P & B Kennedy Holdings Limited

Herncliffe Care Home

Inspection report

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Date of inspection visit:
09 October 2018
15 October 2018

Date of publication:
12 November 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Herncliffe Care home is a 'nursing home'. People in nursing homes receive accommodation and nursing 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 home provides nursing and personal care for up to 129 older people, some of who are living with dementia. There were 119 people using the service when we inspected. The home has six separate wings; Garden wing provides nursing care for up to 24 people living with dementia; Margaret wing provides nursing care for up to 23 older people; Terraces provides nursing care for up to 26 older people; Constance wing provides nursing care for up to 24 older people living with dementia; Alexandra wing provides personal care for up to 17 older people living with dementia and Victoria wing provides personal care for up to 14 older people. Each wing has its own communal areas including lounge and dining space.

The inspection took place on 9 and 15 October and was unannounced. At the last inspection in June 2017 we rated the service Requires Improvement. We found breaches of regulation relating to person centred care, safeguarding service users from abuse, staffing and good governance. 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, Is the service Safe?, Is the service Effective?, and Is the service Well Led? to at least good." At this inspection we found improvements had been made and the service was no longer in breach of any regulations.

A registered manager was in place. 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.

Overall we found the service provided high quality care and support. People who used the service, relatives, healthcare professionals and staff provided good feedback about the home and said people's care needs were met. Some further improvements were needed to the safety of the service, namely ensuring there were consistently enough staff on duty throughout the home and ensuring the administration of topical medicines such as creams was done in a consistent way. These issues had already been identified by the management team and plans were in place to address them.

People were safeguarded from abuse and improper treatment. Well understood policies were in place to protect people from harm. People said they felt safe and secure living at the home. Overall, risks to people's health and safety were well managed. Risk assessment documents were in place to guide staff. Staff we spoke with knew people well and the risks they were exposed to.

Most medicines were safely managed and given as prescribed. Better systems were needed to ensure the administration of topical medicines were recorded in a consistent way.

The premises were suitable for their purpose and had been adapted to meet people's individual needs. The home was clean and odour free.

Staffing levels were sufficient in most areas of the home, although they required review in Margaret wing and at mealtimes. Staff were recruited safely. Staff received a range of training and developmental opportunities and told us they felt well supported.

The service had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards and acted within the legal framework. People were involved in decision making to the maximum extent possible.

People's nutritional needs were met by the service. People had access to a suitable range of food. On the first day of the inspection we found some aspects of the mealtime experience needed improving. This had been rectified by the second day of our visit.

People had access to a range of professionals to ensure their healthcare needs were met. We saw good partnership working had been developed between the home and other professionals to ensure people received good quality, co-ordinated care.

Staff treated people with kindness and compassion and knew them very well. Information about people's past lives and interests had been used to stimulate conversation and provide activity that was meaningful to people. People were listened to and their opinions valued.

People's care needs were met by the service. Each person had a range of appropriate care plans in place and we saw evidence needs were being met. People's likes and preferences were sought to ensure care was person-centred.

People, relatives and staff praise the management team and said they were approachable. They all felt able to raise issues or make comments which were taken on board and used to improve the service.

We found a friendly and inclusive atmosphere in the home with all staff working well together and in the best interests of people living at the home. Clear, caring values were in place and staff consistently worked to them.

The registered manager had good oversight of the home. There was an established team of managers who were all responsible for monitoring the quality of the service. There was a strong emphasis on continuous improvement of the service. People's views and opinions were a key part of this. The owner was very involved in the home and worked in it on a daily basis.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Whilst staffing levels were appropriate in most areas, staffing levels at mealtimes and on the Margaret wing needed to be reviewed. Staff were recruited safely.

Overall risks to people's health and safety were assessed and mitigated and staff knew the risks people posed well. People were involved making decisions about risks associated with their care

Most medicines were given consistently and safely. Improvements were needed to ensure the administration of topical medicines were always recorded.

Is the service effective?

Good

The service was effective.

Staff had the right skills and knowledge to care for people. Subject champions were in place to improve the quality of care.

