Bingley Wingfield Care Limited

Bingley Wingfield Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Bingley Wingfield on 23 July 2018 and found improvements from our last inspection. At our last inspection in September 2017, medicines were not always administered or recorded safely and properly, staffing levels did not fully ensure people's care and support needs were met and systems to assess and monitor the quality of the service were not sufficiently robust. This meant the service was in breach of Regulations 12, 17 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of 'is the service good' and 'is the service is well led' to at least good. At this inspection we found sufficient improvements had been made which meant the service was no longer in breach of Regulations. The registered manager and provider shared actions they were working on to maintain and further improve the service for people living at Bingley Wingfield.

Bingley Wingfield is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 44 people in an adapted building, over three storeys. At the time of our inspection there were 27 people living at the home and one person was admitted on the day of our inspection.

We found the provider had effective systems in place to monitor the quality of care provided and where issues were identified they acted to make improvements. Medicines were being stored and managed safely. We found there were enough staff to take care of people and to keep the home clean.

Staff were recruited safely and received appropriate training. They told us the training was good and relevant to their role. Staff were supported by the registered manager and were receiving topic specific supervisions although individual supervisions to discuss their ongoing development needs required further development.

People who used the service and their relatives told us staff were helpful, attentive and caring. We saw people were treated with respect and compassion. People told us they felt safe living at the service and we saw people's healthcare needs were being met.

Care plans were up to date and detailed what care and support people wanted and needed. Risk assessments were in place and showed what action had been taken to mitigate any risks which had been identified. People felt safe at the home and appropriate referrals were being made to the safeguarding team when this had been necessary.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff knew about people's dietary needs and preferences. People told us there was a good choice of meals and said the food was very good. There were plenty of drinks available for people in between meals.

Activities were on offer to keep people occupied. Visitors were made to feel welcome and were offered refreshments.

The home was clean, well decorated and tidy. All the bedrooms were single occupancy and contained personal items such as ornaments and photographs.

The complaints procedure was displayed. Records showed complaints or minor concerns received had been dealt with appropriately.

Everyone spoke highly of the registered manager and said they were approachable and supportive.

We found all the fundamental standards were being met. Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were recruited safely. There were enough staff to provide people with the care and support they needed and to keep the home clean.

Staff understood how to keep people safe and where risks had been identified, action had been taken to mitigate those risks.

Medicines were managed safely and kept under review.

Is the service effective?

Good

The service was effective.

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

Meals at the home were good, offering choice and variety.

People were supported to access health care services to meet their individual needs.

The legal requirements relating to Deprivation of Liberty Safeguards (DoLS) were being met.

Is the service caring?

Good

The service was caring.

People using the services told us they liked the staff and found them caring and kind. We saw staff treated people with kindness and patience and knew people well.

People looked well cared for and their privacy and dignity was respected and maintained.

Is the service responsive?

Good

The service was responsive.

People's care records were easy to follow, up to date and were reviewed monthly.

Meaningful activities were on offer to keep people occupied, according to their choice.

A complaints procedure was in place and people told us they felt able to raise any concerns.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place who provided effective leadership and management of the home.

Effective quality assurance systems were in place to assess, monitor and improve the quality of the service.

Bingley Wingfield 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 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.

This inspection took place on 23 July 2018 and was unannounced. The inspection was carried out by two adult social care inspectors 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 care service. The expert-by experience used on this occasion had experience of elderly and dementia care.

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams.

The provider had completed a Provider Information Return (PIR). A PIR is a document we require providers to send us at least once annually to give key information about the service, what the service does well and improvements they plan to make.

We spent time observing care in the lounges and dining rooms. We normally use the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. However, we did not use SOFI on this occasion as many people were able to speak with us during our inspection. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included four people's care records, three staff recruitment files and records relating to the management of the service.

We spoke with six people who used the service, four relatives, four care workers, the catering manager, the

activities co-ordinator, a visiting healthcare professional, the registered manager and the provider.

Good

Is the service safe?

Our findings

At our last inspection in September 2017, we found the service was in breach of Regulation 12 (safe care and treatment – safe management of medicines) and Regulation 18 (staffing). At this inspection, we found sufficient improvements had been made and the service was no longer in breach of these Regulations. The registered manager told us they were aware some improvements were still needed but they and staff had worked hard since the last inspection to make significant improvements.

