

Yorkare Homes Limited

Westfield Park Nursing Home

Inspection report

Westfield Lane
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December 2015
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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 

Overall summary

This inspection took place on 30 November and 1 December 2015 and was unannounced. At our last inspection of the service in January 2014 the registered provider was compliant with all the regulations in force at that time.

Westfield Park Nursing Home is situated in the village of Hook, near Goole. It is registered to provide accommodation and care to 111 people. The service

supports older people, people who have a physical disability and people living with dementia. The service is split into two separate units with the dementia unit being known as The Haven.

The registered provider is required to have a registered manager in post and there was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and that there were enough staff to meet people's needs. Staff had been employed following robust recruitment and selection processes. Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust.

People's nutritional needs had been assessed and they told us they were satisfied with the meals provided by the home.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to

support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community.

People spoken with said staff were caring and they were happy with the care they received. They had access to community facilities and most participated in the activities provided in the service.

Staff received a range of training opportunities and told us they were supported so they could deliver effective care; this included staff supervision, appraisals and staff meetings.

The registered manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We saw from recent audits that the service was meeting their internal quality standards.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Assessments were undertaken of risks to people who used the service and staff. Written plans were in place to manage these risks. There were processes for recording accidents and incidents. We saw that appropriate action was taken in response to incidents to maintain the safety of people who used the service.

There was sufficient staff on duty to meet people's needs and medicines were managed safely so that people received them as prescribed.

Good



Is the service effective?

The service was effective.

Staff received relevant training, supervision and appraisal to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

People reported the food was good. They said they had a choice of quality food. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs. People told us that care was good and they received appropriate healthcare support.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Good



Is the service caring?

The service was caring.

People who lived at the home told us they felt staff cared about them and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

Staff were motivated and inspired to offer care which was compassionate and person centred. People told us that they were treated with dignity and respect and this was observed throughout our visit.

People were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

Good



Is the service responsive?

The service was responsive.

Care plans were in place outlining people's care and support needs. Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

People were able to make choices and decisions about aspects of their lives. This helped them to retain some control and to be as independent as possible.

Good



Summary of findings

People were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

The service was well led.

People were at the heart of the service and staff continually strived to improve. People who used the service said they could chat to the registered manager, relatives said the registered manager was understanding and knowledgeable.

The registered manager carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked there.

Staff were supported by the registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with the registered manager.

Good



Westfield Park Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 30 November and 1 December 2015 and was unannounced. The inspection team consisted of three adult social care inspectors, a specialist advisor in older people and dementia care 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 experts-by-experience who assisted with this inspection had knowledge and experience relating to older people and those living with dementia.

Prior to our visit we looked at information we held about the service, which included notifications. Notifications give us information about how well the registered provider has managed incidents that affect the welfare of the people who use the service. The registered provider had

completed a provider information return (PIR) for this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection process we contacted the local authority safeguarding adults and local authority quality monitoring teams to enquire about any recent involvement they had with the service. They told us they had no concerns about the service.

During the inspection we spoke with a director of the company, the registered manager, deputy manager and 12 staff. We also spoke with 22 people who used the service, 11 visitors/relatives and one healthcare professional visiting the service. We spent time in the office looking at records, which included the care records for six people who used the service, the recruitment, induction, training and supervision records for six members of staff and records relating to the management of the service. We spent time observing the interaction between people, relatives and staff in the communal areas and during mealtimes. We used the Short Observational Framework for Inspection (SOFI) on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

We asked people if they felt safe, if the staff assisting them had the right skills and if they felt the premises were safe and secure. All the responses we received were positive about the service. Comments included, “All the staff are lovely” and, “I feel safe here”. One person who came into the home on a regular respite stay said, “It is lonely at home, here I have good company with the residents and the staff.”

Visitors we spoke with said they felt their relative and other people using the service were safe in the home. One visitor said, “Yes, I think the environment is safe and the staff are conscious of any hazards around the service.” When asked about safety one relative said, “I have no complaints whatsoever on that score.” They described the care in the service as, “Rolls Royce” compared to other services in which their relative had been. Two other relatives visiting their family member said, “They (the residents) are safe from any external and internal threat” and another relative whose family member had a tendency to fall said, “They are safe here. If they try to move without asking for assistance the staff are straight on to it and I think that is why they have not had a fall.”

None of the people we spoke with had any concerns about anything they had seen in the home. However, they confirmed that if they were concerned in any way they would, “Talk with the senior staff” and all were convinced that swift action would be taken.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable people from abuse (SOVA). The registered manager described the local authority safeguarding procedures which consisted of a risk matrix tool, phone calls to the local safeguarding team for advice and alert forms to use when making referrals to the safeguarding team for a decision about investigation. Discussion with the local council’s safeguarding and commissioning teams prior to our inspection indicated they had no concerns about the service.

Checks of the safeguarding records held in the service showed that there had been a total of 17 instances in the last year when the safeguarding risk matrix tool had been used, when alert forms had been completed and when the

CQC had been notified. These were completed appropriately and in a timely way. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We spoke with four staff about their understanding of SOVA. Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse. Staff said they were confident their registered manager would take any allegation seriously and would investigate it. The staff told us that they had completed SOVA training in the last year; the training records we saw showed that the majority of staff were up-to-date with safeguarding training and where staff required refresher training or updates the training officer for the service had booked them onto courses in 2016.

When we asked people who used the service and relatives if there were enough staff on duty we received a mixed response. Some felt there were enough on duty but others said there were times when the service was short staffed.

