Advinia Care Homes Limited

West Ridings Care Home

Inspection report

Off Lingwell Gate Lane
Lofthouse
Wakefield
West Yorkshire
WF3 3JX

Tel: 01924826806

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection was unannounced and took place on 21 & 22 November and 4 December 2018.

West Ridings is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Accommodation is provided for up to 180 people, across six units, although one unit had not been in use since 2015. At the time of the inspection, there were 133 people living in the home.

At the time of the inspection West Ridings Care Home consisted of the units Swaledale (general nursing), Calderdale (dementia care nursing), Wensleydale (dementia care), Airedale (residential care) and Wharfedale (residential care).
There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We identified four breaches in the regulations in relation to, safe care and treatment, staffing, fit and proper persons employed and good governance.

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We found weaknesses in how the service was run and managed. There was a lack of clinical oversight across the service. Some staff did not feel fully supported or clear in their roles and responsibilities. Audits of the quality of the provision were not robust and there were significant gaps in documentation.

Staffing levels on the whole were sufficient in number to meet people's needs, although little consideration had been given to the skill mix of the team, particularly on the Calderdale unit.

Recruitment, induction and training was not robust and there was very little evidence staff were sufficiently vetted or had the right skills to support people safely. We found some concerns in the supervision and support of staff.

Management of medicines was not sufficiently safe. We found concerns around the supply of people's medicines, stock balances and recording.

There were missed opportunities for lessons to be learned when accidents and incidents occurred.

People were supported to have maximum control and choice over their lives and staff supported them in the least restrictive way possible. Policies and systems in the service supported this practice although staff understanding of the legislation around people's mental capacity was variable and decisions made in people's best interests were not always clearly recorded.

People's dietary needs were appropriately met, although people did not always have access to drinks in their rooms. There were effective links with other professionals to support people's care and health needs.

Staff had a kind and caring approach and showed respect when interacting with people. There was appropriate regard for people's privacy and dignity.

Activities were variable; there were some meaningful opportunities in place and staff knew people as individuals, although not all people were happy with activity provision. People and relatives knew how to complain, although we found weaknesses in the recording of and response to complaints raised.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Staff recruitment processes were not robust and appropriate safeguards were not in place for agency staff.

Medicines were not managed safely.

Accidents and incidents were not thoroughly analysed or used to inform future learning.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not suitably trained and supported to carry out their work. The skill mix of the staff team was not always considered.

Assessments of people's care needs were in place, although there were some gaps in information.

There were effective links with other professionals.

Is the service caring?

Good

The service was caring.

Staff had a kind and caring approach to working with people and there was evidence of good relationships between people and staff.

People's privacy and dignity was respected.

Visitors were welcomed at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always consistently completed and reviewed.

There was some evidence staff knew each person well and some activities were meaningful and well resourced.

Complaints were recorded but it was not always clear what the outcome of some complaints had been.

Is the service well-led?

Inadequate

The service was not well led.
There was a lack of robust oversight of the quality of the provision, particularly with regard to clinical practice.

Some staff lacked direction and did not all feel there was sufficient management support.

There were weaknesses in documentation to support how people's care was being managed and how the service was run.

West Ridings 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 21 & 22 November, and 4 December 2018 and was unannounced. The inspection team consisted of four adult social care inspectors, a specialist professional adviser in dementia nursing, a pharmacist and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service. Their area of expertise was care for older people.

Before the inspection we reviewed information we had available about the service. We had not asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed safeguarding alerts and notifications submitted to us by the service. A notification is information about important events that the registered provider is legally required to send us. For example, where a person who uses the service suffers a serious injury. We took this information into account when we inspected the service. We liaised with the local authority safeguarding and commissioning teams and the clinical commissioning group (CCG) to discuss information about the service.

We spoke with the registered manager, unit managers, the deputy manager, 19 staff caring for people as well as ancillary staff. We spoke with 28 people who used the service and nine people's relatives/visitors as well as two visiting professionals. We looked at care records for 17 people and records to show how the service was run.

Inadequate

Is the service safe?

