Care Quality Commission

Bupa Care Homes (CFHCare) Limited

West Ridings Residential and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place over two days; 27 January and 3 February 2015. At the previous inspection in July 2014, the provider was asked to make improvements to records relating to people's care. The provider had made some effort to improve care records; although we found they still lacked detail and clarity. The provider informed us new documentation was planned to be implemented in the near future.

West Ridings Residential and Nursing Home is located on the outskirts of the city of Wakefield. It provides accommodation for people who require; residential care, nursing care and care for people with dementia. The service comprises of six separate houses – Wharfedale unit (residential); Calderdale unit (nursing dementia); Wensleydale unit (residential dementia); Airedale unit (residential); Swaledale unit (general nursing) and

Summary of findings

Kingsdale unit (nursing intermediate care). The care provided on Kingsdale unit is commissioned by The Mid Yorkshire Hospitals NHS Trust and provided in partnership with staff employed by the Trust.

At the time of our inspection there was no registered manager in post. An acting manager from the organisation was running the home and the recruitment process was being implemented to secure a permanent manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff understood how to ensure people were safeguarded. They knew people's individual abilities and risk assessments to help people maintain their safety. There were many illustrations of safe practise, although there were some concerns in relation to how we saw one person moved and handled and how one person's dressings were applied.

Staffing levels were adequate in some areas, although in some units we found staff numbers were not always sufficient to meet people's needs in a timely way.

Some aspects of the premises were in need of refurbishment and there were strong odours in places, which created an unpleasant environment for some people. This was most apparent on the Wensleydale unit, which we were told was due for refurbishment. We saw the Kingsdale unit had been reorganised to create a more homely feel to the communal areas than when previously inspected.

Medicines were managed safely overall. However there were some recording discrepancies relating to stock levels and temperatures of the refrigerator and medicine room in one unit. There was a medication error on one unit that was being addressed by the acting manager.

Staff had opportunities to complete regular training, although they had received limited training in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). This meant their knowledge of people's rights in relation to consent was inconsistent.

The quality of the food and drink provided was good and the cook was knowledgeable about people's individual dietary needs. People enjoyed their meals on the whole and they were supported to make sure they had adequate nutrition and hydration. People were supported appropriately to maintain good health and had access to healthcare professionals as required.

People were appropriately supported by caring staff who demonstrated patience and compassion in their work. There was evidence of strong and supportive relationships and staff knew people's individual needs well. People were encouraged to express their views and their privacy and dignity was promoted.

People's individual care needs were regularly assessed and reviewed and care records were kept up to date to reflect this. However, care records were mostly task focused rather than person-centred.

The complaints procedure was prominently displayed and people and relatives knew how to make a complaint if they wished to. The acting manager was aware of complaints that had been received and responded to these appropriately.

There was a temporary management arrangement in place and staff reported poor morale that was slowly improving. Staff were clear about their roles and responsibilities and described a more positive and open culture than was previously apparent.

There were weaknesses in the quality assurance systems. The recording and analysis of information was not robust enough to ensure management had reliable indicators of the strengths and weaknesses of the service. There was no clear strategic vision for the future of the service development.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires Improvement

The service was not always safe.

Although people told us they felt safe and we found many examples of safe care we found some aspects of practise that required improvement, such as how people were moved and handled and how dressings were applied.

Staffing levels did not meet people's needs in a timely way in some units and staff were often moved to cover shortfalls in other units.

There was appropriate management of medicines overall, although there were errors in some recording and we were made aware of a drug error on the day of our visit.

Is the service effective?

Requires Improvement

The service was not always effective

Few staff demonstrated an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards and the importance of this legislation in protecting the people they cared for.

People were well supported to eat and drink and staff had good knowledge of people's individual dietary needs.

People's healthcare needs were met overall and the service worked closely with other professionals.

Is the service caring?

Good

The service was caring.

Staff cared for people in a kind and compassionate way, with sensitive regard for people's individual needs.

