way of communicating and we saw this was detailed in their care plan. Staff sat with the person and offered one to one support, but with no activities or items of interest for the person to engage with.

Complaints information was available to people in their rooms. Complaints were not responded to in a robust and thorough manner. One person we spoke with said they had been in bed for a long time because there was no suitable lifting equipment to help them get out of bed. They told us staff had attempted to use a lifting sling but they had not felt safe and asked staff to stop. Since then, they had not been assisted to get out of bed. They told us they felt upset because they needed to sit up due to their health, yet they could not achieve this. They said they had not been in the bath or the shower for several weeks and although staff washed them, they wanted to be out of bed. They told us they had complained about this to the staff but nothing had been done and staff did not take them seriously. We asked the manager if they had recorded the person's concerns or responded in line with the complaints process, and we were told it had not been regarded as a complaint, only 'a query' so this had not been done. The manager told us a specialist sling had been ordered for the person and they were awaiting delivery. There was evidence that some complaints made were appropriately managed. However, the complaints listed on the home's computer system differed from their written complaints record. Some people and relatives we spoke with said they did not know how to raise a complaint. The clinical services manager told us they were not aware of any complaints that had led to service changes and said they had not been involved in the complaints process due to their limited time in post.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 16 (1)(2) because complaints were not consistently responded to or recorded.

Inadequate

Is the service well-led?

Our findings

Some people told us they thought the service was well run. One person said: "It's good that people like you [CQC inspectors] come and check but you don't need to worry, it's good here". Another person said: "It all seems fine to me, I can't think of a reason to say it isn't". Another person said: "It's not run well, they make excuses after excuses and they don't communicate with me". Relatives we spoke with said they knew who the unit manager was and some relatives said they knew the general manager. One relative said: "It comes from the top, that's how places are run. I can only speak for the unit my [family member] is on, but I'm happy with what I find.

The manager had continued in post since the last inspection and their application to register with the Care Quality Commission was in progress, awaiting completion. Staff mostly reported feeling supported by the manager and some staff considered the home was run better than in previous times. One member of staff said: "[Manager] is really approachable" and another said: "I like [manager], calls a spade, a spade. Some of the staff reported feeling things had improved and we found staff morale was linked to staffing levels; for example, where staff on some units had been frequently asked to provide cover for other units when short staffed, this affected morale and staff did not feel as well supported. Some staff however, did not feel as well supported and felt that overall leadership was bullying in nature, with nothing resolved. Some staff told us they did not feel confident of management support if they followed the whistleblowing process.

Staff said there was improved teamwork in some parts of the home. One member of staff on Wensleydale told us: "Everyone is pulling together as a team lately". Staff on Wharfedale said :"All staff are good on this unit, they all pull together when we are short staffed". Staff told us they were not asked for feedback about the service and two members of staff on Calderdale said they 'had never had a team meeting'.

Staff did not all know or understand the visions and values of the service. The member of staff responsible for training told us they emphasised Bupa's visions and values during the induction for new staff and although we saw this was illustrated on the programme for induction, staff who had worked at the service for a long time did not know what these were. For example, we spoke with two senior unit staff about the visions and values. One said "Pass", indicating they did not know. The other said: "To be the best service that we can offer, everybody is somebody's loved one. if I saw something wrong I think how would I like it". The clinical services manager said "Visions and values are ensuring residents' needs are being met, that they are healthier and happier". The residential services manager said visions and values were laid out in the mandatory training and management were striving to achieve these values through monitoring in the daily walk about. They told us the vision had changed recently: "We want everyone to enjoy working here, for residents to be safe and tackle any problems to the best of our ability". When we asked the manager what the visions and values were for the organisation they said these were about developing relationships and listening to staff, sharing the positives as well as negatives. They said: "I will discuss the business with them. If I can't deliver then I will be honest with them."

We found the management team had made some efforts to improve the culture in the home and encourage communication. The manager told us they were aware there may be different sub-cultures due to each of

the units operating differently. Staff described an 'open door policy' and one manager said a management clinic drop in session had just been set up for staff to attend in early July. This was with the aim of ensuring staff had access to management to express concerns easily. We saw the poster advertising this on one of the unit's noticeboards. The manager had recently introduced an anonymous feedback form for staff to share views, although this had not yet been used. We were also informed about several staff rewards initiatives run by the company. The manager said that they made sure people were celebrated for their positive contributions through this scheme. 'Every day hero' certificates were available as a template for thanking staff for their achievements when staff had gone over and above in their work. However, one unit manager was sceptical about this initiative and said that no information was given about how this should be used with staff. They did not know the strategies other unit managers used to motivate and reward care staff.

Systems with which to monitor and evaluate the quality of the provision showed some improvements over recent inspections, although they were disjointed and lacked consistency across the service. There were tools in use to record information and report this through to managers, at both service and provider level. However, these records did not serve a purpose to identify trends and patterns and there was limited feedback to staff once managers had reviewed information. For example, each unit manager returned information to the senior management team through a quality matrix form, which included headings such as nutrition, reviews by GPs, medication status, use of bedrails, deaths, safeguarding referrals, complaints, resident involvement and incidents. This recorded what the incident was, not what action was taken. This information was discussed at the weekly management meetings and the monthly heads of department meetings. Unit managers said they did not receive any meaningful feedback or minutes from these meetings. One unit manager told us they had not seen any results of these meetings since July 2015. The manager told us information was not collated across the service to look for overarching themes or trends and no feedback was given to Bupa through the quality matrix.