Our findings

Staff recruitment procedures were not safe. We looked at seven staff files and found these did not contain evidence of thorough checks. For example, there were missing references and staff had been appointed without full checks made to ensure they were suitable to work with vulnerable adults. We spoke with the registered manager who said some staff had been appointed by the provider and therefore she had not been involved in the process. The registered manager was unable to demonstrate how some staff for whom English was not their first language, had had their competency in English assessed when working at West Ridings. The registered manager told us this had been assessed by the provider prior to them working in the home. We contacted the provider following the inspection and they told us where staff did not speak English, this had been assessed at the recruitment stage and they sent documentation to evidence this.

Where agency staff were used, their identity had not always been verified. For example, we asked to see three staff profiles where agency staff had been used, but these were not available and the registered manager confirmed these had not been obtained prior to the staff working in the home. The registered manager was unable to show how they ensured the registration of qualified nurses was valid as there were no regular PIN checks made and not all nurses' registration status had been recorded.

We concluded the provider was in breach of Regulation 19, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.
When people's assessment indicated risk, such as with moving and handling, there were risk assessments in their care plans which guided staff how to support people. We saw details of equipment needed for each person and how many staff were needed to support them. However, we found some conflicting documentation regarding people's sling types which put people at risk of not being supported safely. We also found staff had not had training in safe moving and handling techniques, since transferring to the new provider.

We found where people displayed behaviour which challenged, staff had very little guidance as to how to manage these situations. For example, care plans stated staff 'will monitor' but did not state how this would be done to ensure people's safety. At the time of the inspection, an incident, where a person's behaviour had presented a challenge on one of the units, meant some people reported feeling unsafe. We noted from the person's care records incidents of a similar nature had been occurring, but no clear guidance had been put in place for staff to safely support the person and others.

Accident and incidents were not well recorded and there were inconsistencies in documentation and management reviews of these. For example, detail in some of the accident records did not correspond with the management reviews.

People were positive when asked if they received their medicines on time and we saw medication was administered in a caring and professional manner. However, we found the systems and processes to ensure safe management of medicines were poor and as a result, people were not properly supported to receive medicines in a safe or timely manner. We found the Calderdale unit in particular, was significantly under

resourced for medication administration due to the complexity of people's medication needs. On both nursing units the morning medication round took a long time to complete. In the Calderdale unit staff told us people's complex needs meant staff's attention was diverted when they were administering medicines and so this caused a delay in completing the medicines round.

We looked at the care records for one person who required their medicines to be given covertly (disguised). Their care plan indicated their medication should be placed in a cup of tea and staff should then 'monitor when [the person] is having a coffee to makes sure [they] had all their medicines'. There was evidence that staff had sought advice from the GP but this did not specify each medicine that was to be given covertly and also did not indicate the method of administration (for example, if the medication was to be crushed or mixed with food). When medicines' original form is altered, this can have an impact on their effectiveness or cause unwanted interactions with other medicines. We shared our concern with the unit manager who told us they were working with their local pharmacist to address this issue and improve their processes and documentation in this area.

We found concerns with the stock control of medicines and the inspection identified some people had been without medicines for up to three days. We brought this to the attention of the registered manager and asked them to carry out their own investigation and make the necessary safeguarding referrals for the people concerned. We found one person was delayed in receiving pain relief via a pain patch due to a delay in the stock being delivered. The registered manager told us there were problems with the supplying pharmacy and they were in the process of trying to improve this.

Stock counting of medicines was taking place, but this was not thorough or consistent. We checked a significant sample of medicines and found discrepancies between the stock present and the recording of what was available.

Recording of people's medicines was poor. For example, the information on the front photograph page on some records we reviewed was basic and not fit for purpose and the identification of people's needs was poor. There was a lack of documentation for specific medicines ordered.

We found errors and weaknesses on medicines administration records (MARs). One newly admitted person did not have their photograph on their MAR which meant they were not clearly identifiable. There was conflicting information on the correct dose of medication to be taken. For example one person's MAR statedtheir medicine was to be taken once a day but the labels on the medication packets stated twice a day. Where people needed medicine 'as required' (PRN) there was not always clear information such as a PRN protocol, to guide staff. Where we saw there was a PRN protocol for one person's medicine, this was not detailed on their MARs.
Staff competency was not always checked prior to medicines being administered. One member of staff who was training to be a senior carer had not been signed off as competent to give medicines, yet had signed their initials on the MARs.