People's dignity and privacy was given high regard and staff were discreet and respectful when providing care.

People had access to advocacy services to speak up on their behalf where necessary.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Care planning was not detailed to ensure people's particular preferences were known and met by staff. Care plans lacked personal information and did not assist staff to provide person-centred care. Some records lacked important detail, such as methods for moving and handling.

People were aware of how to complain if they wished to and were confident their views would be heard.

Summary of findings

Concerns and complaints were dealt with appropriately and staff were beginning to use them as opportunities for learning and development.

Is the service well-led?

Requires Improvement

The service was not always well led.

Temporary management arrangements had created some instability in the staff team and had affected morale; we saw that this starting to be addressed and staff were beginning to report improvements.

There were weaknesses in the services analysis of significant trends in quality monitoring data. Recording of information was of poor quality and so did not effectively support management overview of service delivery.

The management was responsive to immediate issues, rather than being proactive in anticipating risks.

West Ridings Residential and 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 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 over two days, 27 January and 3 February 2015 and was unannounced.

The inspection team consisted of six adult social care inspectors, two specialist professional advisors with expertise in tissue viability and governance, and an expert-by-experience in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. We reviewed notifications before the inspection and these included some information of concern that people were not receiving personalised care that met their individual needs.

We spoke with 41 people using the service, 16 of their relatives and friends or other visitors, interviewed staff and reviewed records. We made observations of care in all six units. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed 10 care records in detail and a further 36 care records specifically in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards information. We reviewed documentation to show how the service was run. We spoke with the acting manager, 28 staff in various care roles and ancillary staff.

Requires Improvement

Is the service safe?

Our findings

People consistently told us they felt safe and said what they liked about their home. One person said: "I like the company best." They also said "As these places go this one isn't bad." Another person said: "Knowing that other people are around." A further person said "I'll tell you what – this is my home. That's how it is. My home."

One person told us they did not feel anxious or nervous in their surroundings. Another person said: "I am safe and well looked after." We observed one person who had lived in the home for less than a month. They were unable to communicate with us verbally although we saw they were happy to interact with every member of staff and other people proactively and appeared to enjoy the conversations. We asked their relative whether they felt their family member believed they were safe they told us "[They] settled very well."

We spoke with people about their relationships with others in the home. Most people who responded to the questions felt that there were no issues around relationships with others living in the home and believed that if there were staff would intervene in a manner that would not cause them concern. One person said: "I get on well with most people in here, it's very sociable." One person and their relative told us about a time when another person had become aggressive and was intimidating. They said they had raised this with staff and the manager who had dealt with this in a satisfactory way.

A visitor told us that their relative had moved from one unit to another in the home because their behaviour had become more challenging for that part of the service to manage and so they had moved in order that the service was able to safely manage their needs. They said that the move had been initiated by the staff and said "It was appropriate and well managed." They told us: "The environment in this unit is more appropriate, it has a quieter atmosphere and the staff have more time to work one to one with residents." This indicated people were appropriately placed to meet their needs within the home.

Staff we spoke with had a good knowledge and gave clear examples of how to safeguard people and what to do if they were concerned a person was at risk of abuse. Staff were confident in the whistleblowing procedure and felt able to challenge and report poor practice. We did note that one senior member of staff who had been in post for eight months, had not undertaken any safeguarding training. Another senior care worker we spoke with told us they were aware of both how to detect signs of abuse and of external agencies they could contact. They told us they knew how to contact the local authority adult protection unit and the Care Quality Commission (CQC) if they had any concerns.

Staff understood individual risks to people. Personal risk assessments, equipment and care for people's pressure areas were mostly managed well. For example, risk assessments for pressure care areas were up to date on the records we checked and pressure relieving equipment was checked and used appropriately. Staff told us if they had a concern about a wound they contacted tissue viability specialist nurses and they visit within three days or sooner if staff requested this. Staff gave the example of taking a proactive approach to wound care by saying they swabbed wounds if they were concerned about infection. A stock of dressings was kept in the medicines room.