On the dementia unit we observed that the staff were visible in all the communal areas and relatives told us, “Yes there are always enough staff on duty now.” When we asked them to qualify what they were saying they said, “Well in the past there has sometimes not really been enough, but now they seem to have it sorted” and, “There are enough staff now, sometimes when they have been training it is a bit short, but that hasn’t happened for a while now.” With regard to the flexibility of the staff one visitor said, “They would bend over backwards for you, there is nothing you could ask of them that they wouldn’t try to do if they possibly could.” Another visitor who continued to do a great deal for their relative such as washing and showering (through choice and not necessity) said, “If I have any problem with [Name], which sometimes I do, I only have to press the bell and the staff will be there immediately.”

On the nursing unit we observed that staff were extremely busy and we were told that they were two staff members short on the morning shift. One member of staff who we spoke with said, “We could do with more staff, especially in the mornings and if someone is off, it is difficult to juggle priorities and I feel awful if people sometimes have to wait

Is the service safe?

but sometimes they do.” Another staff member told us, “Staffing levels are okay but it is difficult to get agency staff in quickly – this doesn’t affect the care we give but does affect how fast we can attend to everyone.”

We spoke with 17 people who lived on the nursing side of the service and over half of them told us they often had to wait a while before a member of staff came if they rang the bell for attention. We observed that one person rang their bell as we went into their room to speak with them. It was more than 10 minutes before a member of staff came. This person was in their pyjama’s at 11:00 and had earlier asked for a bath before they got dressed, staff had told them that would be okay but no-one had come back. The person told us, “I prefer a bath to a shower but I have to wait for the staff to take me.” The staff member that did respond said, “We have not forgotten you, we will get around to you”, but they did not give the person any indication of how long that might be. The staff member then turned up just as the person was given their morning drink and took them for their bath, the member of staff said, “I’ll bring you another drink after your bath.”

One relative spoke with us about the nursing unit and told us, “They could do with more staff in the mornings, [Name] can ring for a while before they come to them, so unfortunately they now shout for them.” The person using the service confirmed this saying, “I can ring for ages but nobody comes so I shout and get told off”, they also said, “Most (the staff) are okay, but some just charge about.” However, another relative said, “I have turned up early on an afternoon and there is always someone around. Never turned up and not been able to find staff.” We also spoke with five people in their bedrooms in the nursing unit. When asked about waiting times for care or assistance we were told by all five people that, “Everything is fine, I don’t have a problem with this.”

The registered manager told us “We recognise that the service is a large one and when staff are busy seeing to people in their bedrooms it may appear as though there are few staff on duty.” Discussion with the registered manager indicated that they used a ‘dependency tool’ to assess the needs of people who used the service and subsequently the levels of staff required to meet those needs. We saw that the dependency levels for the service were calculated each week and the last one for 19 November 2015 indicated that the staffing levels were 60 hours over the minimum levels. The registered manager

told us that no agency staff had been used in the last month and that the regular staff covered any gaps in the shifts. We were told that there were currently 90 people who used the service and that there were 24 care staff on duty in a morning, 22 care staff on duty in an afternoon and 10 care staff at night. Plus there were some additional staff for flexibility over meal times and up until 22:00.

We looked at the rota sheets for the four weeks leading up to our inspection. These indicated which staff were on duty and in what capacity and the staff we met on the inspection matched those on the rota sheet. The rotas showed us there were sufficient staff on duty during the day and at night, with sufficient skill mix to meet people’s assessed needs. The staff team consisted of unit managers, nurses, care staff, ancillary workers, administrator, activity co-ordinator, catering staff and maintenance personnel. We fed back to the director and the registered manager during our inspection the concerns raised with us about staffing on the nursing unit. We were told that they would look at staff deployment and break times to see if adjusting this could improve the response times to people’s requests for assistance in the mornings.

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. We were given access to the records for accidents and incidents which showed what action had been taken and any investigations completed by the registered manager.

Staff told us, “Staff are aware of emergency procedures in terms of incidents to people, for example if someone collapses, or in terms of the environment, such as in the event of a fire. We do fire drills and training.” We found that the fire risk assessment was reviewed in June 2015. A fire drill was carried out in July 2015 and personal emergency evacuation plans (PEEP’s) were in place for people who would require assistance leaving the premises in the event of an emergency. These were kept together in one file for ease of access in an emergency and were up to date.

The registered person monitored and maintained the safety of the premises. We looked at documents relating to the servicing of equipment used in the service. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment serviced included the fire alarm

Is the service safe?

and the nurse call bell, moving and handling equipment including hoists and slings, portable electrical items, water systems and gas systems. We were sent a copy of the electrical wiring certificate for the service within 24 hours of our inspection, this showed that the electrical system was deemed to be satisfactory by the electrical contractor who had tested it and that the system was due a further check in February 2016.

Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person for wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights, window opening restrictors and bed rails. One member of staff told us, "We keep people safe by checking our equipment, using the right moving and handling techniques and keeping our training up to date." These environmental checks helped to ensure the safety of people who used the service.

We looked at the recruitment files of six members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The registered manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

The nurses and senior care staff informed us that they had received training on the handling of medicines. One staff member told us, "I have done a distance learning course on medicines. We have competency checks as well. I was supervised for a while before doing medicines on my own." This was confirmed by our checks of the staff training plan and staff training files. We saw that the medicines policy and procedure had been reviewed and updated in April

2015 to ensure it followed the National Institute of Health and Care Excellence (NICE) guidance and the Royal Pharmaceutical Society guidance on best practice with regard to administering medicines within a care service.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. People we spoke with said their medicines were administered on time and were always available when needed.