Storage of medicines was secure, although staff were unable to demonstrate how they ensured and recorded safe temperatures for storage. This meant there was no guarantee medicines had been stored at the correct temperatures. We discussed this with the registered manager who said they would review this with staff.

There were risk assessments for the service as a whole, including premises although there had been few recent reviews of these. There was no outdoor risk assessment, even though there were hazards, such as a pond in one of the outdoor areas. Where hoists were used by staff to help people stand or transfer from bed

to chair, to use a toilet or shower, these had been serviced regularly but there were no routine checks of individual slings. We noticed some equipment was worn and one pressure relieving cushion was torn in several places. The registered manager told us they relied on the maintenance staff to make sure premises and equipment were safe, but there was no management oversight of this.

The examples in this domain illustrate the provider was in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Individual risk assessments had been carried out for a range of areas such as medication, diet, cognitive ability and health. We saw individual risks had been noted on the wall chart in each unit manager's office, so there was an overview of the risks in each unit.

Care staff had access to records so they could obtain information to support people to stay safe. Staff we spoke with said they referred to care records as well as discussing in handover meetings, any aspects of people's safety.

Most people we spoke with thought the service was a safe place to live. People's comments included, "I am safe, the doors are always locked at night and I have an alarm bell. There is a fire bell if there is a fire", "I have a walking frame to keep me steady on my feet" and "I feel safe. I like to keep my door open so I can see and hear people." However, one relative told us they had concerns that staff did not check the people as they should do.

Staffing levels were appropriate to meet people's needs overall, although the qualified nurse staff were extremely busy at times on each of the nursing units and this impacted upon the time it took to complete medicine rounds. On the nursing units there were not always two nurses available which impacted upon medication times as there was only one nurse to do both medication and nursing tasks. Staff told us that the rota was planned on a four-weekly basis but that it could be adjusted to accommodate any changes that might be required. The registered manager told us staff remained within their own units as much as possible to ensure consistency of care and only occasionally worked on other units. Staff we spoke with mostly said they felt staffing levels were acceptable and they felt there were enough staff on duty at every shift. However, there were no opportunities for the nurse on Swaledale to have supernumerary time unless they used their own time to do this. One member of staff told us there were the 'best staffing levels ever had'.

People and their relatives said the staffing levels were acceptable overall. One person told us, "On the whole yes [staffing levels are satisfactory]. Sometimes people want to go to the toilet all at once but they always manage to get people sorted."

People told us the call bells were usually answered in a timely manner. People we saw in their rooms mostly had a call bell within reach. People's comments included, "Staff answer in a few minutes. Sometimes I have to wait for the toilet. I waited about half an hour this morning", "When I press my call bell in a morning to get help to get up staff come as quickly as they can no more than 10 minutes." Another person said, "I have got a call bell which I press if I need anything, they usually come quickly, only once they didn't and that's because there'd been an emergency." One relative was concerned that their relative couldn't reach their call bell and said, "[Person] can't reach their buzzer". We saw that the person's buzzer was just out of reach.

Staff rotas confirmed the numbers of staff were largely consistent. We found a period of time where there had been no senior care staff on duty at night, although the registered manager showed subsequent rotas where this had been addressed. The registered manager told us this had been an oversight and in an emergency the staff would call the nurse on site.

Staff understood the signs to be aware of and how to report any safeguarding concerns. Staff understood how to use whistleblowing procedures and the provider had a policy which encouraged staff to speak out if they had any concerns. However, staff were not all confident concerns about poor practice would be listened to or dealt with appropriately.

Arrangements were in place for making sure the premises were kept clean and hygienic. We observed the premises were mostly clean, although some areas were in need of attention, such as chair arms and dining furniture. Staff understood their roles and responsibilities in relation to hygiene. Supplies of personal protective equipment (PPE) were available and used when delivering personal care. Most toilet and bathroom areas had adequate paper towels, liquid soap and toilet paper, although in the Airedale unit we found these were not always in place. People's comments included, "It is cleaned every day, and it doesn't smell."