However, we saw one person in the Calderdale Unit whose skin care was not managed well. Dressings did not correspond to the care plan, the bandages were soiled and in the wrong position, creams were not being applied twice daily as per the instructions from the hospital. We saw that a four-pronged metal bandage clip had been used and had moved so that it was pointing outwards. The metal prongs could be seen and felt through the tubular bandage. Our specialist advisor had concerns that the incorrect bandage applied to vulnerable skin could potentially cause tissue damage and bandage clips are no longer in general use due to their potential to cause damage; they have sharp points that could injure the resident or other people. We made the registered nurse and the acting manager aware of this and they agreed to make an immediate response.

We observed many examples of people being moved and handled safely throughout all areas of the home. However, we observed an incident on the Wensleydale unit in which staff used inappropriate moving and handling techniques, which we immediately challenged with the staff concerned. We raised this with the acting manager who said they would address this issue without delay.

Requires Improvement

Is the service safe?

The above two examples illustrated there was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 9, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some aspects of the premises and environment required attention to ensure people's safety. For example, the home had a number of large patio doors in areas accessible to vulnerable people. We saw some of these doors were not clearly marked and the glass could have been mistaken for clear space. The provider may wish to note the guidance published by the Health and Safety Executive in their document 'health and safety in care homes' which requires large areas of glass to carry conspicuous markings or other features sufficiently obvious that people will be unlikely to collide with them. We noticed the taps in some communal bathroom had an immediate cut off when released which meant that they had to be utilised with two hands; for some people these may be difficult to use. The water was extremely hot, which was reported to senior staff who agreed to address this at once. In two of the bathrooms on the Swaledale unit the grab rails at the side of the toilet were quite loose, which some people may not feel safe using and so increase the potential risk of falling.

On the Swaledale unit there was a strong odour which was being disguised by air freshener. The general repair of the unit was good although paintwork was marked in numerous places and looked scruffy. One relative we spoke with said the 'smell can be over-powering sometimes' but it was usually from the rooms, never from the person. They said their family member's room was 'always spotless'. We found the Wensleydale unit in particular had mal-odours and fixtures and fittings were worn and in need of replacement. We discussed this with the acting manager who told us refurbishment of the home was ongoing. We saw evidence of this in other units that had required improvement in our previous inspections.

Staff told us they thought people received safe care. For example, they felt housekeeping had improved and there were much better infection control procedures in place. One member of staff said: "I think people are safe. Good set of carers here. We ask people what they want to do. Give them a choice. We carry portable bleeps around to try to get to people as soon as possible."

We found staff recruitment procedures were robust and staff were appropriately vetted and assessed as suitable before commencing work. Staff we spoke with said they had been thoroughly checked before starting their employment. We noted that there was a high turnover of staff in the home and the vacancy for the registered manager had yet to be appointed to.

We found there to be sufficient numbers of staff deployed to meet people's needs in some units, but in others it was apparent staffing levels did not support people's needs. For example, on the Swaledale unit we saw people in their rooms did not receive timely attention when they needed it and the staff struggled to provide effective assistance for people with their meals who needed high levels of support. One person called out over four times before they were acknowledged; staff asked if they wanted a drink and after 20 minutes another member of staff realised they needed personal care support.

Staff we spoke with on the Swaledale unit said they felt under pressure at times. They said they were being asked to carry out additional roles, such as the role of host, and provide cover on other units, with little in the way of handover. Staff also felt they were leaving people longer in their beds as they could not get round to everyone. A relative said they had seen staff telling people it was 'time to go into their rooms as they needed to sleep' and they were not sure if this was more due to staff shortages than personal need. On their visit on one of the inspection days this relative said they had waited 10-15 minutes before seeing any member of staff.