There were enough staff on duty to care for people safely and keep the home clean. There was a good staff presence around the home and people's requests for assistance were generally responded to in a timely way. Most people who used the service and relatives told us they felt there were enough staff on duty. The care team were supported by cleaning and laundry staff, chefs, a handyman and an activities co-ordinator. One person told us, "Yes, there's enough staff." A relative told us, "There are always enough; I've no concerns." However, another person commented, "They could do with more staff; there are never enough."

We looked at the rotas and saw five care staff and a nurse were deployed in the morning and four care staff and a nurse in the afternoon. At night, there were three care staff and a nurse on duty. Staff we spoke with told us there were enough staff on each shift to ensure people's needs were met. However, some staff told us staff numbers could be improved around mealtimes and during the late shift. We observed at lunchtime that the activities co-ordinator was encouraging and assisting four people with their meals in the downstairs dining room. We saw 10 people chose to eat their meals in the main lounge on the ground floor but staff did not remain in the room to check people were managing to eat independently. We spoke with the registered manager who told us staffing levels could be increased if people's needs changed and/or occupancy levels increased. They assured us they would review staff deployment, especially around mealtimes, to ensure these areas were covered appropriately.

Medicines were stored, managed and administered safely. We saw medicines were stored in locked trolleys, cabinets or a medicines fridge. The nursing staff took responsibility for administering medicines and we saw them doing this with patience and kindness, explaining to people what their medicines were for and why it was important to take them. Staff had received training in the safe management of medicines and their competency was checked by the registered manager. We looked at a sample of medication administration records (MARs) and saw people were given their medicines as prescribed. Checks were completed on boxed medicines each day to ensure the amount in each box tallied with what was documented. We saw the nurse checked these thoroughly and highlighted a medicines error through this process. We saw this was immediately investigated by the registered manager and actions taken to ensure no harm had come to the person, such as speaking with their GP. Medicines were audited weekly by the registered manager and we saw where these checks had identified concerns, appropriate actions had been taken, including further staff supervision and observation.

One person was prescribed an 'as required' medicine to be used as a sedative. Whilst we saw no evidence this was given inappropriately, care planning did not refer to this as a last resort after other techniques had been used. We spoke with the provider and registered manager who agreed to review the way this had been

documented. From our discussions and observations, we were confident this was used as a last resort and other interventions such as distraction and de-escalation techniques were used primarily.

People were kept safe from abuse and improper treatment. People who used the service told us they felt safe living at the service. One relative told us, "Yes… The attention is always there" and another relative said, "[Relative's] safe. [Person] has a sensor on the floor. They know when [person] has got up."

Staff had completed safeguarding training and said they would report concerns to a senior member of staff, the registered manager or the safeguarding team. The registered manager had made appropriate referrals to the safeguarding team when this had been needed. This meant staff understood and followed the correct processes to keep people safe.

The registered manager told us the service did not use restraint and staff were due to attend training in behaviour that challenges and de-escalation techniques to help ensure they were confident in these areas. This had been identified as a training need by the registered manager following a recent incident. One person told us, "One lady shouts, but the staff handle it well."

Records showed safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. This included checks prior to people commencing employment such as references from previous employers and a satisfactory Disclosure and Baring Service (DBS) check. The DBS check helps employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people.

We saw a range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on the fire, electrical and gas systems and lifting equipment such as hoists and slings. The registered manager and the provider conducted out of hours and weekend checks to ensure the service was functioning safely at all times.

Personal emergency evacuation plans (PEEPS) were in place and these were up to date and relevant. Weekly fire alarm tests took place. This meant staff knew what action to take should an emergency situation arise.

The home was clean, tidy and odour free, apart from an area around the main stairs and hallway which we noted first thing in the morning of our inspection. However, we saw cleaning staff used specialist equipment to remove this during our inspection and the odour was no longer present. We saw staff had access to personal protective equipment (PPE), such as gloves and aprons, with PPE stations newly installed throughout the home. Staff were using these appropriately. People we spoke with spoke positively about the cleaning staff and told us the home was always clean and tidy. Staff had received training in infection control and regular hand hygiene and infection control audits took place to ensure practice remained safe.