Requires Improvement

Is the service effective?

Our findings

We found significant gaps in staff training and the registered manager told us this was an area being addressed by the provider. Training records showed staff had not had any recent training in key areas, such as moving and handling, medicines, dementia care, first aid and managing behaviour. Staff we spoke with had not had any wound management training and some staff had gaps in their knowledge of particular areas, such as mental capacity. Staff told us much of the training they had was through e-learning and some staff said they were expected to complete this in their own time. The registered manager confirmed where this happened staff were paid to do so.

The provider did not have a robust competency check process in place. Staff competency was not consistently checked to ensure staff were capable of supporting people safely or effectively. Where competency checks were recorded, we found the staff who had checked this competency had not had any recent training themselves, such as in medicines administration.

We found there had been little consideration as to the skill mix of staff working in the Calderdale unit. People living in the Calderdale unit had very complex needs and staff lacked training, skills and experience in supporting people effectively. For example, when people living with dementia demonstrated behaviour which challenged, staff did not always know how to support them appropriately. The registered manager told us this was an area being considered.

Some staff told us they received regular supervision and we saw some records which evidenced this. The registered manager told us there was support for the nurses from their peer group, however, there were no mechanisms in place to ensure they received sufficient clinical supervision.

We concluded the provider was in breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

The practice of handovers varied from unit to unit. Some handovers were more detailed than others and documented clearly, whilst others were less so and there was limited evidence of consistent practice across the whole site to communicate key messages between shifts.

People and their relatives said they thought staff knew how to do their jobs. One relative said, "I don't have any evidence to say they are not well trained. They know how to move [name?] with their walking frame." One person said, "When I go to bed they know how to lay me and I always wake in the right position. They know how to handle me."

We spoke with visiting professionals who said admissions processes were followed to ensure people's needs were met. People's dietary needs were suitably met. There were different options for meals and staff knew people well and their individual food preferences. Where people were living with dementia we found there were not always visual choices to help them decide what they might like to eat. We made a recommendation this is reviewed so people are properly supported to make informed choices. Where

people wanted to sleep later we found they were supported with their meals when they woke up.

People told us they enjoyed the food on the whole, although one or two people said it was not always to their liking. Comments included, "You do get a choice but the chef could do better. We get enough snacks and drinks", "I don't like the spicy food we sometimes get. We get about three choices at lunch time and two choices at tea time. For example, Jacket potatoes, omelettes, and salads. We get two drinks day and we can ask if we want more. We do get biscuits and cake before meals." "It's no four star restaurant but it looks a good standard.", "I quite like it, for me there is enough choice." and "It's horrible, the way it is cooked. It is over cooked and it is inedible sometimes. I have spoken to people about this but it hasn't got any better." Another person said the food was excellent and there was plenty of it.

We saw there were regular opportunities for drinks, although some people did not have regular access to drinks within their rooms. One relative told us that they were not happy about this. They said, "I have to come every day because their hot drinks are always cold and they have a small glass for juice or water but it is always empty they don't fill it up or regularly check." We discussed this with the registered manager who agreed to review this.

Where people needed one to one support for meals, such as on the Swaledale unit, this was promptly given. One person said, "I'm a fussy eater but food is good, I get a choice, I don't always want what's on offer and will sometimes just have yoghurts or a snack, but can have anything at any time. If I want something to eat at 3am they'll get it for me." We found a calm settled atmosphere, tables were set with flowers, mats, napkins, glasses, cutlery and crockery. We saw staff helped people with their breakfast, giving choice and chatting, with a patient and cheerful manner.

People's needs were met by adaptation, design and decoration of the premises. There was suitable signage such as exits and bathrooms were visible to help people orientate. The service was warm and comfortable within all the units. Some doors to people's rooms were closed and others were open in order for the person to see the comings and goings of people. We checked a number of rooms and saw there were personal items on display which gave them a homely feel.