There were some minor deficits in medicine recording particularly hand written medicine entries on the MARs. It is best practice for two staff to sign each entry to show that they had checked what had been recorded on the MAR was the same information as was on the medicine label attached to the bottle or box of medicine dispensed by the pharmacy. This was not evident on the hand written entries we saw in the MARs. We found on one entry that the staff had not included the instruction for the medicine to be 'administered with or after food'. This was important as the person receiving the medicine could become nauseous if these instructions were not followed appropriately.

We found that people who used the service were able to communicate with the staff, including the people who had a diagnosis of dementia. We observed staff asking people if they wanted pain relief before dispensing their medicines and people who spoke with us said they received their medicines on time. In discussion with the staff we found that they had good knowledge and understanding of each person's needs including their ability to communicate with others. The staff told us they used this knowledge to assess if people were in pain or unwell, even when the individual might not indicate that verbally. The care plans we looked at took people's abilities and needs into account and were written in a person centred way. We saw evidence in the care files that people had their medicines reviewed by their GP on a regular basis.

Is the service effective?

Our findings

People and their relatives reported that the home provided effective care overall. One relative told us, “The staff have the right kind of skills to look after people, especially the two unit managers on the dementia unit. Staff are very attentive and have the ability to do their jobs well – some more than others. The staff are very skilled at calming individuals down when they are anxious.”

Information from the registered provider indicated that three staff had completed a dementia mapping course with Bradford University. This knowledge was used to highlight the importance of the effect of a person’s environment and the interaction they had with both their peer group and the staff caring for them in improving their quality of life. For example, it was highlighted that a simple hello every time a member of staff walked past a particular person using the service was all that was needed to keep this individual content – when staff didn’t they showed negative reactions and became more withdrawn. We saw a planned map to observe people’s interaction and activities for the service. This had been completed for ten people between September and November 2015.

The staff monitored people’s health and wellbeing. People were able to talk to health care professionals about their care and treatment. We saw evidence that individuals had input from their GP’s, district nurses, chiropodist, opticians and dentists. All visits or meetings were recorded in the person’s care plan with the outcome for the person and any action taken (as required). We saw the chiropodist was visiting, they asked people individually if they would like any foot care and treatment was carried out privately away from the communal spaces. One relative told us how the staff had arranged for an eye test for their relative living in the service and that they now had new glasses. They told us, “Everything is addressed by the staff, it is great.”

People who spoke with us said they were very satisfied with the communication between themselves and the staff. One relative was visiting their partner who used the service they told us, “[Name] seemed a little different to me today and they are sometimes like this when they have a water infection. I mentioned it to the staff and they said they would check it out. They are always very responsive to any kind of suggestion I make and I have confidence that if they say they will do it, they will.”

We saw that the service had a gym for use by the people who used the service. However, two people told us that the gym sessions were no longer taking place. One person said, “My legs are getting useless, there is a gym we used to go to on a Monday and Thursday but they can’t get an attendant so we can’t use it and don’t get enough exercise.” We spoke to the director about this who said the member of staff who used to run the gym classes had left. However, we were told that attempts were being made to recruit someone who could continue the classes.

Feedback from health care professionals on the effectiveness of the care was positive. For example, one health care professional who gave us information about the service said, “This is a lovely home. I have a single point of contact and staff ring me if there is any need for a visit. I have a good relationship with the staff and there is a positive atmosphere in the home, it is a pleasure to come here.”

Staff within the service were monitoring and reviewing risks relating to people’s mental and physical wellbeing. This meant people were kept safe and they received appropriate interventions as needed from health and social care professionals. For example, behaviour management charts were kept on file where needed. Behaviour management plans and risk assessments had been reviewed and updated in the care files we looked at. We observed that staff demonstrated flexibility in a number of ways including not restricting people on the dementia unit from moving about the unit, but walking with them and chatting as they went along the corridors.

We were told by the staff that, “Restraint is not used in this service, we only support people with mild dementia. We try to distract them if they are anxious.” One visitor said, “The staff are incredibly good with people who may ‘flare up’ occasionally.” They went on to say, “They are quickly there and soothe and talk with people until, before you know it it is all over.” Another visitor said, “The staff are aware that some remarks by other people living in the service may provoke an agitated response from [Name], and the staff are aware of this and try, where possible to avert it.”

We looked at induction and training records for six new members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who lived at the home. Staff completed a four week induction which orientated them to the service and covered corporate information

Is the service effective?

such as employment issues, policies and procedures and layout of the building. Each new member of staff then went on to complete a Skills for Care induction and they were allocated a member of staff to mentor them. Skills for Care is a nationally recognised training resource.

We observed one new member of staff who was on their induction. They were being shown by more experienced staff how to provide drinks to people and being told a little about each individual. One member of staff told us, “I was brand new to the caring role when I first came here. I had an induction where I spent time with other staff and now the new starters have several days induction and shadowing.” Another member of staff said, “Good induction. You work through a workbook and complete different units.” A third member of staff said, “I had an induction and was asked if I felt confident before working unsupervised. I was able to do shadowing of more experienced staff. We are a good team of staff who work together well and managers ask for feedback on new starters.”

The staff told us they had three monthly supervision meetings and annual appraisals with the management team. They told us that they found the supervision sessions beneficial as they could talk about their concerns and were given feedback on their working practice. We were able to view the supervision records during the inspection.