People's nutritional needs were met and there was a good choice of food available to people.

The service was compliant with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

The service worked with other health professionals to ensure people's healthcare needs were met.

Is the service caring?

Good

The service was caring.

People praised the staff who supported them. We saw staff treated people with kindness and compassion.

Staff knew people well and took account of people's preferences and histories when providing care.

People were given choices and were listened to. People's views were used to make improvements to the service.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed and a range of appropriate plans of care put in place. Staff knew people's needs well.

People had access to a varied range of activities in the home and there were good links with the local community.

A system was in place to log, investigate and respond to complaints. Any complaints were taken seriously by the service.

Is the service well-led?

Good

The service was well led.

People, relatives and staff praised the leadership in the service and said managers were approachable and listened to them.

The management team had good oversight of the service and was committed to continuous improvement.

People's views and opinions on their care were sought and used to make improvements to the way the service operated.

Herncliffe Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 15 October 2018 and was unannounced. On the first day, the inspection team consisted of five adult social care inspectors and two experts 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 experiences had experience of older people's care. On the second day the inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed information available to us about this service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed safeguarding alerts; share your experience forms and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law. We also spoke with the local authority Commissioning and safeguarding teams to gain their feedback about the service. We also received feedback from three healthcare professionals who worked with the service.

During the inspection we spoke with 20 people who used the service, 11 relatives and 16 care workers including senior carers. We also spoke with the training co-ordinator, an activities co-ordinator, two domestic assistants, five unit managers, the clinical services manager and the registered manager. We reviewed 14 care plans, medicine records, and other records relating to the management of the service such as training records, audits and checks. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the mealtime experiences, activities and how staff interacted with people throughout the day.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in 2017 we found safe staffing levels were not always maintained. At this inspection we found a general improvement had been made and target staffing levels were usually maintained. However, further improvements to staff deployment were needed in some areas of the building namely the Margaret wing and at certain times of day such as mealtimes. The management team were already aware of this and were taking action to resolve the problem.

We received mixed feedback about staffing levels in the home. Most people said they were adequate. A relative said "I think there's enough staff." Another relative said, "I've never been worried about staffing levels and you see the same faces." However, one person said, "Sometimes they answer the buzzer after 2 minutes, but I've had to wait up to 35 minutes when they are busy." Some relatives also said they thought more staff were needed at times. For example, one relative said, "The things they could improve on are staff because on a weekend it's a skeleton staff which means [relative] gets his food about an hour and a half later than through the week and [relative's] starving by then."

We observed care, spoke with people and staff and found on most units staffing levels were adequate. However, we found the Margaret wing would benefit from more staff at times particularly in the morning and over the lunchtime period. One staff member said, "Most on here need two people and some need three but there are only five of us today and the dining assistant left at 9.30 for training so we are short, but we are always like this." We saw this had been identified by the registered manager and was being addressed with a commitment to increasing staffing levels on this wing.

On the first day of the inspection we found the lunchtime experience could have been improved on some of the units, with staff not always being deployed in the right places at the right times resulting in people experiencing delays in getting their meals. We saw this had been addressed by the second day with better deployment of staff and extra staff made available to assist at lunchtime.

Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people. Records showed these included checks on their backgrounds and work history.

People said they felt safe and secure living in the home. One person said, "I feel safe here, there is always someone here." A relative commented, "I feel [relative's] safe; very much so." They also commented, "We can go home and not have any worries, it's the peace of mind."

Safeguarding policies and procedures were in place and were followed. Staff had completed safeguarding training, understood how to recognise abuse and said they would not hesitate to report concerns to a senior member of staff, the registered manager, the safeguarding team or CQC. The registered manager had made appropriate referrals to the safeguarding team when this had been needed demonstrating the correct procedures had been followed to keep people safe.

