Advinia Care Homes Limited

West Ridings Care Home

Inspection report

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16 December 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
West Ridings is a residential care home providing personal and nursing care for up to 180 people across six separate units, although one unit has not been used since 2015. Swaledale unit provides general nursing care, Wharfedale and Airedale units provide personal care, Wensleydale unit provides personal care for people living with dementia and Calderdale unit provides nursing care for people living with dementia. At the time of the inspection there were 116 people using the service, six of whom were in hospital.

People's experience of using this service and what we found
The registered provider did not have effective systems of governance in place to maintain and improve the quality and safety of the service.

There had been improvements in infection prevention and control practices to prevent the spread of infections, however not all risks had been recorded. The provider took action to address this and risk assessments were completed to evidence the measures in place to reduce risks.

Staff were not always supported with role specific training, to ensure they had the knowledge and skills to support people.

Feedback about whether there were enough staff to meet people's needs was mixed. People's needs were met in a timely manner during our inspection. The provider did not evidence people's dependency levels were used to allocate staffing, as the staffing level tool was faulty and managers at the home were not aware of this. The provider rectified this after our inspection and reviewed staffing levels.

Staff were knowledgeable about people's needs and people told us the staff were caring. Some care records needed to be updated.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Improvements were required in the recording of best interest discussions for some people.

People told us they felt safe and staff we spoke with had a good understanding of how to safeguard adults from abuse.

Safe systems of recruitment were followed to ensure staff were safe to work with vulnerable people.

Accidents and incidents were reviewed to ensure appropriate action had been taken and lessons had been learned to reduce the risk of a re-occurrence. People received their medicines as prescribed.

The home was clean throughout, with additional cleaning being completed during the COVID-19 pandemic.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
The last rating for this service was requires improvement (published 31/10/2019).

At this inspection the provider was in breach of two regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
This inspection was prompted in part due to concerns received about infection prevention and control, staffing levels, medicines, managing risk and the management and governance of the service. A decision was made for us to inspect and examine those risks. We found evidence during this inspection that people were at risk of harm from some of these concerns, however we did not find evidence that harm had occurred.

This report only covers our findings in relation to the key questions Safe and Well-led which contain those requirements and concerns. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained the same as requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for West Ridings Care Home on our website at www.cqc.org.uk.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority and CCG to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

West Ridings Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

The service had a manager registered with the Care Quality Commission, however they had left the service in September 2020 and a regional support manager was managing the service until a new manager could be recruited. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by three inspectors, a specialist advisor specialising in nursing care for people living with dementia 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.

Service and service type
West Ridings Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was announced at very short notice. Inspection activity started on 24 November 2020 and ended on 16 December 2020. We visited the home on 24 November 2020.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and health commissioners. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. 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 spoke with eighteen relatives on the telephone. We spoke with seventeen members of staff including the support manager, the clinical services manager, nurses, unit managers, senior care workers and care workers, housekeepers and an activity coordinator.

We reviewed a range of records during and after our visit to the home. This included six people's care records and multiple medication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training and supervision data, staff rotas, quality assurance records and including policies and procedures. We looked at two staff records in relation to recruitment. We received further feedback from the local authority infection prevention and control team.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks to people's safety were not always assessed and recorded. For example, risk assessments had not been completed for three people using the service who were unable to self-isolate due to specific health conditions, when tested positive for COVID-19. We saw staff supporting and diverting people and the support manager told us enhanced cleaning was in place, however information was not available to inform staff how best to support and divert each individual to minimise the risks.
- Risk assessments that were subsequently completed were identical and did not identify how each individual could be supported to keep themselves and others safe.
- A risk assessment had not been completed to ensure the risk of infection from COVID-19 was minimised when staff moved between units. The provider told us there was no risk identified with staff moving between units as neither unit had COVID-19 positive people using the unit, however this was not recorded.
- One risk assessment had not been updated to reflect a person's current needs re: falls, however action had been taken to mitigate the risk and staff we spoke with were aware of this.
- Some staff had not completed training in managing behaviour that may challenge others and this meant there was a risk staff may not have the skills and knowledge to support people safely.

The above issues were a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the provider completed the relevant risk assessments and arranged for staff to complete required training.

- Most risks had been assessed and appropriate equipment was in place, such as motion sensors to reduce the risk of falls. One relative said, "The staff have tried to do as much as they can and [my relative] has not fallen for a while."

Staffing and recruitment

- The service was adequately staffed, although most staff told us there were sometimes insufficient staff to deliver person-centred care. Comments included, "No time to spend quality time with individuals", "The care we give is good but we are often stretched" and, "We feel stressed a lot, agency use and staff shortages don't help, night duty is almost all agency."
- The support manager told us staffing levels were regularly reviewed and we saw dependency assessments in individuals care records. However, the dependency tool used to calculate staffing levels was faulty and this had not been picked up by managers.

This contributed to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider ensured the fault was rectified and told us some units were over staffed due to the dependency calculator only using direct care needs to calculate staffing levels.
● We observed staff responding to people's needs in a timely manner, although staff were busy, and care was delivered in line with people's care plans.
● Activity coordinators were also employed to support people, however two out of four activity coordinators were absent from work or the post was not filled.
● Most relatives told us they thought there were enough staff and some felt there had been some shortages due to the pandemic and a high use of agency staff. One relative said, "I think there are enough staff but am not sure about in the night. The staff always seem to be around, there are not many but they are there when you want them."
● The provider reviewed staffing levels following our inspection to ensure there was sufficient staff on duty.
● The provider had recruited to vacant posts and staff continued to be safely recruited.