The service had been awarded a five-star rating for food hygiene by the Foods Standards Agency. This is the highest award that can be made and demonstrated food was prepared and stored hygienically.

Accidents and incidents were recorded and analysed to see if any themes or trends could be identified. Records showed what action had been taken following any accident or incident to reduce or eliminate the likelihood of it happening again. We looked at records which showed no concerning themes or trends. The registered manager gave us examples of how learning had taken place following incidents; for example, following a recent mental health crisis.

Good

Is the service effective?

Our findings

People told us the care and support they received was effective and staff knew their care and support needs. Our observations and discussions with staff confirmed this.

The registered manager completed needs assessments before people moved into the home. The assessment considered people's needs and choices and the support they required from staff, as well as any equipment which might be needed. For example, we saw pressure relieving equipment and moving and handling equipment in place, as well as bed and door sensors where people were at risk of falls. We checked some electronic pressure relieving mattresses to see if these were set for the correct weight of the person. We found these were mostly correct although one was set too high for the person's current weight, since they had recently lost weight. The registered manager assured us this would be altered immediately. From their response we had confidence this would be actioned.

We saw evidence the registered manager kept up to date with best practice. For example, they attended events run by the local authority, provided staff with training on new legislation such as the General Data Protection Regulation (GDPR) and kept up to date with NICE guidance.

Staff we spoke with told us training opportunities were good and there was plenty of training on offer. One staff member said, "Yes, I feel the training has helped me do my job." The registered manager told us new staff completed induction training and those new to care were enrolled on the Care Certificate. The Care Certificate is a set of standards designed to equip social care and health workers with the knowledge and skills they need to provide safe, compassionate care.

Training consisted of a mixture of face to face by an external training provider and online training to supplement this. The training matrix showed staff received a range of training in subjects which included moving and handling, safeguarding, fire safety and dementia. Records showed training was kept up-to-date. Staff had been supported to achieve further qualifications in health and social care. This included level 2 and 3 qualifications in health and social care.

Staff were provided with regular supervision sessions on specific topics, such as how to support a service user with behaviours that challenge and other issues and best practice. However, the registered manager was aware they needed to develop supervisions to include more individual sessions for staff support and guidance. Staff we spoke with told us they felt supported and said they could go to the registered manager at any time for advice or support. The registered manager carried out annual personal development meetings with staff to appraise their role and development needs.

People's nutrition and hydration needs were met. People who used the service told us meals were good. Comments included, "We get a choice of two (main courses) and we can make suggestions", "The food's not bad at all" and "I like the food but I don't eat a lot." We tried a sample of the food served at lunch time and found it tasty, well prepared and nutritious. People's food was well presented and looked attractive.

We spoke with the catering manager. They said they enjoyed working at the home. They explained that the menu rotated on a four-week basis, based on people's likes and preferences. Food was prepared using fresh ingredients daily. There was a choice of hot and cold options at breakfast, and two main options at lunch and in the evening. A system was maintained to monitor if people had been given meals. This helped ensure nobody was missed or forgotten about; for example, those who stayed in their own rooms. Information in the kitchen alerted staff to any specific dietary needs such as those that needed food fortifying or required food of a different consistency. A staff member told us, "We had someone who was gluten intolerant and lactose intolerant and we cater for that - we try!" However, we found for one person the information in the kitchen regarding the consistency of food they required did not match the person's care plan or what care staff were telling us. We raised this with the registered manager who took immediate action to ensure this was promptly updated.

People who had been assessed as being nutritionally at risk were referred to the GP and/or dietician and were weighed regularly. Records were also being maintained of what they were eating and drinking. We looked at one person's care record who had lost 10.5kg weight since February 2018 and found a nutritional care plan had been put in place and reviewed regularly. The person had been referred to the GP and dietician who had assessed them and requested a high calorie diet for the person which we saw was being offered. The person was being weighed weekly and a food/fluid chart was in place, although we found some of these required improvements in the detail of their completion. For example, some of the person's food charts had missing entries where we could not establish whether they had been offered meals. There was no evidence of snacks given on the food charts. We spoke with the registered manager and they explained the person sometimes refused meals but accepted this should be have been documented on the chart. From our discussions, we were confident this was a one off issue and would be addressed.