Overall, we concluded risks to people's health and safety were assessed and mitigated. People said that the

service managed risks well. One relative said, "When she first came from home she had been falling lot but now they have put her in a chair to stop her falling which I'm pleased with." Another relative said "I think she is very safe here, yes as she has all the equipment she needs."
People had a range of risk assessment in place which covered areas of identified risk. The risks and benefits of interventions such as the need for bed rails were assessed with people being involved in the decision-making processes. Risk assessments were electronic which meant staff could see real time updates to plans of care via smartphone devices. People had clear moving and handling plans in place, a copy of which was on the back of bedroom doors for staff to refer to.. Staff we spoke with had a good understanding of the people they were supported and the risks they were exposed to. In most cases we saw safe plans of care were followed. However, on the Alexander wing, we saw staff were not reminding one person to use their mobility aid in line with their care plan, and the lounge was not always being supervised in line with the safe plan of care. Action was taken to address these shortfalls during the inspection.

Overall, we concluded medicines were safely managed but some improvements were needed to the management of topical medicines. One person told us, "Staff are very conscientious with medication. They support me well." Medicines were administered by trained nurses or senior carers on the residential units who had their competency to give medicines safely assessed. We observed medicines were given safely and patiently with gentle encouragement provided. Medicine Administration Records (MAR) were electronic which provided many safety mechanisms. For example, it would highlight if someone had not received their medicines in a timely way, and prevented staff from giving doses of medicines too close together. Medicine Administration Records (MARs) were well completed and stock balances kept, ensuring all medicines were accounted for. Some people were prescribed medicines which had to be taken at a time in relation to food. We saw there were suitable arrangements in place to make this happened. Medicines were stored securely. Protocols were in place that clearly described when medicines prescribed for use 'as required' should be administered.

Where people received assistance with topical medication, body maps were in place to indicate where creams were to be applied. However, we found the recording of the administration of topical medicines such as creams to be inconsistent. Care staff applied these medicines, and were required to record on the electronic care management system. However, this was not always the case. We raised this with the registered manager to ensure it was addressed.

People and relatives said the home was always clean. A relative said "It's beautifully clean. Everything is beautiful and clean." We saw the home was clean, tidy and odour free. We saw staff had access to personal protective equipment, such as gloves and aprons and were using these appropriately. 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.

The premises were safe, secure and suitable for their purpose. Safety features were installed on the building to help ensure people's safety, for example, radiator guards to protect against burns and window restrictors to reduce the likelihood of falls from height. Key safety checks took place to keep the building safe. We found the home to be in a good state of repair. Personal emergency evacuation plans (PEEPS) were in place for the people who used the service. These gave information about what support people would need should an emergency arise.

Incidents and accidents were recorded and analysed by the registered manager. We saw evidence actions were put in place following incidents to improve the safety of the service.

Good

Is the service effective?

Our findings

The registered manager completed a pre-assessment before people moved into the home. The assessment considered people's needs and choices and considered the support they required from staff, as well as any equipment which might be needed. We saw best practice guidance such as guidance of the National Institute for Health and Care Excellent (NICE) was followed to help ensure effective care and treatment practices.

Staff had the right skills and knowledge to provide effective care. One person's relative told us, "The care they give is so professional." Staff told us the training was good and had equipped them with the required skills to provide safe and effective care and support. New staff had a comprehensive induction to the service. Staff new to care or those that did not have a qualification in health and social care were enrolled on the care certificate. This is a government-recognised training scheme, designed to equip staff new to care with the required skills for the role

Existing staff received a range of training and this was kept up-to-date. Training was conducted in-house and some senior staff were designated trainers in topics such as moving and handling and dementia care. Staff praised the provider's pro-active attitude to allowing staff to access and attend further training. For example, a staff member told us they had a special interest in learning more about speech and language therapy, so the provider had paid for them and other interested staff to attend an external course on the subject.

Staff had received training in dementia care, and relatives had also attended to help support them to understanding more about the condition. Champions were in place in key areas such as mental capacity act, dignity and dementia. We saw the roles were meaningful and had led to improvements in care. For example, the dignity champion role had led to the installation of 'pledge trees' in the home, where each staff member committed an individual pledge to improve the lives of people living in the home. The nutrition champion had put in place a number of measures which had resulted in people's nutritional input increasing, including the introduction of colourful plates and bowls, considering music and people's position in the room to maximise their comfort. This had led to people eating better.