People were asked their consent and were consulted before staff supported them with any care. People made their own decisions about routine matters, such as what to eat or wear.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

There was variable practice regarding the recording of decision specific mental capacity assessments and best interest decisions and these were not always completed. The care plans we reviewed indicated the provider was considering people's ability to make choices and decisions about their care. However, when people's health indicated they could lack capacity or had variable capacity, the necessary assessments and

best interest decisions were not always recorded. For example, one person's records indicated they had variable capacity but there was no evidence of decision specific assessments being completed; staff told us this person was able to make day to day decisions. The records of care of another person who was living with dementia indicated 'all decisions to made in [person's] best interests' however there was no evidence of this being recorded for specific decisions such as medication or personal care. We spoke with the unit manager about this, they showed us a blank form that should be used in these circumstances but acknowledged it was not in place in this instance.

Staff told us they had received training in the MCA. However, their understanding of the main principles and how to use it in practice was inconsistent. One staff member told us one person was not able to make decisions because they had a hearing impairment. People with sensory impairments should not be assumed to lack capacity and the assessment of their capacity should include ways to support them to communicate effectively. Another staff member was able to tell us the process that should be followed when assessing someone's capacity, namely their ability to retain and weight up information.

Some staff gave us good examples of what good dementia care looks like. One staff member told us that when providing care to people with dementia they "were patient with them because they had lost the ability to retain information and it's important to reassure them; [make] familiar things available." Another staff member told us, "With dementia the person is not lost, they know their likes and dislikes."

There was evidence people were supported to access health and social care professionals when needed. Records kept in care plans showed people had access to, GPs, district nurses, chiropodists, opticians, advocates and hospital services. People's comments included, "I have just seen the dentist and the doctor. I talk to the manager of the unit if I am unwell or a staff member.", "I have my feet done.", "A lady comes to do my feet and they ring the doctor straight away if you need one. I haven't seen a dentist yet. I don't imagine there will be a problem." and "If I want to see a doctor they ring for one."

Good

Is the service caring?

Our findings

People told us they felt well cared for. Comments included, "They call me by my name and talk to me. They knock on my door before coming in they tell me who they are.", "They do knock on my door and close doors and curtains when they are doing personal care and they speak in a normal tone. I have found it difficult to settle here it's not as good as home. They are as good as they can be." and "They are very gentle when they move me in the hoist. They have a laugh with me and we tease each other. They always cover me up with a rug when moving me."

Relatives we spoke with told us the staff cared well for their family members. One relative said, "I have no concerns about the staff. They are polite and kind." Another relative said, before coming to the Airedale unit their family member had been reclusive and depressed. They described the unit as "a new lease of life" and said the service was "a haven" for their family member.

One relative said they had been "overwhelmed by the kindness of staff" and when their family member had arrived on the unit, they "made them feel so welcome." They told us, "Staff are lovely, treat [person] with respect always, very caring. It's always clean, no odours, very homely. [Member of staff] is very good, approachable, I know if I had any concerns I could go to them and they'd be sorted. I leave here knowing [person is] safe and being well looked after."

We observed many interactions between people living in the home and care staff. We saw people were treated with kindness, respect and compassion. Staff showed they knew people well in the way they spoke with them and the things they talked about. Staff were very knowledgeable about the people and had a good understanding of their needs. For example, staff knew that one person liked a glass of wine in the afternoon and when they asked if they were ready for their drink there was lots of banter about how big a glass they preferred. We saw many occasions where staff engaged people in friendly banter or sensitive reassurance. We saw occasions where staff noticed if people were feeling uncomfortable and offered support to help them feel better, such as by adjusting clothing or offering a blanket.
We saw staff were careful when supporting with moving and handling. For example, staff explained to one person what they were doing and put the sling on the person and covered their legs with a rug to protect their dignity. Staff talked to the person all the time about the procedure but also about everyday things such as were they expecting any visitors today and about the weather. The person was quickly and successfully moved in to their wheel chair.

Assessments and care plan documentation showed consideration for people's communication needs, preferences and characteristics protected under the Equality act such as gender, religion, sexual orientation and disability.

People's social history and preferences were documented in care plans which contained information to assist staff in forming caring relationships with people, such as people's hobbies and interests. People and their relatives told us they were aware of and had involvement in the care planning process.