We saw one resident on the Kingsdale unit waited 10 minutes for a response when they tried to summon help. They had wanted assistance to get back into bed but their bed had not been made. Staff only responded to this call when we discussed this with the registered nurse, which gave us concerns the person would not otherwise have been attended to.

Staff, relatives and people throughout the home gave mixed views about staffing levels and people's experience of staffing was dependent upon which unit they were in and how dependent they were on staff for support. We found overall there was a breach in Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's needs were not always met in a timely way.

Requires Improvement

Is the service safe?

Two relatives we spoke with said: "They could do with more staff, they're always rushed off their feet." They gave examples that on one occasion they arrived to visit their family member at 10.30 and by 12.00 when they were going to leave, it was nearly lunch time their family member had not been washed and dressed.

On the Wharfedale unit one person said: "Staff are very good. I can't grumble about them. Some people need more help and there aren't always enough staff. There are only two staff at night". Another person told us if they needed the toilet at night they had to 'wait and hope'.

We asked people and visitors for their impression of staffing levels in the home and they gave us mixed responses. One person said: "I haven't been here long but there appear to be enough." A visitor told us "I think that there was a problem with staffing but it seems to have improved. I don't come at night so I can't tell you about that. Another person told us "It used to be home from home here but now there just aren't enough staff. At any time." A visitor told us: "They have cut the staff numbers and it shows, they are always busy. Too busy." Another person told us "No way are there enough staff." One resident told us "It's always easy to find a member of staff, there's always someone around."

We inspected medication storage and administration procedures in the home. We found that medicine trolleys and storage cupboards were secure, clean and well organised. We saw that the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and room temperatures were checked and recorded to ensure that medicines were being stored at the required temperatures. However we found the daily fridge temperatures chart had not been completed on nine occasions over the past two months in one unit.

Whilst one person at the home was capable of self-administration of their own medication all other medicines were administered to people by trained care staff. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. The staff maintained records for medication which was not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor.

We observed medicines being handled in a safe and appropriate manner. On the Swaledale unit we observed each person's medication was in blister packs where possible and each tablet put into its own dispensing cup. These were then placed on a tray for that particular individual and distributed at that time. During administration each person was advised what tablets they were taking and why, including one that dissolved in liquid. However, we observed one nurse distributed medication to five people but none of the people were seen to swallow the medication by the nurse and the medication was placed on a table that other people were sitting to. We noted this practise was not in keeping with the policy on the medication trolley which stated that they should be witnessed to be taken and then the records signed.

We looked at medication charts and reviewed records for the receipt, administration and disposal of medicines. A record was kept to show medicines which had been destroyed.

We carried out a random sample of ten supplied medicines dispensed in individual boxes. We found that on two occasions medicines found to be inaccurately accounted for on the Wharfedale unit and the stock levels of the medicines did not concur with amounts recorded on the medication administration records (MAR) sheet. Medicine room and fridge temperatures were not consistently recorded; problems were around documentation and accurate recording.

We saw that MAR sheets were complete and that people had received the medication they had been prescribed. However, it was brought to our attention that one person's medication had been incorrectly administered on one occasion and ear drops had been mistaken for eye drops.

This demonstrated a failure to protect people against the risks associated with the unsafe use and management of medicines.This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed this with the acting manager who told us this would be reported appropriately to the agency who had supplied the member of staff and action taken to ensure no repeats of an incident on this kind. We saw that medicines

to be given before food were clearly indicated and were given as directed. We found people's medicines were available at the home to administer when they needed them.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw that controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

We saw that where people had been prescribed warfarin, the appropriate dosage of warfarin was dependent on the outcome of a regular blood clotting test determined by the international normalised ratio (INR) method. The outcome of the test indicated the dose of warfarin to be given over the coming period. We saw that a protocol was in place for all to follow to ensure the blood results were accurately recorded and the correct dose of warfarin dispensed.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date.