We looked at records of staff training to check that staff had the appropriate skills and knowledge to care for people effectively. We saw that staff had access to a range of training deemed by the registered provider as both essential and service specific. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. Records showed staff participated in additional training to guide them when supporting the physical and mental health care needs of people who used the service. This training included topics such as palliative care, pressure ulcer prevention, dementia care, conflict resolution, Deprivation of Liberty Safeguards (DoLS), Mental Capacity Act 2005 (MCA) and equality and diversity. The training officer told us, “Some courses are computerised, some distance learning and some face to face.”

We saw evidence of how the service offered families additional support to help them understand and accept their relative’s changing care needs. For example two

members of the same family had been enabled to access training on dementia care. Their new found knowledge had helped them understand the changes that living with dementia had brought about in their relative. Being able to ‘manage’ these changes meant the family was able to take the person living with dementia back to their own home for short breaks. This was something that meant a lot to all parties.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

Records showed that four people who used the service had a DoLS in place around restricting their freedom of movement. Each of the four people required an escort when leaving the service to keep them safe whilst out and about in the community. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS. A further four applications had been submitted and were waiting for the local ‘Supervisory Body’ to assess and approve the documentation.

Staff had completed training on Mental Capacity awareness during the last year and were aware of how the DoLS and MCA legislation applied to people who used the service and how they were used to keep people safe. We saw in care records the home had taken appropriate steps to ensure people’s capacity was assessed to record their ability to make complex decisions.

Staff followed the basic principle that people had capacity unless they had been assessed as not having it. In discussions staff were clear about how they gained consent

Is the service effective?

prior to delivering care and treatment. Staff told us, “People are supported to make their own choices about daily life. We can use picture boards to help people make their decisions”, “People are able to do what they want to do here. Such as choose their own clothes, meals, where they wish to sit” and, “I have done MCA training. Most people here can make their own decisions.” One person told us, “You can do what you want to within reason. Staff do not mind when you get up or go to bed and they are always around if you need help.”

Where people had a person acting as their Power of Attorney (POA) this was clearly recorded in their care file. A POA is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare and/or finances) on behalf of the person who chose them to act on their behalf at a time in the future when they no longer wished to make these decisions or lacked the mental capacity to make those decisions.

People or their representative had signed consent to care forms to show that they agreed with their plans of care and support.

We discussed people’s care with different members of staff. Staff demonstrated to us that they were aware of what care each person required to meet their needs. Staff were able to say which people had input from the district nurse or dietician; they also knew what health problems each person had and what action was needed from them to support the person. Entries in the care files we looked at indicated that people who were deemed to be at nutritional risk had been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing/eating problems. We saw that the staff completed food and fluid charts when people were deemed at risk of poor nutrition or dehydration and the registered manager completed a skin care and food/fluid chart review each week. The last one was completed on 29 November 2015; one person was noted as having lost weight in the last two weeks and they saw their GP on 30 November 2015.

Everyone we spoke with said they received sufficient drinks and meals that were appropriate to their needs. One visitor told us, “The staff come round and ask each day what people who use the service would like to eat the following day and write it down”, they then went on to say, “I’m not sure whether my relative remembers what they order – in

fact I’m pretty sure they do not – but nevertheless I think they enjoy what is provided. For my part the food always smells very appetising.” Another visitor said, “[Name] does not eat very much and it is a bit hit and miss what they will eat. The staff try to tempt them by offering a range of things – and they are always up for puddings.”

On the dementia unit there was a supply of cold drinks in the lounge and the staff were proactive in encouraging people to drink outside of the routine provision of a hot drink mid morning and mid afternoon in which any visitors were included. With the hot drink in the afternoon one visitor told us, “There is always something in the way of a piece of cake, or fancy biscuit or something nice to eat.” Another visitor spoke about how mealtimes could be flexible when people had been out of the service on social activities. They told us, “We were a little late back for tea; not only did they save tea for my relative, but they invited us to partake of a tea and provided it without us even asking.”

Observation of the lunch time meal showed that the food was presented very well. We saw that people were shown the meals available and asked what they would like to eat. Everyone was provided with a hot or cold drink and sauces/condiments were offered and given. People chatted to each other and staff so there was a relaxed and enjoyable atmosphere in the dining rooms. Staff moved around the service offering support to people as needed. We overheard staff asking if people wanted help with cutting up their food and people were asked if they would like more to eat and this was given where requested. The food looked appetising and people said the food was very good and that they really enjoyed mealtimes.

The Haven (dementia unit) did not have set meal times to allow flexibility for those whose memory problems caused some disfunction to their daily routines. The staff told us, “If a person has their breakfast at 11:00 then they might have their lunch at 14:00, or might have supper.” We were told that one person often got up and asked for cereals during the night; this request was complied with.

The registered provider told us, “We visited the University of Stirling when designing the service to see how this could enhance people’s lives at Westfield Park. We also attended National Care Shows and completed research for the latest designs such as the fake restaurant fronts in the Haven.” Our observation of the Haven showed that ideas that had been incorporated into the service included corridors

Is the service effective?

decorated in different themes such as travel or the sea to give people visual stimulation. Bedroom doors had photographs or something to remind people of their past life/interests such as swimming to help people recognise their own room, as we were told by the staff that some people did not recognise photographs of themselves anymore.