We saw staff were patient and caring. Staff had regard for people's privacy and dignity and took measures to ensure personal care was discreet. One person said, "[Staff] treat me with respect, all of them. Got a call bell which I press if I need anything, [staff] usually come quickly, only once they didn't and that's because there'd been an emergency". However, we saw people's confidential and sensitive information was not always stored securely because some office areas where sensitive information was kept were left unlocked and sometimes with the door open. Information was archived in filling cabinets which were not locked and each office had a white board with relevant but sensitive information about people. For example, if they had a 'do not attempt resuscitation' (DNAR), DoLS and mobility needs. We made a recommendation for the provider to review how confidentiality is maintained in relation to information accessible in the office.

People were well dressed and had their hair done and it was evident their personal care needs were met. Some doors to people's rooms were closed according to their choice and others open in order for the person to see the comings and goings of people. We checked a number of rooms and saw there were personal items on display which gave them a homely feel. We saw the laundry staff knocked on a person's door with their laundry. The person had a list of clothes they had sent, several of which were not named. The laundry staff offered to take them back to label them, which the person was pleased with.

Visitors told us they were welcome at any time and we saw people had private areas to speak with their visitors, as well as their own rooms and communal areas.

Requires Improvement

Is the service responsive?

Our findings

People's pre-admission assessments were detailed and clear. We did not see any evidence of consideration of the accessible information standards in the writing of the care plans. There was no assessment of people's cognitive and sensory abilities in relation to accessing their care plan. For example, an assessment of whether the person could be supported to access their care information in large print, easy read formats or alternative languages.

Care records contained some clear information, but also information which was contradictory or missing which meant there was a risk people may not receive appropriate care. For example, one nutrition care plan showed different amounts of thickener needed for one person's drink. People's continence needs were recorded in care plans but where people needed a catheter the information was not always made clear for staff to provide appropriate support.

Care reviews were not always effective. One person's care record showed they were losing weight, yet there was nothing in the care plan to indicate weight loss or to show dietary needs or action taken to increase weight. There was no information about this in the person's monthly reviews.

Care records did not consistently document people's care and support needs. For example, in one person's care record, the section 'my day, my life, my future' was not completed. In another person's record we saw their lifestyle care plan was detailed as was their life history. People's end of life choices were detailed in some of the records we looked at but some contained more detail than others. We saw evidence of personalised documentation and daily logs of people's care, but there were weaknesses in others.

We spoke with one person who said they had not had their wound dressing changed, despite staff being aware and daily care records clearly stating this. We saw this had been communicated in the night to day handover, yet nothing had been done about this all day. We brought this to the attention of the unit manager and the registered manager.

Some people told us they would like to have more opportunities for showers and baths, although other people were more satisfied. Comments included, "I get a bath once a week. I don't really like showers. They give me a wash every day. I can just ask if I want a bath.", "I would say it's of a good standard." Two people told us they had a set day each week for their bath or shower and did not feel able to request one in between times.

There was a range of resources available for people to use and enjoy. People told us on the whole they had enough to keep them occupied. Comments included, "I like to knit and read the paper; I get a paper every day. I do go to the bingo I enjoy tha.t", "I like my puzzle book and my kindle and we had a game of bingo this morning. It's your choice to join in. There is enough to do." On the notice boards were diaries of activities such as arts and crafts, a singer, outings and shopping, one to one activities and games, as well as a remembrance service.

There was evidence activities were person-centred. Activity forms for each person showed recent events. For example, one person's record showed they enjoyed a hand massage, liked listening to singing from the tea dance, they had watched the royal wedding and had their nails painted. We saw there were activities staff who engaged people in group and individual opportunities. We observed a bingo game on one unit which all seemed to enjoy. Some people read books and others were chatting or sitting quietly. There were jigsaw puzzles which we saw some people completing. On the Swaledale unit we saw an organised interactive session with people making Christmas decorations. Relatives joined in when they visited and were offered drinks. Staff asked people individually what was the best Christmas present they had received, giving each person chance to respond and getting others to join in. We observed lots of laughter and staff kept everyone involved.

On the Wensleydale unit we saw staff held people's hands and made eye contact with them whilst singing and there was a very jolly atmosphere. People enjoyed joining in with a karaoke session.