The MAR sheets identified a record of any allergies.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. We saw records which demonstrated under what circumstances PRN medicines should be given. The registered nurse we spoke with demonstrated a good understanding of the protocol. We saw staff asked people whether they wanted pain relief, giving them the option of whether they wanted any or not.

We spoke with people and visitors about the routines around medication. One person told us: “The staff give me my tablets” and indicated that they felt that it was at the same time each day. Another person told us: “The staff look after my medication, they give it to me every day. It’s more or less at the same time.” No people or visitors felt that there were any problems with receipt of painkillers. One person felt that “They would only give me paracetamol after they had spoken to the doctor. I’d have to wait for it.”

We observed staff use personal protective clothing (PPE) appropriately and they paid close attention to hand hygiene. We spoke with cleaning staff who explained their routines for ensuring the home was maintained and systems in place, such as colour coded cloths to minimise the spread of infection. We spoke with the housekeeping manager who explained the systems in place for supporting staff with their cleaning routines. The risks of infection were minimised through effective hygiene practises.

Requires Improvement

Is the service effective?

Our findings

People told us staff had the skills to look after them well. One person said: "I am well looked after." A visitor told us: "The staff have the skills and knowledge to deliver appropriate care." Another visitor told us about their observations of the staff. They said: "They deliver good care but I'm not sure they do much talking unless they're working with a resident." One person told us they felt confident in their ability to provide care and treatment well. They told us: "They [the staff] are very sensible."

We spoke with a relative who said 'things are fine. My [family member] had respite here and chose to come in here when they could no longer cope at home. I have seen nothing to concern me and I feel at ease. There are always staff around and I visit at different times of the day. My [family member] is content'.

Some staff we spoke with had a good knowledge of people's individual needs. They described the care they provided for people and gave examples of ways in which they responded to people's individual needs and preferences. Carers' knowledge of people living in the service was quite detailed, although one member of staff could not tell us why the person that they were a key worker for was in receipt of care on the nursing unit.

The staff handbook set out staff's roles and responsibilities. Common induction procedures were in place and staff recently employed described their induction as thorough. One member of staff said they had received five full days of training, 'the best they had ever received'. They told us this was 'enjoyable and prepared me for the job'. Training records showed staff received induction, fire safety, infection control, nutrition and hydration, Control of Substances Hazardous to Health (COSHH), medicines management, safeguarding, moving and handling, challenging behaviours, data quality, mental capacity and dementia.

The training coordinator told us that the training programme for staff was part of a total training package called 'Bupa-Learn'. Induction was provided for new starters and took four days. Staff started work the day after this if they were suitably vetted in line with recruitment procedures. We were told that the service employed 184 staff in total and the service had a current completion rate for mandatory training of 95.8%. Specialist courses were available for nursing staff, kitchen staff and maintenance staff. Care staff were supported to undertake level 2 and 3 qualifications in Health and Social Care. Training was provided as both e-learning and face to face training. The training coordinator told us that they directly delivered some of the training courses and staff we spoke with told us that they found the course interesting.

Staff were able to describe the programmes of training available for induction, ongoing mandatory training, updating training, qualifying training and additional training that staff might discuss with their manager during supervision. We asked one member of staff what training programme had helped her the most and they said 'dementia awareness'. We asked what it was about the training that had been most valuable and the carer said that it covered different ways of communicating with people who had dementia. The carer said that one person who had since left the home and gone to live elsewhere had some cards with words and pictures on them that the person's relatives had brought in so that they could choose different foods and drinks. They said as a result of the training the staff had started to use the cards with the person and found them useful. Up to that point they said that they had been on the shelf and they hadn't known what to use them for. They said that the person had now left, taken the cards and there was no other equipment that they could use to communicate with people. There was no other evidence that staff used the training that they had received or discussed ways in which they could provide a more person centred service to people particularly with dementia who lived at West Ridings.