Unit managers we spoke with said there was inconsistency in how information was discussed and shared. One unit manager said: "Each unit does quality discussions about care slightly differently. The Wensleydale manager is very active with this". Clinical risk review meetings were held and we saw documentation of these. The clinical services manager said they were only just starting to understand how these operated as they were new in post but felt these were a mechanism for seeing how all the risks linked together in terms of reviewing individual care. There were numerous meetings where concerns, quality issues and risk were discussed but there was little evidence of the outcomes of these discussions and there was no central register for logging risks.

Two of the unit managers we spoke with were aware of the service improvement plan (SIP) which was used to address and review quality issues in the service. The information about this was cascaded at the heads of department meeting. One manager told us there was a lack of information about progress on this plan and staff involvement with this was poor. They said that staff would probably not know what the SIP was. Unit managers had been involved in a meeting to discuss the findings from the CQC report and we saw minutes of the meeting that confirmed this. The residential services manager said they had not been involved in the monitoring of the action plan as their task was reviewing care planning and the audit of these. Care planning audits resulted in performance improvement plans and coaching to improve staff performance in certain areas.

Quality walk rounds were done by the management team for which there was a template where issues could be picked up and acted upon. Quality issues we saw were communicated with senior staff in '10 at 10' meetings but with limited detail. For example, we observed one of these meetings and saw audit results were shared in respect of a medications audit, however, the details of the audit were not shared. Feedback at this meeting was given about the success of a new project 'me and you time' which was an innovation by

the manager for ancillary staff who volunteered to spend additional individual time with people who were more socially isolated. We heard how the chef had made time to support this initiative and how one person had responded positively to it.

The residential services manager told us the organisation support was made by a weekly visit from the regional manager. They said that there was also a services improvement manager who helped out with documentation and systems. They told us "The new regional manager is much more hands on [they] go and see things for [themselves]". They also felt that there was more the organisation could do to enable the managers to have a stake in the service development. One member of staff said they knew the regional managers by sight when they walked round but did not know them by name. They went onto describe that things had been very stretched in terms of management capacity before the clinical services manager was appointed. The manager said they felt supported by the organisation and said: "You've always got other departments looking out for you. If I'm not sure what I'm doing I can always contact somebody".

The home had recently taken part in 'care homes open day' which was hailed as a success at the '10 at 10' meeting we observed. The home also was participating in the Vanguard initiative in Wakefield. This initiative has been drawn up to improve care standards in care homes by a range of measures, one being increased access to the wider multidisciplinary team and enhanced pathways to primary care. So far contact had been made with a dietician who had offered training for the staff on nutritional assessment and food fortification. The manager informed us about this and senior staff on each unit were aware of this session which was advertised on the units. The manager told us that it was helping with networking. They commented that equipment seemed to be available more readily since the Vanguard had been started at the home.

Bupa policies and procedures were accessible to staff on the intranet. Checks were carried out routinely for premises and equipment and where remedial action was required, this was taken and recorded. We had to alert staff to a pressure relieving equipment that was sounding an alarm on the Calderdale unit. Systematic checks of utilities, such as gas, electricity and water were carried out. Lifting equipment checks were in place supported by relevant documentation. However, we looked at checks of slings used with lifting equipment and found that although these were recorded as being regularly checked, there were no serial numbers on most of the slings to be able to identify which sling was which. Also, the records varied as to the safe working load. For example, the check for one sling stated the safe working load was 200kg, yet on a different date the same sling recorded a safe working load of 160kg. This meant checks of some equipment were not carried out thoroughly.

We asked the manager what had taken place as an improvement that the service was proud of. They told us moving and handling had improved; they explained how staff had been using inappropriate techniques and so a raft of initiatives had been introduced. For example, staff were trained, walkabouts were conducted where individuals were shown on the spot when they were using inappropriate techniques. In addition, all staff had signed to say they understood the moving and handling information in care plans. They told us they had brought in a new trainer who was observing practices. The trainer could not verify this had happened as they told us this was managers' responsibility.

Of significant concern was that no lessons had been learned in response to serious incidents in which moving/handling for two people had resulted in serious harm in 2015 on the Kingsdale Unit. Although the organisation made a decision to close the Kingsdale Unit, these serious incidents had not been thoroughly reviewed or attempts made to improve practice as a result of these. For example, no root cause analysis had been done by the organisation until four months after one of the incidents, and there was no evidence of any investigation into the other incident. When we asked staff about the learning from the incidents which occurred on the Kingsdale unit they told us managers had been directed not to communicate with staff

about these. One unit manager told us " the issues that led up to the closure of the unit were shared in a meeting with managers but this was not shared more widely care with staff. They went on to say that detailed information was not shared because of the disciplinary issues and this had related to confidentiality. Things were just discussed more generally; these highlighted that residents should not be left unattended, that we should continue with observations after falls and make sure that documentation was recorded accurately. They said that they were not aware of learning in terms of use of equipment". Another member of staff said information from the Kingsdale unit was not passed on and they were not aware of any learning and information sharing regarding the incidents, although they had been signposted by their line manager to the CQC report. This meant there were systemic failures in governance that meant improvements had not been made to ensure staff were adequately trained in how to operate equipment, to ensure equipment was suitable for the people who were using it, and to ensure people's moving and handling assessments were properly carried out.

The manager confirmed there were no systems in place for lessons learned, but said: "I can honestly say I know what's going on on-site". They told us they had worked hard to improve their visibility in the service.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures. There were weaknesses in communication throughout the site, with the manager, and with the wider organisation. Where serious failings in the service had been previously identified around the management of risk, little action was taken to improve practice and prevent future harm to people. Following the inspection we asked the provider to submit information to assure us of people's safety in relation to risks.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17 (2)(a) there were significant weaknesses in the systems and processes in place to monitor and improve the quality of the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not always delivered in line with their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Equipment was not always suitable or available to all people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not responded to, recorded or acknowledged

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not always sufficient to meet people's needs in a timely way.