However, on the first day of the inspection we spoke with some people who were not happy because their Christmas shopping trip had been cancelled at short notice. They said it was because of the inspection but there had been a lack of communication around this. When we spoke with the registered manager about this, they explained the staff deployment was not appropriate as it would have meant there were no activities staff available for anyone else in the home had the trip taken place.

People told us they knew how to raise a complaint if they wished to. We looked at the record of complaints and found although there were some recorded, it was not always clear what the outcome of these had been.

Inadequate

Is the service well-led?

Our findings

There was a registered manager who had been in post since before West Ridings had changed to a new provider. We found there was a lack of oversight in relation to the quality of the service provision. Quality audits lacked depth and did not adequately identify areas in need of improvement, such as those highlighted throughout the inspection. Where some audits made reference to actions needed, we found these were not sufficiently addressed, but carried forward from month to month with limited follow up or accountability.

A monthly management overview record was kept of accidents and incidents but this did not match with the number of accidents and incidents recorded. The detail in the accidents and incidents record was not thoroughly checked or sufficiently used to ensure lessons were learned. For example, there was no information in the quality governance file about an incident in which two people had gone missing. The most recent audit for infection prevention and control was dated August 2018 and stated, 'to be done next month' but the subsequent one we saw, dated October 2018, was blank. Where care plan audits identified action was required, no further information was added to show whether actions had been completed.

There were weaknesses in the clinical oversight across the whole home. Daily walk rounds were carried out by senior staff who may not have the necessary skills to identify concerns. For example, we found a medicine recording error on one of the nursing units which was not identified at the walk round because the senior staff lacked the clinical expertise to recognise this as an error. On both of the nursing units we found the qualified nurses did not have sufficient opportunity to maintain an overview of the care practise as they were involved in clinical tasks. We saw a list of nurse registration numbers, but this was incomplete and had not been checked since March 2018. This had not been identified by the registered manager or provider.

People told us they thought individual units were well run, although they were not all aware of who the registered manager was for the whole site. We had mixed views from relatives about how the service was run overall. One relative said, "We were a bit concerned when [the provider] took over but it's carried on as good as it was before. Only thing different is we've no host [a previous staff role to support people with mealtimes], which is a shame as [host] was really good and all the people liked [host]. We wanted [them] to stay but [the provider] said they didn't employ hosts in any of their other homes". One relative said other than having no host, they would "give them a gold star".

Some staff we spoke with said they thought the new provider was supportive and would be making improvements, although other staff told us they had not seen much provider presence in the home. We saw the regional manager who visited on the first day of the inspection. They told us they were new in post and beginning to establish a working relationship with the registered manager. There was limited evidence of the provider oversight of how the home was being managed.

Staff we spoke with all said they enjoyed caring for people at West Ridings and they told us there was close teamwork in each of the units. Some staff told us the registered manager had supported them to achieve a suitable work-life balance and they felt able to approach them to discuss any concerns. However, we found

some common themes upon speaking with staff, regarding lack of management support for them in their roles and poor communication. Some staff told us they did not find the culture in the home was transparent or open enough for them to raise any concerns confidently.

We found staff did not have clear enough direction as to their roles and responsibilities and some staff reported not feeling supported in their work. For example, some staff told us they were unsure of their job roles and what was expected of them and some staff told us they were not prepared adequately through induction for the work. Staff told us they did not regularly see the registered manager present in the units.

The registered manager told us how they worked closely with partners and other providers to develop the service. During the inspection there was a planned Wakefield district activity meeting for all activity organisers to share ideas and best practice. However, the activity staff were unable to attend as they were involved in activities during the inspection.

Documentation to support how the service was run was inconsistent. There were gaps in information relating to staff and people living in the home, as well as missing policies and procedures. We found the service was using documentation belonging to the previous provider and there were no policies or procedures available for us to look at. Records for the maintenance of premises and equipment were in place, but there was a lack of robust oversight of checks having been made.

We concluded there was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Staff were not recruited safely.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There was poor management oversight of the quality of the provision.

The enforcement action we took:

Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	Staff recruitment practices were weak and there was no verification of agency staff.

The enforcement action we took:

Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	Staff had not received training and were not properly supported to carry out their roles.

The enforcement action we took:

Warning notice issued.