There were choices available for every meal and alternatives offered if people did not want what was on offer. We heard kitchen and care staff asking people what they wanted for breakfast and lunch and patiently explaining the content of meals to aid decision making. Jugs of juice were available in the lounges and in people's bedrooms and we saw staff offered people hot and cold drinks regularly to ensure people remained hydrated.

People's healthcare needs were being met. In the four care files we looked at, we saw people had been seen by a range of healthcare professionals; for example, GPs, nurse practitioner, district nurses, dietician, speech and language therapists and opticians. A district nurse told us they had seen improvements with communication over the last year. They said staff contacted them appropriately and followed any advice they were given. The registered manager and staff confirmed they had a good relationship with the district nurses and other specialist nurses and they were able to ask them for advice.

Since our last inspection we saw improvements had been made to the home to create a more comfortable and homely surrounding. For example, extra seating areas had been created both on the ground floor and upstairs, where people could enjoy quiet time. The registered manager told us they had purposefully not put a television in the new upstairs lounge so people could enjoy the space peacefully. Toilets and bathrooms were easily identified with large signage and people's bedroom doors had a number, their name and some had a picture and information which was relevant to them. People's bedrooms contained personal items which were important to them, such as photographs, pictures and ornaments.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service was acting within the Mental Capacity Act. People's capacity to consent to their care and support arrangements was assessed.

Where people lacked capacity and it had been assessed that the accumulation of restrictions amounted to a deprivation of liberty, appropriate DoLS applications had been made. There was one authorised DoLS in place and several applications were awaiting assessment by the local authority. The person who was subject to a DoLS had enjoyed walking throughout their life. Staff accompanied the person to allow them to continue this, with walks to the local post box to maintain their independence. This showed care and support was offered in the least restrictive manner. The registered manager had a good understanding of their legal responsibilities under the Act and kept updated information about the progress of people's DoLS applications, liaising with the local authority regularly.

People told us they were asked for their consent before care and support was provided. Care plans were written in people's best interests. Where people lacked capacity, best interest decisions had been made involving families and healthcare professionals.

The registered manager kept information about which people had a Lasting Power of Attorney (LPA). A LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions. LPAs can be put in place for property and financial affairs or health and welfare. This showed us the registered manager understood their responsibilities to act within the legislation.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us the following about staff and living or staying at Bingley Wingfield; "We're happy with the staff; they are kind and friendly…. One staff (member) was going to the shop and she asked me what I wanted", "The staff are really kind and caring" and "They look after (relative) really well; (person's) clean." One relative commented, "Staff care about me; they have become my family. It was our anniversary the other day and I had forgotten." They told us staff had reminded them about the event and the chef had made and decorated a cake for them and their relative.

Care files contained some information about people's life histories, interests and hobbies, although this information needed developing further in some people's care records. The registered manager and provider were aware of this and were updating this information.

People looked relaxed and comfortable around staff and were happy to see them. There was a calm, friendly atmosphere and we saw staff took time to sit and chat with people. We heard some good-humoured banter shared between staff and people who used the service which resulted in laughter and further conversation. From our observations it was clear staff knew people well.

We saw staff treating people well with dignity and respect. For example, as people arrived in the lounge in the morning we heard staff complimenting their looks. This extended to the registered manager, who knew people well and stopped to have conversations with people about their day.
We saw staff bending down to the same level as people when engaging in conversation.

Staff knew people well and their individual needs and plans of care. We saw staff were sensitive to people's needs and spoke calmly and gently. This gave us assurance that people would receive appropriate care.

Staff treated people with dignity and respect. We saw staff knocked on people's doors before entering their bedrooms. For example, we saw the nurse responsible for administering medicines in the morning of our inspection knocked on people's doors, announced themselves and asked permission to come in. One person told us, "They (staff) come in at a certain time and they say, 'does it suit you (to go to bed now),' but if I'm watching something, I stay up."

People who used the service and relatives told us they had been involved in developing their care plans. Care plans showed regular reviews took place with people's comments recorded to aid in the provision of appropriate care.

The service was in the process of working with people to create life history folders with information on people's past lives and interests to aid better understanding of the people they were supporting. The activities-coordinator demonstrated to us how this work had been applied. For example, staff had found out one person used to be an estate agent, so activities had been undertaken with the person around looking at house details which they had enjoyed.