Our observations of the service showed that people were settled and relaxed within the units we looked at. Individuals were able to walk around freely and interact with each other and staff as they wished. There was a good contrast between the walls and the hand rails down the corridors to help people see the hand rail, which aided some people's mobility around the home. There was clear signage throughout the service for bathrooms, toilets and other facilities.

People had access to an allotment garden which was enclosed and we were told by staff that in summer the door from the service into it was always open. This was an area where chickens were kept and where gardening could be done by people using the service during better weather. The garden area was currently dug over and left for the winter. As well as being attractively decorated and furnished, the service was stylishly dressed for Christmas. People who used the service were pleased with the service. One person told us, "I like my room, I can look out, sometimes I see squirrels" and another said, "The facilities are very good, purpose built. The rooms are very nice and the separate toilet is very nice, there are no malodours which I had noticed in other homes I visited before I came here."

Is the service caring?

Our findings

Our observations of the service showed that staff on the Haven and on the nursing side of the home were caring and considerate of people who used the service. We saw they had different approaches to care and support and this was reflected in people's feedback to us during our inspection.

We saw that staff on the Haven unit interacted with people and visitors in a positive way. One relative told us, "The two unit managers are good communicators. They fill me with confidence about [Name's] care, the staff are good and very welcoming." Other visitors said, "Staff seem to genuinely care. I have not seen any signs of poor care here" and, "Staff will try to support people to be independent. At one time they tried to get [Name] to be active and come out of their room. I told them to let [Name] do what they wanted to do and the staff have respected this."

Our observations of the staff in the Haven lounge and at lunch time indicated they were very appropriate in their approach to people who used the service. Their verbal and non-verbal communication skills were good and there was a calm and serene ambience. People and relatives told us, "The staff are kind, caring and approachable" and, "Good lasses, I won't say anything bad about these girls."

One relative said, "All the staff are caring at different levels." When we asked them what they meant by this they said, "Well the older ones you can just tell that it is a vocation for them, but the younger ones sometimes seem a bit unsure what to do." They went on to say, "I think there is role-modelling by the older staff and then the younger ones become more like them." Their opinion was "As in every walk of life there are some who are more 'feeling' than others and you can't alter this." They also said, "I have never come across a member of staff with a bad attitude at this home."

A visitor on the Haven unit said, "[Name] has deteriorated since they came here, but not because of the care they receive, which is second to none, but because of this dreadful illness." The visitor came every day to see their relative or a member of their family did, and they had not really come to terms with having them in care. They said, "I am getting more used to it and the guilt is subsiding a bit." They said their relative ate well and had always been a 'two pudding man'. Although we spoke with the visitor when

they were with the person that used the service the person was unable to comment in any meaningful way regarding what was going on. However, when we asked the person for permission to talk to the visitor about them they said "Aye go on lass."

On the nursing side of the service we saw that staff were caring and considerate, they spoke clearly to people using the service when giving care. However, in the morning they appeared very rushed and we did not observe care staff spending social time with people during our inspection. We were later informed by the director that staff had carried out an activity session with 13 people for 40 minutes whilst we were engaged elsewhere in the building.

We did overhear one care staff being a bit brusque when speaking to a person who had been ringing the bell. The staff told us, "One member of staff has had to go home ill so we are short staffed." Our checks of the staffing rotas showed that even with one member of staff short, the service had ample staff on duty to meet people's needs.

Although most people living on the nursing unit had a photograph and the name of a key worker in their room none of those who spoke with us said they saw their key worker regularly. One person said, "I haven't seen them for a bit, I don't know if they are still here or working upstairs, they haven't told me." This indicated that on the nursing unit the key worker system was not working well and there was evidence of some poor communication practices between people and staff.

Given that the focus of the nursing unit was about encouraging people to be as independent as possible, we saw little evidence that the care staff engaged with people in a meaningful way. From our observations of the unit we found that the people who were fairly confident and assertive were satisfied with the service. However, those that needed more engagement or encouragement were less so. The information we received from people using the service and from relatives was that if a person did not ask for or express an interest in something, then no-one actively engaged with or spent time talking to them. We observed care staff working at computer terminals but did not observe any in a room talking with people unless they were called for by the call bell. The people we spoke with didn't want to, "Upset anyone" and some said they were happy but from the conversations we had with people this indicated that they had no meaningful interactions with staff.

Is the service caring?

The majority of the people on the nursing unit were physically dependent, but had capacity. However, what they said to us gave the impression they felt they were expected to comply with staff requests and follow rules. They said they had little freedom to move around, go outside in the gardens or do things for themselves, although people said they could go out with friends or family. More than one person said, "You know what the rules are when you come here" although several said, "There are a lot of worse places." We spoke with five people on the unit who were satisfied with their care and support. They told us, "It is a lovely place here, the staff are helpful" and, "I am quite happy here. I have everything I need." At the end of our inspection we spoke with the registered provider and registered manager about the differences in staff approach that we had observed during our inspection. They told us that they would look at this in detail and talk with the staff.

We found that people who used the service were immaculately dressed in clean, smart, co-ordinating clothes. Their hair was brushed and many had been to the hairdressers, including the males. Finger nails and hands were clean and well cared for and gentlemen were clean shaven (if that was their choice). One person told us that their laundry was done for them but said, "It doesn't always come back straight away or you get someone else's things, but your own clothing usually turns up." Other people said the laundry service was, "Okay."