There were varied levels of support for staff and practise with regard to supervisions was inconsistent across the home. Some staff we spoke with told us they had not had a supervision meeting with their manager 'for a long time' and other staff said group supervisions were held, but not individual supervisions. One member of staff told us: "I had one to one supervision with the registered manager and clinical services manager about a month ago. It is regular but I don't know when the next one is booked in". Registered nurses on both Kingsdale and Calderdale stated that they did not get feedback from management. One registered nurse said they did not get clinical supervision. This meant staff were not consistently supported throughout the home in their roles of caring for people.

Requires Improvement

Is the service effective?

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We found although some staff could describe the effects of their training, other staff lacked knowledge of the MCA and DoLS and the effectiveness of their training had not been fully assessed. As a result, there was mixed knowledge and practice across the home with regard to MCA and DoLS and so people's rights were not always protected.

Staff on the Calderdale unit had little knowledge of the MCA or DoLS. We reviewed 19 care plans in relation to this and identified two people that clearly needed to be considered for DoLS. This was because our observations of the environment and scrutiny of 19 people's care plans suggested the provider utilised a number of methods which may constitute a deprivation of liberty. The front door was locked. Some people had sensitivity mats at the side of their beds to alert staff if the person was vacating their bed. Some care plans recorded diagnoses and other indications of reduced mental capacity. Some care plans recorded through mental capacity assessments that people lacked the capacity to make decisions about their care and welfare. Some people had for their safety been placed under varying degrees of close observation. Whilst each element of restrictions may not constitute a deprivation of liberty, it may be the case that accumulation of restrictions being experienced by some people may amount to unauthorised deprivation of their liberty.

We spoke with the registered nurse in charge of the unit about our observations in respect of these possible deprivations of liberty who agreed with our observations that in two instances the provider may be exercising control over people's care and movements. We also discussed this with the acting manager who had a thorough understanding of the MCA, DoLS and the legal framework surrounding restraint. They agreed to commence the assessments for the two people concerned. We saw care plans clearly recorded 12 people had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions.

We were told of a person on another unit who lacked the mental capacity to make decisions for themselves and had no family or friends it would be appropriate to consult with. We were informed the person had been scheduled for a hospital in-patient operative procedure. We saw the local authority had instructed an Independent Mental Capacity Advocate (IMCA) to support the person when important decisions or reviews of care need are being made. The senior care worker was aware of the appointments of an IMCA and knew of the need to involve them in decision making.

On the Wensleydale unit we saw that care plans clearly recorded 17 people had made an advanced decision on receiving care and treatment. The care files held 'do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and fully completed recording the person's name, an assessment of capacity for this element of care, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff who knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

We spoke with staff about the use of restraint and they were able to distinguish between lawful and unlawful restraint. They were able to define what may constitute restraint, in particular the use of bedrails. We were told that bedrails were used to prevent vulnerable people from rolling out of bed or where people were anxious about doing so. Staff said that bedrails were never used to confine people to bed or to discourage people who may wish to leave their bed.

The above examples meant there was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke with people about their impressions of meal times. Those who responded were broadly positive in their reactions. One person told us: "The food is nice enough, better than some places." Another person said: "It's nicely cooked." Some people told us that there was a choice of food but no one could tell me about how choices were

Is the service effective?

offered or what choices were available for that day's meal. One person said: "There are always vegetables with the meals, which I think is very important. We can have fruit whenever we want it."

Several people said they had to wait for their meals One person told us: "We are often sat at the table waiting for up to an hour. The staff will be stood there chatting to each other." Another said: "Being kept waiting for our food is normal. It's not nice to be just sitting at the table waiting."

We spoke with the cook, who demonstrated very good knowledge of the dietary needs of people throughout the home. They told us they liaised with people and staff to ensure individual needs were thoroughly catered for.