Visitors were welcomed warmly, whatever time they came. Staff greeted people by name and asked if they wanted refreshments.

Staff encouraged people who used the service to be as independent as possible. For example, we saw at lunchtime, people were encouraged to eat independently with assistance given as the last option. Staff also encouraged some people to help in the garden, planting items. This helped maintain people's skills and provided a good activity for people. Another person was supported to help clean and tidy up as part of a plan to reduce their anxiety and agitation.

We looked at whether the service complied with the Equality Act 2010 and how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussion with the registered manager, staff, people and relatives showed us the service was pro-active in promoting people's rights. Information about advocacy services were displayed throughout the service for if people did not have anyone to speak on their behalf. A review of care and support planning had taken place to ensure care plans considered people's diverse needs. This had led to improvements taking place to better evidence this.

Good

Is the service responsive?

Our findings

People who used the service and relatives told us they had been involved in the care planning process. One person told us, "Yes, they have asked if I need any more help and about my tablets."

The registered manager made sure people's needs were assessed before they moved into the home and care plans developed from this. We saw the quality of pre-assessments had improved over the last few years with the current document being very comprehensive.

Care records contained risk assessments relating to activities of daily living such as mobility, eating and drinking, oral needs, continence and personal care. The risk assessments and care plans had been reviewed monthly and where an issue had been identified, action had been taken to address and minimise any identified risk. For example, we saw some people had been referred to the dietician or GP if at nutritional risk and specialist pressure relieving equipment was put in place to reduce the risks of some people developing pressure sores.

Care was personalised according to people's individual needs. For example, one person thought they worked at the home, so staff gave them a 'wage' and 'keys' and kept them busy as part of the plan to reduce their behaviours that challenge. Staff we spoke with were all familiar with this plan of care. Detailed daily records of care were maintained by staff which provided evidence people had received care in line with their care plans.

Whilst people had oral risk assessments in place, there was a lack of specific care plans in place detailing the support people needed to maintain good oral health. We raised this with the registered manager who acted to address this. Immediately following our inspection, they put plans in place to incorporate information about people's oral health into each person's personal health plan, with specific oral health care plans if this was assessed as a concern. The registered manager also printed and gave a copy of the NICE guidelines regarding oral health care to the care and nursing team for further discussion to ensure they were offering the best standards of care.

We saw people's personal preferences were recorded such as what they liked to eat and drink and how they liked to spend their time. Although some people's life histories needed further development, the registered manager had plans to action these.

People's end of life care needs were planned for, although we saw some information was generic where the person had not wanted to discuss the topic. The registered manager and provider told us they had liaised with the palliative care team and the service's end of life champion when developing the plan, which was then expanded with further information when discussions had taken place with people and/or their families.

Complaints were taken seriously and processes were in place for investigation and analysis. However, no formal complaints had been made during the year. The registered manager explained they spoke with people and documented in a concerns book when any concerns were raised, however minor, so these were

addressed immediately. Processes were in place to complete lessons learned exercises following any concerns to reduce the likelihood of reoccurrence. Several compliments had been received through the annual survey and through cards from relatives. These included, '(Care) enhanced [person's] life', 'Thank you to all the 'angels' at Wingfield', 'You have done a great job with lots of loving care', 'In recent times, staff are polite, welcoming and engaged with their commitment to patients and visitors' and, 'Always staff on hand.'

We looked at what the service was doing to meet the Accessible Information Standard (2016). The Accessible Information Standard requires staff to identify record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. The provider had developed an accessible information policy. We saw people's communication needs were assessed when they came to the service. The provider and registered manager had developed care plans specifically to identify people's accessible information needs, although some of these needed further development to show what actions had been taken because of these needs. The registered manager told us further detail was being added to the communication care plan incorporating accessible information and how the service supported people.

People were offered a range of activities in the mornings and afternoons. The service employed two activities co-ordinators who worked six days each week between them. The co-ordinators were working with people individually to find out more about the person and their likes, dislikes and preferences to aid in the provision of person centred activities. A good range of activities took place, which included gardening, arts and crafts and games. This included sensory activities. For example, samples of common plants had been brought in which people could feel and discuss. In addition, the fire service and police had been engaged to visit to help provide reminiscence based activities.