We saw that visitors came to the home throughout the day and that they were made welcome by staff. It was apparent that these were regular visitors who had a good relationship with the staff and the registered manager. They chatted to other people who lived at the home as well as their relative or friend. Family members told us that they were made to feel welcome at all times and that they were well looked after. One person told us, "Friends can come anytime, they are offered a cup of tea. They can also take me out, it is very good and relaxed, very hospitable." Another person said, "My relative comes to visit with their family and their "Girls" which are two Labradors and they can come in too."

Care plans included information about a person's previous lifestyle, including their hobbies and interests, the people who were important to them and their previous employment. This showed that people and their relatives had been involved in assessments and plans of care. For

people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the registered manager.

When we asked people if the staff encouraged them to be as independent as possible, they replied, "I can't do much but they never hurry me" and, "Yes I do what I can for myself whilst I can". Visitors we spoke with were also positive about how staff provided care and support. We were told by one visitor, "They care about people whatever happens and they respond to any difficulties in a calm and pleasant manner." Another relative said, "It goes without saying that the staff are caring here. They will do anything you ask. When [Name] had a fall, they rang me up and told me that the doctor had been called and that [Name] was okay. This set my mind at rest and I knew they were keeping an eye on [Name]."

Someone else who was visiting a friend said, "The majority of the staff do seem caring and in the right job." They qualified this statement by saying, "You will always get some who are better at it than others, that is the way of the world." Another visitor during the afternoon said, "Caring? Very much so. All I've got to do is ask them and it is done."

The registered provider had a policy and procedure for promoting equality and diversity within the service. Discussion with the staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in the care files. We saw that a number of people using the service had different faiths. Visitors and people living in the service confirmed that they were able to take part in different services in the home and attend meetings and services in the community.

We saw that staff called each person by their name and that they were all familiar with each individual. There was some use of terms of endearment – such as sweetheart – but not overly so. One visitor on the Haven said, "Staff will hold [Name's] hand or hold them in their arms when they are crying and give [Name] a kiss on the cheek. It is so lovely to see because many of the people in here probably don't ever get any loving touch any more." We observed that this positive use of touch was only used for certain individuals. The staff told us that they carefully assessed if it would be appropriate or wanted by each individual before

Is the service caring?

using this approach. Staff told us, “People have information folders in their bedrooms that we can read to learn about each person’s needs. If I found out something new about a person this would be added to the folder.”

Everyone we spoke with was happy that their privacy and dignity was maintained. People said, “I’ve got no problem with dignity or privacy, the staff are very good” and “Everything is okay, dignity-wise, all done privately.” In discussions, staff had a good understanding of how to

promote privacy, dignity, choice and independence. They said, “We close doors and curtains and gain consent for tasks. We always knock before going into a person’s room or bathroom as a number of people like some privacy at times.” We observed how staff promoted people’s privacy and dignity during the day by knocking on bedroom doors prior to entering, ensuring toilet and bathroom doors were closed when in use and holding discussions with people in private when required.

Is the service responsive?

Our findings

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide personalised care to each individual. People told us, “We do have a good laugh at times” and, “You won’t find another place like it.” One person on the Haven unit said, “I come for the day nearly every week, it’s fabulous here, I like all the people, not just the staff but other tenants.” They added, “People like [Name] are precious” and “Wonderful place, wonderful people.” Another person agreed and said, “Yes it is wonderful here.”

Assessments were undertaken to identify people’s support needs and care plans were developed outlining how these needs were to be met. People that used the service had their own care file, which contained a number of care plans. We looked in detail at eight of these files. The home used an electronic system which we found was being reviewed and updated regularly. The information recorded within this system was person centred. Records evidenced that the information had been gathered from the person themselves, their family and from the registered person. One respite person’s care file had not been updated from their last visit some months previously, and a body map had not been completed on their most recent admission. We noted that new risk assessments for falls and moving / handling the person had been completed. We discussed the lack of review of this person’s care and support with the registered manager who said this was not normal practice and staff would be spoken with straight away.

Discussion with the registered provider and clinical lead manager indicated that the service had developed and were trialling their own advanced care planning document which had been supported by the community MacMillan Nurse team. We were told they were looking to develop this even further by working with their local GP practices to ensure the staff offered the highest quality end of life care to people who used the service. Following the phasing out of the Liverpool Care Pathway the registered provider had made sure that the service was meeting the objectives of The Gold Standard Framework and NICE guidance for end of life care. The clinical lead manager told us that the feedback of this document had so far been very positive with some people making big decisions with increased

knowledge and confidence. For example, one person living in the service, as a result of discussing their wishes and needs about end of life care, had decided to have a ‘do not attempt resuscitation’ (DNAR) in place, and another person opened up to their family about their worries and fears having previously been silent for fear of upsetting them.

We observed that people had a copy of their care file in their bedrooms. However, most of the people we spoke with were not familiar with it and said they did not take part in the monthly care reviews carried out by the staff. Despite this people who we spoke with and their relatives were satisfied with their input to their care. We saw during our inspection that two staff went into the bedrooms to write in the care files, but they did this near the doorways and didn’t do it together with the individual it concerned. One person told us, “I didn’t know I had that” when we indicated it to them on a low shelf in their room. All the relatives we spoke with said they were involved in partnership with the staff in the care of their loved ones in the service. None were able to say that they were specifically involved in the development of a care plan, but just that they were always kept informed by the staff and always consulted about what was happening. One relative said, “I have not seen their care plan recently but I know there is one. Staff know [Name] well, they can make them smile.”

We received mixed feedback from people and relatives about the quality of the activities within the service. Although from our observations there were a number of different sessions and types of activities taking place during our inspection to capture the interest of people using the service.