Staff knew about people's individual dietary needs and when to raise concerns about people's diet and nutrition. "People are weighed every week and if they weren't eating enough we would refer to speech and language therapy (SALT). If someone needs a special diet, the main kitchen will send someone over to discuss it. We have a patient who needs Halal meat. The cook came over to see what the patient liked to eat and makes Halal meals. Family will also bring food". They said: "On admission we start with a 3 day food diary. The assessor nurse will take information from the medical notes and whether they have been referred to SALT and dietician to follow up. If after three days there is no problem we do not continue with the food diary." Staff described an incident recently regarding a person choking and how they had offered a mashable diet until the SALT assessment was made.

Staff we spoke with on the Kingsdale unit were complimentary about the meals and drinks offered to people. For example, they told us: "There is always cold water and if people want a juice instead we can do this. Most people like the water here. Not many have fizzy drinks. They are offered tea at breakfast, mid-morning, lunchtime and bed time. If someone asks for a drink I would ask the hostess to make a cup of tea. You can tell if someone isn't drinking enough as their skin goes very dry." "The cook brings the food in a hot trolley from the main kitchen. Patients can have toast, canned food, cup a soup, crisps biscuits on the unit. This is recorded in the daily life part of the record. We have a hostess from 8am-6pm offering drinks and snacks".

One person waiting for lunch on Kingsdale unit told us they were 'having gammon for lunch' and said: "It was nice last week." We observed a care assistant asking those sitting waiting for lunch whether they would like an apron to protect their clothing. Individual preferences were considered in relation to food i.e. someone wished for cream on their pudding and this was provided.

We observed the meal service on the Wensleydale unit. People were offered a choice of two main courses once seated at the table. On more than one occasion a staff member brought two plates to the table to show people the meals to assist their choice. This was done patiently and respectfully. We heard one person say: "This all looks lovely." We saw meals were individually plated and then given to the person but this meant people could not exercise choice over which parts of the meal to have and how much of each they received. One person told a member of staff "I can't eat that much." The member of staff reassured them that it would not matter if they left some although this suggested that people could not control the size of the portions that they were served.

There were no condiments on the tables in some units to enable people to season their meals to their taste. One person asked for salt and this was provided. Another person had to ask for a serviette as there were none on the tables. We observed tables set for the evening meal in the Kingsdale Unit on day one. Condiments and serviettes were on the tables.

We observed people being assisted to eat their meal where necessary. On one occasion, the member of staff was focused and maintained general conversation with the person. The member of staff checked whether the person was ready for some more and asked appropriate questions.

We saw another person required one to one assistance during their meal. They were offered choice as to what they ate, with the staff member asking questions such as "What about some parsnips next?" The staff member was smiling and focused on the person throughout.

In contrast on another unit we observed one person being assisted to eat. The member of staff did not maintain much dialogue with the person and appeared disengaged as they waited for the person to finish each mouthful. They loaded the spoon with more food as soon as they had given the previous one and held it over the plate. They did not check verbally whether the person was ready for more and did not offer a choice from what was on the plate. Towards the end of the meal they did begin to ask questions such as

Requires Improvement

Is the service effective?

"Would you like a drink?" and "Are you enjoying that?", but broke off from interacting with the person to have a conversation with a colleague about the introduction of new paperwork.

We observed several incidences of people being offered choices during the meal service. A person that came into the dining room was asked where they would like to sit. Staff were discreet in asking people questions such as "Would you like me to cut it up for you?" and appeared to delay asking to allow the person to attempt to manage for themselves, meaning that staff were mindful of allowing people to retain independence where possible. We saw one plate fitted with a guard and this was positioned correctly on the table to enable the person to eat their meal without assistance.

On Wensleydale we saw there was one member of staff to establish people's' choices and serve the meals. They asked questions, assisted with choice and checked that people were happy with their meal, however as a consequence the service was slow. Several people were seated awaiting their meal for a considerable length of time. Two people were waiting for a meal to be brought to them in their lounge chair. One had been given an apron to wear and both had cutlery in front of them, reinforcing the message that it was dinner time. We noted that they were waiting at 12:50 and later still at 13:05. At this point a meal was taken to a sleeping person opposite them. When this person could not be woken the meal was taken away. One of the people who had been waiting for a minimum of 15 minutes tried to signal that they would have the meal but was not noticed.