Links were maintained with the local community. For example, school children visited the home once a week from a nearby school. Staff said that residents particularly engaged during this time and were interested in this weekly event. People told us how much they enjoyed this. The registered manager said, "People come alive when there are kids about."

Good

Is the service well-led?

Our findings

At our last inspection in September 2017, the service was in breach of Regulation 17 in relation to good governance. A new manager had just come into post who had subsequently registered with the Commission. At this inspection we saw sufficient improvements had been made to the quality assurance process which meant the service was no longer in breach of Regulations.

Audits were being completed, which were effective in identifying issues and ensured they were resolved. These included care plans audits, medicine audits, health and safety audits and environmental audits. We saw if any shortfalls in the service were found action had been taken to address any issues. Themed audits also took place. For example, a recent audit on consent had led to several improvements around how consent was recorded including the role of the relative and LPA. The provider was also involved in the service and monitored the activity of the registered manager. They completed audits and sent action plans to the registered manager to resolve. These were closely monitored to provide assurance that the service continually improved.

The service had recently undergone a 'mock CQC inspection' which highlighted areas for improvement. There was evidence this had been worked through. For example, several improvements were needed to the medicine management system and wound care plans needed to be put in place. We saw evidence these areas had been actioned.

Documentation demonstrating people's repositioning, fluid and food input was not stored or collated in an orderly manner making it difficult to review over a period of time. For example, the provider needed to search several times in different places to find one person's recent food and fluid input charts. The provider agreed they would review this to ensure these could be more easily checked to ensure people were receiving the required care and support. From their response we were confident this would take place.

There was a registered manager in post who provided leadership and support. On the day of our inspection, they were supported by the provider. People and staff praised the management team and told us the registered manager was a visible presence within the home. It was clear from our observations and discussions that the registered manager knew people well and was a familiar face for people living at Bingley Wingfield. The registered manager told us they received good support from staff and the provider and felt able to speak their mind and offer suggestions for service improvement. Throughout our inspection, the registered manager demonstrated they were keen to continue to drive and maintain improvements to the service.

People and their relatives told us they were confident in the management of the service. One person's relative commented about how the service had changed over the last year. They said, "The whole atmosphere is different. She (registered manager) talks to everyone. Any problems, even personal, she will talk to you. She seems to have better control over the staff; there is a better atmosphere."

Staff we spoke with all told us they would recommend the service as a place to live and a place to work.

They told us they had seen improvements over the last year and since the registered manager had taken over the service. Staff told us morale had improved at the service and the team worked effectively together. Comments included, "Love it here, all pull together as a team", "I like it here, friendly, management are easy to approach" and, "Management is good; [registered manager] is supportive."

People's views about the service were sought and acted upon in several ways. Regular resident and relative meetings were held and we saw actions taken because of this were documented in a 'you said, we did' poster displayed throughout the service. For example, people had said the call bell response needed improving. The call bell system had since been upgraded to a system whereby the management could monitor response times to monitor whether people were having to wait unacceptable amounts of time and link this to deployment of staff where appropriate.

The registered manager told us they had consulted people about the new decorations and improvements to the premises. The service sent out an annual survey to people, their relatives and health care professionals. Results were analysed and actions taken where required following this. We looked at results from the latest survey and saw these were mainly positive and included positive feedback about the improvements to the environment. Comments included, 'Relaxed atmosphere; informal and friendly' and, 'Friendly staff – homely feel.'

A range of staff meetings were held. This included management meetings, nurse meetings and overall meetings. We reviewed minutes of these which showed these were an opportunity to discuss quality issues and improve practice.

The service worked with a variety of other organisations to help ensure a high performing service. This included links with local colleges to provide enhanced training to staff, and links with a local university. Work had been done around keeping people mobile around the home and staff from the university were due back to provide staff with training after monitoring people's activity in the home. We saw where people had transferred from other services including hospitals and other care facilities, information had been obtained on the person's needs to aid in the provision of care planning.

The provider had a well-defined set of values in place. Recruitment processes assessed potential candidates against these to ensure staff were fitting with the service's values. Staff we spoke with were committed to providing caring and compassionate care in line with the service's values.