There were two activities co-ordinators working within the service and they covered seven days a week between them. On the nursing unit there was a wall display for “Activities for the week”, this included morning, afternoon and evening activities and events planned by the activity co-ordinators for different days. We observed the activity co-ordinator leading some people in the lounge in a Christmas sing-a-long. However, one relative told us, “The activities are not very good and if [Name] or other people are in their rooms they don’t seem to make much effort to encourage them to come and join in,” another person said, “You have to request to go to things, you are not invited.”

However, we saw that the nursing unit had an activity plan for December 2015. Activities were listed for each day such

Is the service responsive?

as playing music on the record player, dominoes, soft bowls, discussion group, Zumba, bingo, Christmas decorations. There was a theme each month such as October 2015 was children and Halloween; people also had an outing to the Drax tea dance. There was information about additional trips out and entertainers recorded on another list. For example, over a four week period there had been two singers come into the service and three trips out to the Drax tea dance, Langlands garden centre and the Yorkshire garden centre. People had also taken part in monthly craft afternoons.

One person told us, "If there is entertainment I sometimes go, I have the choice but I like my privacy". They said, "If I go to the lounge I can sit anywhere but I tend to go to the same area where the people I know are". One visitor told us, "We went with them to the Yorkshire Garden Centre which is a regular trip so the staff know us and provide tea and so on, and we also went to Drax Power Station Tea Dance. It was wonderful."

We observed that on the Haven unit the activity co-ordinators were interacting with people, inviting them to join them in the conservatory to draw. Suitable music was playing in the lounge and the staff and people were exchanging banter and all interactions were appropriate. The communal areas were stocked with items for people to interact with, including books and magazines, knitting, dolls and other activities such as a rummage box full of clothes for people to sort out. On the morning of our inspection a game of skittles took place and in the afternoon an entertainer came into the service to sing to people.

The registered provider told us that after reviewing their activity program for those people living with dementia they had manufactured their own sensory dementia care products for people who could not join in with the organised activity program. These products included fisherman's jackets, aprons, cushions and mats which had various activities incorporated into them such as zips, buttons, bells and Velcro tabs. One activity board contained bolts, keys, hinges and dials, which were useful as a memory board for a gentleman on the unit.

We saw that on the Haven unit the environment had been adapted for those people living with dementia. The activity board was bright and colourful with pictures and written

information about events going on in the service. Clear signage directed people to the television lounge, restaurant and hair salon. Colour themes were used in the different lounges so people knew which room they were in.

We saw one person busy sorting clothes in the rummage box, pairing up socks and folding clothes. People were sat enjoying the music, tapping along with their fingers. The activity co-ordinator was spending one-to-one time with different people, engaging them in conversation that prompted two people to continue chatting once the activity person had left the area. One person was busy drawing and then started to sing along to the music. Staff were seen to use facial expressions, smiles and humor as well as touch and verbal communication to interact with people. We saw numerous examples of people chatting to visitors, staff and each other. Staff moved around the communal areas checking on people, offering drinks and snacks. People were seen going out with visitors. One relative said, "[Name] is not as far down the dementia road as some others, and sometimes I don't feel that the activities necessarily suit everyone. I have fed this back and it was received positively."

The registered provider also told us about their 'Make a Wish' programme. We were told this was their latest activity initiative which aimed to give all the people living in the service an opportunity to personally choose something they would like to complete within 2016. The project enabled the registered provider to give people a wider choice and personalise their activity program to suit everyone as individuals. One of the people using the service had designed the logo being used to market the program. We observed the wishes board on display where everyone in the service had posted their wish. For example, one person we spoke with had wanted to go to the theatre, to a circus and shopping. They told us that they had been to the circus and had bought two new pairs of shoes, ready for their outing to the theatre.

There was a complaints policy and procedure on display in the entrance hall of the service. This described what people could do if they were unhappy with any aspect of their care. We saw that the registered provider's complaints process was also included in information given to people when they started receiving care. Checks of the information held by us about the service and a review of the registered provider's complaints log indicated that there had been nine complaints made about the service in the last 12

Is the service responsive?

months. All had been investigated by the registered manager and resolved, and the complainants had been provided with a written response. People and relatives who spoke with us were satisfied that should they wish to make a complaint then the staff and the registered manager would listen to them and take their concerns seriously.

One person told us, "I know how to make a complaint if needed. I only have raised small issues such as missing

laundry. When I spoke to the staff about this it was dealt with immediately." There appeared to be no difficulty about raising concerns with either of the managers on the units, or with other members of staff mentioned by relatives during separate conversations. One visitor said about this 'If I have any concerns, I just go to (Name) and they are very, very, helpful.'

Is the service well-led?

Our findings

We sent the registered provider a provider information return (PIR) that required completion and return to the Care Quality Commission (CQC) before the inspection. This was completed and returned with the given timescales. The information in the PIR enabled us to contact health and social care professionals prior to the inspection to gain their views about the service.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

There was a registered manager in post who was supported by a clinical lead manager, deputy manager, two unit managers, a training officer and an office administrator. The registered manager told us that they monitored the quality of the service by regularly speaking with people to ensure they were happy with the service they received. People we spoke with knew the registered manager's name and the two unit managers on the Haven unit. The majority of people said they had the opportunity to speak with them each day.