Staff received regular supervision and appraisal. Staff told us these were valuable and as part of this they received feedback based on comments by people using the service. All staff felt this was a great opportunity to ensure they continued to improve and they said unit managers were receptive to any ideas they had about how things could be made better.

People nutritional needs were met. Most people praised the food and said that if they didn't like something alternatives could be made. People were offered a choice of freshly cooked hot food at breakfast, lunch and teatime, with supper of sandwiches and cake provided in the evening. Since our last inspection, the service had implemented a 'show and tell' menu which displayed photographs of the different food options. People could request alternatives if the menu options were not to their liking or they wanted something different. For example, one person had requested beef dripping sandwiches and Bovril since it reminded them of

home and the kitchen staff had got this for them. There was a three-weekly rotating menu which constantly evolved to incorporate people's choices and requests. We saw a list was kept in the kitchen of people's required diets and any likes and dislikes. This ensured people got food which was right for them. Foods were supplemented with fresh cream, full fat milk and butter where required.

The catering staff put on special themed events to stimulate people's interest in different foods, such as an Italian day, a Greek day and a 40s/50s day. On these days, catering staff would dress up in themed costumes and serve food of that era or country's origins. The kitchen team had also devised special desserts to be served for people during afternoon tea. They received pureed diets instead of cakes. These looked attractive, resembling mousse or trifle, which meant people on soft diets did not feel left out with afternoon treats.

On the first day of the inspection, we found the mealtime experience in some areas of the building needed to be improved. For example, on the Margaret wing, staff were not always fully engaging people during mealtimes or offering encouragement to assist. This resulted in a number of people leaving their meals. By the second day these issues had been resolved.

People assessed 'at risk' nutritionally were referred to the GP or dietician and supplements were prescribed where required. We saw the speech and language therapy team (SALT) were involved where concerns were raised about the risk of choking for some people and thickeners used appropriately to reduce this risk. During our inspection, we saw staff using these to thicken some people's drinks. Staff we spoke with understood how to use these correctly and referred to information folders in the unit office or to information displayed in people's bedroom.

Some people who used the service were having their fluid intake monitored to make sure they were drinking enough. However, the target input was not always recorded and the fluid record charts were not completed in a consistent way. We raised this with the management team who acted to address this.

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.

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. Conditions attached to the DoLS were being met with the service working hard to reduce the restrictions placed on the person. A number of other applications were awaiting assessment by the local authority.

People were asked consent before care and support was provided. Where people lacked capacity best interest decisions had been made involving families and healthcare professionals. For example, the best interest process had been followed to allow people to take their medicines covertly (hidden), the provision

of flu vaccinations and bed rails.

Staff had received training the Mental Capacity Act (MCA) and had received training in the subject. Their answers demonstrated a basic understanding of ensuring people's rights were protected under the legislation. The registered manager had a very good understanding of the MCA and this was reflected in the quality of documentation we reviewed.

The manager had oversight of which people who used the service had Lasting Power of Attorney (LPA) in place. A LPA is a legal document that allows someone to make decisions for you if you're no longer able to. LPA's can be put in place for property and financial affairs or health and welfare. This showed us the manager understood their responsibilities to act within the legislation

People's health care needs were supported. Care records evidenced people had access to a range of health care professionals and their views were used to formulate plans of care. The service had implemented the Red bag pathway, a local initiative to ensure key information was transferred to hospital should people be admitted. Telephone and video conferencing facilities were used to ensure people had prompt access to health professionals, for example, to meet people's end of life needs or if an urgent consultation was required, helping to reduce hospital admissions.

The building was appropriately adapted for the needs of people living in the home. Each wing had its own communal areas where people could spend time. There were also pleasant garden areas. Bedrooms were personalised with people's possessions and photographs. People's bedroom doors were named and pictures were in place to help staff strike up a relevant conversation. Where people were living with dementia, adaptions had been made to support people effectively. For example, contrasting colours were used in decoration and reminiscence and sensory material placed around the corridors with clear signage. On Garden wing the corridors were wide and there were stable doors along the corridor. The top part of the door was open allowing people to look outside. We saw this had a positive effect, as when people got to these doors they looked outside and then happily turned around and returned to the lounges. One relative said "They make it very homely."