Preventing and controlling infection
● We were somewhat assured that the provider was using PPE effectively and safely. Some staff occasionally touched their masks and this was addressed by managers. We have also signposted the provider to resources to develop their approach.
● People and relatives told us staff wore masks, gloves and aprons to prevent the spread of infection. One relative said, "The carer did have a mask on when I did a window visit last week."
●Improvements had been implemented to the layout and practices of each unit in line with recommendations from the local authority infection prevention and control (IPC) team, to reduce the risk associated with COVID-19.
●The home was clean throughout, with additional cleaning being introduced due to the COVID-19 pandemic and staff had received training in IPC.

Learning lessons when things go wrong;
● Staff recorded and reported all incidents and took appropriate action to prevent them from happening again and the provider reviewed all incidents to look for patterns.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe and relatives told us any concerns were acted on. One relative said, "When [my relative] rings their buzzer the staff come quickly, they spend time with [my relative] in their room, this has all [their] personal belongings, which makes [them], feel safe and secure." One relative raised a concern with us and the support manager took action straight away to ensure the person was safe.
● Staff knew the potential signs of abuse and what to do to report any abuse. The provider had an effective system in place to report and act on allegations of abuse when they arose.

Using medicines safely
● Medicines were received, stored, administered and disposed of safely. Staff involved in handling medicines had received training. A small number of relevant staff had not completed specific training in using the new electronic system. After the inspection, the provider ensured these staff were trained and assessed as competent with this system.
● Regular medicines audits were completed and action had been taken to reduce medicines errors.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider failed to ensure there was effective leadership and management of the service and quality assurance systems were not always effective in identifying and resolving issues.
- The provider did not maintain oversight and up to date records of staffing and dependency levels, training and staff supervision.
- The provider did not always ensure action was taken to mitigate risk, for example, lack of risk assessments for some people was identified by the quality assurance team prior to our inspection and not acted on.
- The registered provider did not ensure all staff and managers received appropriate support, training, professional development and supervision. For example, one unit manager and one carer had not received supervision since April 2020 and February 2020 respectively.
- The registered provider did not ensure all best interest discussions with the relevant person were recorded.

The above issues were a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the registered provider did not assess, monitor and improve the quality and safety of the service and accurate records were not always kept.

- Senior staff completed observations in relation to moving and handling, medicines and infection prevention and control.
- The management team completed audits and the providers quality team completed visits to the service. Some action had been taken as a result to improve the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People we spoke with were generally happy with the care. One person said, "They have been very good. I've been very comfortable here. Never had to complain."
- Some relatives told us there was poor communication from the provider regarding issues such as visiting rules.
- Most relatives told us the service was well led. Comments included, "I do not think anything needs altering, I have never seen the staff raise their voice or shout. They communicate well with me when my [relative] needs things." and "It's been wonderful- I have no complaints. The care and attention from those young girls

has been excellent."
● Relatives told us they had been involved in agreeing and reviewing their relatives care needs. One relative felt it was sometimes difficult to get the information they needed and communication needed to improve.
● Most staff told us they did not always feel supported by the provider but felt supported by unit managers when one was in post. Comments included, "The care is very good despite all the challenges. I have no manager so it is difficult to know who to turn to, but the clinical services manager is approachable."
● Following our inspection two unit managers, a new permanent manager and an additional clinical services manager, who had all been recently recruited, commenced employment at the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider and management team understood their responsibilities and acted on the duty of candour. Relatives told us they were kept informed of any incidents that occurred and the rating from the last inspection was on display in the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● One person told us the management did not respond when complaints are raised, for example about the quality of the food.
● Most relatives told us managers were responsive if they had any concerns and took the necessary action to address them. One relative said, "We have reported concerns, had a meeting and things been dealt with. I think it is a service that is managed well."
● The provider had not recently requested feedback from residents and relatives. One relative said, "A new lady took over and I'm not sure there have been any recent family resident meetings but we do get a newsletter with information fairly regularly. I think the culture is good." A second relative said, "There is a friend of the unit group so we do have an opportunity to influence some things."
● Relative told us the staff were caring and worked hard to deliver person centred care. We observed kind and caring interactions on the day of or inspection. Comments included, "The staff offer person centred care. My relative is well fed and socialises", "When we had a window visit recently the staff supported my relative to be able to hear us and It was nice for the staff to do this and make it happen."
● Most staff told us there was poor communication from senior managers and few managers meetings or briefings for staff and managers. Some staff told us some meetings had been held and minutes were also circulated to absent staff.
● The provider told us they had standing meetings to share information with staff and updated families and staff via emails during the pandemic.

Working in partnership with others
● The management team worked in partnership with community professionals and organisations to meet people's needs.

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 Risks to people's safety were not always assessed and recorded and staff did not always have the skills and knowledge to support people safely. (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not assess, monitor and improve the quality and safety of the service and accurate records were not always kept. (1) (2) (a) (b) (c)