Relatives were aware of, and knew the name of, a Director of the company who had a hands-on approach to the running of the home and visited on a regular basis. One visitor told us, "This place is well run, the manager and staff are friendly and they listen if you have any questions." Another relative said, "I would recommend this service to anyone. I am very happy with the care. There is a calm atmosphere and if you visit on a Sunday there are lots of families here, music playing and you get a glass of sherry. It is very relaxed and friendly." Other relatives told us, "Everyone is very helpful, very supportive and the place is managed well" and "Yes I do feel involved and there is a positive atmosphere here."

We found there was an open, fair and transparent culture within the home. Staff described the registered manager as, "Approachable" and "Straight talking." They said that they could talk to them about any issues and they were listened to and that information discussed with the

registered manager was kept confidential whenever possible. Staff had regular supervision meetings and annual appraisals with the registered manager and these meetings were used to discuss staff's performance and training needs; they had also been used to give positive feedback to staff.

Care staff said they felt their work was appreciated, they felt valued and their opinions mattered. Staff told us, "We get good support here. Work can sometimes be tiring but you can get support from the unit managers." "There is a good atmosphere here for people and staff. We work well as a team and any concerns would definitely be talked about" and, "We are told about any need for change, especially if there has been an incident." One staff told us, "We can express our view points at meetings and there is open discussion. It is a friendly home and a good team of staff. Manager has an open door policy and listens to you. Staff discuss any mistakes made so that they do not occur again." Two members of staff commented positively on the health benefits package they received as part of their employment with the registered provider, and said that they didn't get this anywhere else.

People were encouraged to maintain their links within the community through their social activities such as meetings with the local church and schools, visitors/family and friends taking them out and trips with the staff into the local area to garden centres, pubs and shops. We were told by the registered provider about the community fundraising carried out by the staff and people who used the service. Staff spoke with people living in the service and together they chose charities they wished to raise money for. In 2015 a large amount had been raised for MacMillan and Alzheimer's UK charities. This was achieved by staff skydiving, holding a party in the home and people doing a sponsored walk in the grounds. This gave people a purpose and a sense of achievement. It also helped people to build some lovely relationships with staff.

Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires, meetings and one to one sessions. This information was usually analysed by the registered provider and where necessary action was taken to make changes or improvements to the service.

The responses we received from people who used the service and relatives was mixed about their opportunities to participate in meetings and express their viewpoints. We

Is the service well-led?

found that those people who lived on the Haven unit were very satisfied, but some of the people living on or visiting the nursing unit felt excluded and less able to make a difference.

The relatives we spoke with on the nursing unit said they had not been “Invited” to relative or residents meetings or asked to complete a survey. Although they were aware that relatives meetings were held, they didn’t feel encouraged to attend. They commented, “They do have residents meetings but they are always at 17:30 and I cannot be here then” and “I don’t think anyone comes, nobody comes to ask if you would like to come to the meetings, I don’t think they encourage residents to attend those meetings either, certainly they haven’t asked my relative”. Two people on the nursing unit said, “I have never been to a meeting or asked to attend”.

One relative told us, “I have not been to the meetings. I am aware of them but don’t feel the need to go. I have no concerns and I get the newsletter.” Another visitor mentioned one of the Directors by name and said, “They are so approachable” and, “I always fill in the survey that they send me.” They also said there were meetings roughly once a month, and the Director came to one of them. A third relative said, “When you bring something up at a meeting then they do act on it.” When we asked for an example of this they said, “Well there was a football table and it got left in one part of the home more or less permanently. When I asked if it could be – say – a month in one and then a month in another – it was brought back during the following few days.” They went on, “They are like that the managers and even the owners, they listen to what we say.”

We spoke with the Director and the registered manager at the end of the inspection and discussed the divided feelings of people who used the service and relatives about their inclusion within the service. We were informed by the director and registered manager that families were sent out emails regarding meetings, notices were put up and letters sent out with the dates on for the forum meeting. Questionnaires were sent out to all families and people using the service, these were also left in the reception area for anyone else who wished to complete one.

The opportunity to attend meetings and complete surveys was the same throughout the service, but the main difference was how the staff enabled and encouraged

people and relatives to participate. The fact that the key working system on the nursing unit was not effective also meant people felt staff were not communicating with them and gave further impetus to their feelings of being ‘left out’. We were given reassurances that action would be taken immediately to look at these issues and decide how best they could be resolved.

Quality audits were undertaken to check that the systems in place at the home were being followed by staff. The registered manager and deputy manager carried out monthly audits of the systems and practices to assess the quality of the service, which were then used to make improvements. The last recorded audits were completed in November 2015 and covered areas such as reportable incidents, recruitment, complaints, staffing, safeguarding and health and safety. We saw that the audits highlighted any shortfalls in the service, which were then followed up at the next audit. We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed by the registered manager monthly, and again annually. We also saw that internal audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified.

Visits to the home were made by the contract monitoring officer of East Riding of Yorkshire Council. We saw their last report for the service and they told us that they did not have any issues of concern with the service provided.

The registered provider continued to strive for excellence with their services. In the last year the service was nominated for a number of business awards. The service was part of the top 20 Recommended Care Homes in Yorkshire and Humberside in December 2014. This recognition was given following recommendations from people using the service and their family members. In February 2015 Westfield Park won the Service Business of the Year for Goole and Howdenshire Business Awards, and people living in the service were able to take part in the awards ceremony which was held in the service. Westfield Park was also a finalist in the Care Employer of the Year – Great Yorkshire Care Awards in November 2015. This nomination was in recognition of how well staff were treated, which had a knock-on effect to the care of the people using the service.