Good

Is the service caring?

Our findings

People said they were treated well by staff. One person said "The staff are nice, and we share biscuits and sweets." Another person said, "Everything is lovely, everything's great as they look after me well and anything I want I only have to ask, all the girls are very nice." A relative said, "It's friendly, the staff and the care are exceptional." A staff member told us "Staff go out of their way for the residents. They will come in during their own time and spend one to one time with certain residents and they do their shopping for them."

Staff interacted with people in a calm and reassuring way demonstrating kindness and compassion. It was clear they had developed good relationships with people. We saw staff took time to sit and chat with people. We heard some good-humoured banter shared between people who used the service and staff which resulted in laughter and further conversation. Staff were patient and caring with people, sitting to talk with them and exchanging hugs or holding people's hands for comfort and support. A relative told us, "All I can say is on this unit, they tick all the boxes. Carers are excellent. The whole team is excellent. What fabulous care."

Care files contained information about people's life histories, interests and hobbies. This helped staff understand the people they were caring for. One care worker explained how important this was and gave the following example, "[Name] loves football, we used to go out on the lawn a kick a ball around. They can't do that now but we still talk to them about football." On the second day of our visit we heard another care worker talking with the person about football, this showed us staff knew about people's lives and interests.

We saw the service took steps to help people maintain relationships with people. Visitors were made welcome to the home throughout the day. The service had supported one person to safely visit the theatre with their partner, an outing which was important to both. A visitor told us, "I am always made to feel welcome, offered a drink and asked if I want a meal."

People said they were treated with dignity and respect by staff. We saw people were treated with dignity when staff were transferring people safely, speaking to them throughout and taking care to maintain their dignity. We observed staff knocked on doors before entering and always asked people for consent before providing care and support. People looked clean and well cared for with staff taking care to maintain their preferred appearance. One person was very well dressed with their hair and nails done up. They told us they found the staff to be very helpful and they help them stay well-dressed which was important to the person.

Staff could explain measures they took to ensure they promoted people's privacy and respected their dignity such as encouraging people to do as much as possible for themselves. One care worker told us, "I always ask people to wash their own hands and face. One person likes to shave and so I pass them their equipment." Another care worker said, "I always ensure people are comfortable with what I am about to do. I ensure they remain covered and always ask their preferred method of support,"

Staff said that they focused on giving people choice and control over their lives. We saw staff regularly asking

people what they wanted to do and listening to their responses. People had various opportunities to air their views. For example, regular care reviews took place, people were asked to complete surveys and resident meetings took place. People and relatives said they felt involved in plans of care and this was evident from records we reviewed. We saw evidence people's requests were listened to. For example, people had wanted traditional fish and chips wrapped in newspaper for tea, so the service had ensured this was provided.

People who used the service were supported to be as independent as possible. This was evident in care planning. For example, we saw the service was working effectively to encourage one person to do more of their care for themselves.

We looked at whether the service complied with the Equality Act 2010 and in particular 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. For example, the use of adult sensory tools, religion, diet, choice of carers. Individualised communication techniques were used. For example, one staff member explained a person had picture and word cards to help them express their wishes and would use 'thumbs up' and 'thumbs down' to help ensure their disability did not compromise communication with staff.

Good

Is the service responsive?

Our findings

People and relatives said the overall quality of care was good and met individual needs. One person said, "I'm happy with everything here she is so well looked after." Most people said the service responded to their requests or any requests or changes in their needs. One person said, "They keep looking in to see I'm alright and they don't wait for me to ring." Another person said, "I only have to press the buzzer if I want a drink or something."

Care records were electronic which enabled real time information to be accessible to all care staff. We found most records were person-centred with details of each support need clearly identified. They were well structured with clear reference to key needs. For example, one person needed assistance with mobility, and their care record stated, "If there is time please help me to do my exercises. I would like to stand up and down twice with the aim of strengthening my leg muscles to stop them from stiffening," showing a good level of detail. Whilst most care plans were sufficient, some needed more detail recording, for example, some skin integrity care plans needed more information about people's equipment and repositioning regimes. We spoke with the management team and were assured this would be addressed.

Staff we spoke with had a good understanding of the people they cared for which gave us assurance appropriate care was delivered in line with care plans.

People's religious needs were assessed prior to admission. We saw evidence that people were supported with their needs in this area, for example, people had been supported to see religious clergymen.

Daily records of care were maintained. These provided evidence people's care needs were met. Systems were in place to ensure people received regular care, for example, regular continence care and pressure relief. Daily notes reflected the support offered to each person and commented on the person's wellbeing.

People received annual reviews of their care. One person said, "We have a yearly review but there is no need as we are updated every time we come. They (staff) are on the ball. Here, you know they do the right thing."

The service employed six activity co-ordinators who worked covered seven days a week. The service was also developing a network of volunteers to further enhance the opportunities available to people. The home had a minibus which meant people could go on regular days out. Most people said they were happy with the provision of activities. One person told us, "The activities are Bingo and dominoes and sometimes we go out in the town, I'm happy and it's quite pleasant." Another person said, "There is always something going off and there's always Bingo on Mondays which I like, and I get plenty of visitors. A relative said, "There are two lovely girls (who come to do the activities); they do sing songs, knitting, jigsaws, painting and bingo. They have an old-fashioned café downstairs where they [residents] can make their own drinks. It's great." Records showed a range of activities took place on each wing. On the day of our inspection, we saw a number of people were supported to go out into the countryside, using the service's minibus. Entertainers visited the home and some alpacas had recently visited as well as themed nights being held.

The service maintained good links with the local community. For example, there was regular contact with the local school and school children came into the home to spend time with people. People were also supported to attend places in the community such as a local dementia café.

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. We saw people's communication needs were assessed and support plans put in place to help staff meet their needs. Staff communicated well with people to provide comfort and reassurance using appropriate techniques for each person. We saw staff had learnt and were able to speak small phrases with one person whose first language was not English, through liaising with the person's family and researching on the internet. Documentation was available in different formats such as easy read should people require it.

The service provided good, person centred end of life care. It had achieved Gold Standards Framework (GSF) accreditation which meant it had been independently assessed as providing high quality end of life care. People's end of life care needs were assessed with people fully involved in the process of completing advanced care plans. Following any deaths, reflective practice took place to see whether any aspect of the person's experience could have been improved. The service assessed itself against a number of performance areas such as the availability of anticipatory medicines and unnecessary hospital admissions to evaluate the quality of its end of life care. Analysis showed continuous improvement had taken place following the measures put in place to meet the GSF. A health professional said of the end of life care, "The home embraces new thoughts/ideas and recommendations and are very proactive to deliver the best service." We saw lots of positive feedback had been received about the end of life care experiences in the home. One person said, "Towards the end of her life you looked after her in such a caring way as well as making sure that she had any appropriate medical care and medication, it was the little touches."

A system to log, investigate and respond to complaints was in place. People and relatives all said that the management team and provider were approachable and they felt able to raise issues with them. One person said, "They are all very approachable and if there are any problems I would speak with the nurse in charge." Another person said, "I have no problems with anything but if I had then I would mention it to [provider] and he would sort it out for me." We saw the registered manager acknowledged and replied to complaints in a timely manner. Investigations were open and thorough and the home apologised where it had upheld people's complaints. We saw a low number of complaints had been received.

Good

Is the service well-led?

Our findings

A registered manager was in place. They had worked at the home for a number of years and had good oversight of the home and how it operated. They were supported by a team of senior staff including a clinical services manager and unit managers for each of the six wings. The provider also worked at the home on a daily basis and had regular contact with staff, people and relatives. Staff we spoke with had a good understanding of their roles, and had clearly defined responsibilities. We saw the staff team worked effectively together to ensure good performance of the home.

People, relatives and staff all praised the management team. A person said, "I'm happy here as I've got used to it and it's like family and I definitely wouldn't want to go anywhere else."
One relative said, "We were impressed when we first came. The main manager visits every unit every day. She knows all the residents by name and there's always a 'Hello' for everyone."

Staff told us morale was good and they felt supported in their role. A staff member said, "It's an absolutely lovely home and I've worked in a few; this is the best. The management is there for you. They provide you with lunch, homemade soup and homemade bread. I've worked in other places and this is lovely." Another staff member said, "Love it here, the staff and managers all do really care they make sure everything is done properly." A third staff member said, "I feel so proud to be working here, it's like a second family, couldn't recommend it enough to anyone." A fourth staff member said "The owner of the home; it's been in the family, is very hands on. We can call him for anything."

We found the management team open and committed to make a genuine difference to the lives of people using service. We saw there was a clear vision about delivering good care, and achieving good outcomes for people living at the service. We found all staff including the receptionist, care workers, registered manager and provider being helpful and considering the needs of people who used the service. This made for a warm and inclusive atmosphere in the home.

The home had clear aims and values in place. These were individualised for each of the six wings reflecting the different client groups and staff team. This showed a person-centred approach adaptive to diverse needs of people who used the service. Staff were aware of the values and their performance against them was monitored by the management team.

A range of audits and checks were undertaken to monitor how the service was operating. This included inspections of each wing by the manager which looked at a comprehensive range of areas. Audits of care plans also took place by a dedicated staff member. The electronic care management system allowed good oversight of people's care needs. Actions were taken following audits to ensure improvement of the service. For example, a unit manager told us where medication issues had arisen, staff were immediately retrained and provided with supportive supervision and observations to ensure they were fully competent.

The registered manager had a good understanding of how the service was operating and was committed to continuous improvement. We saw they took positive action to address minor points for improvement that

we raised throughout the inspection. The service measured the performance of new initiatives and projects to ensure they benefited people who used the service. For example, following the introduction of the nutrition champion and following work undertaken to meet the Gold Standards Framework (GSF) the effect on people in these areas had been monitored, showing improvements to people's outcomes.

Staff sentiment was monitored through an annual staff survey. Following the survey, staff opinion had been used to continuously improve the service. Staff told us regular team meetings were held which were an opportunity to discuss any concerns, offer support to staff and drive improvement of the home. A staff member said, said, "The manager takes on board what we say and do the best they can." Senior staff from each wing and department attended three monthly quality improvement meetings with the provider to discuss ideas about improving the service experience for the people who lived at the home. For example, new dementia friendly plates and bowls had been sourced as a result of ideas discussed at these meetings.

People's views and opinions were sought and used to make improvements to the service. Resident and relative meetings were regularly held. We saw evidence topics such as the menu, changes in the home, and activities were discussed at these meetings, with people fully involved in any decisions which needed to be made. An annual survey was also completed where people could air their views confidentially about the service. A 'You said, we did' board was in place demonstrating the action taken following the previous survey to ensure improvement. For example, people had wanted to see more activities, so six co-ordinators were now in place and a network of volunteers had or were in the process of being recruited.

The registered manager had established excellent links with other agencies. They attended meetings with the local authority, care provider forums and were on the panel for the Bradford Care Home Improvement board. Discussions took place at these meetings around legal and regulatory obligations, quality risks in the market, cost of care, serious concerns and transforming care strategies for Yorkshire & Humber. The registered manager took an active role to ensure best practice was constantly developed within the service. For example, they had been asked to be a facilitator on the Primary Care Homes panel. This panel would be looking at working in partnership with GP's, district nurses and other healthcare professionals in the local area. The aim being to develop effective partnerships looking at ways to make improvements in the district, in areas such as virtual ward rounds, and reducing hospital admissions. They had also worked with universities to aid in studies about health and social care, to help improve the outcome for care home residents.

Providers are required by law to notify The Care Quality Commission (CQC) of significant events that occur in care settings. This allows CQC to monitor occurrences and prioritise our regulatory activities. We checked through records and found the service had met the requirements of this regulation. It is also a requirement that the provider displays the quality rating certificate for the service in the home, we found the service had also met this requirement.