We spoke with people about their access to other health professionals such as doctors, dentists and chiropodists. One person told us that she had an infection and that "the staff got a doctor for me." Another person told us about a range of people that they could access. They said "my chiropodist, they can just walk in and get on with it. If I wanted a doctor I've no doubt they would get me one." People's care records clearly illustrated where their health needs had been referred to other professionals. One person spoke to us about problems with their hearing and said they were very pleased with the speed of staff's response. Staff gave examples of how they acted promptly to relieve distress by describing people's wound care and how they contacted the District Nurses to attend the same day.

Good

Is the service caring?

Our findings

People told us they felt well cared for. One person said: "The staff are very kind to me" and another said: "They are just all lovely". One person said: "It's like a family." One person said: "It's very nice here – I've no complaints whatsoever. I tend to have the same staff but they do work long shifts. All of the staff are helpful. If I press my buzzer, staff come immediately." In this person's view they said: "Nothing could be any better."

Where people were unable to communicate with us verbally we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. These observations showed people experienced positive contact with staff in a caring and compassionate way.

We asked visitors whether they thought their relatives and friends were well looked after. One visitor told us: "I don't think there are any problems with the care." Another said "I think [my friend] is well looked after." The person told us that they agreed. Another visitor told us: "As [my relative]'s health has failed they've adapted but they try and keep [my relative] as independent as they can."

One visitor spoke about their relative's preference to wear co-ordinated outfits. They said "[Staff] always make sure [my relative]'s clothes match – even their shoes and handbag. That's how [my relative] always was and you can see that it's spot on."

Staff told us they enjoyed their work with people. Comments described how they 'enjoy looking after the people' and 'the challenges you face'. One member of staff said: "We're here to make a difference in a good way for them'. Staff said people were treated well and one member of staff said: "It's a key principle of what we do." Staff spoke with us about what helps them to care for people. They said: "We were told, think it's your own parent and what you'd do for them. When I leave a patient I will always check they have something to do, like read a magazine". "I read the care plans. They are good and have everything in them that you need to be able to care. At weekends when it is less busy, I will go through them all to know what's what".

Staff told us how they obtained the views of people they were caring for: "I'd sit and talk to them and ask them what they want, such as, do you want to go the hairdresser. I never go off duty without saying goodnight to all of them. We were taught that way." Staff said they give people choices as to whether they would prefer a male or female carer and respect people's dignity by knocking on doors before being asked to enter.

Staff on the Kingsdale unit said they encouraged people's independence and to be involved in their own care; "People do fall here but no one has had a major injury. They want to get better and once they start feeling more confident, they will try and do things for themselves. We try to remind them that the buzzer is there all the time". "People are involved in their care plans. They tell us a lot, we sit with them and try and find their likes and dislikes. If we can't get information from the patient, we get if from their families. Families do tend to come in with their relatives on admission".

"The ultimate goal for patients is to go home. They are really motivated to improve. We set goals with people around mobility and independence. We encourage staff to give choice all the time."

Staff told us where people had 'do not attempt cardiopulmonary resuscitation' orders they always checked these were still appropriate.

We spoke with one carer in the Wharfedale unit about their knowledge of one person. They appeared to have a thorough understanding of the person, their history and preferences for care.

Staff described how they provided care which ensured people's privacy and dignity. They said that people had a choice about when they got up. Menus were set but there were choices and if people didn't like what was on the menu they could choose something else. On one residential unit we asked about the number of people who are up already in the morning when day staff come on duty. One carer told us" It can vary, certain people don't want to get up, the night staff get people up sometimes, it just depends"

When we spoke with staff they talked about the care provided for people. "They're like your extended family; I'm going to give to these like I'd like to care for my [relatives]" One staff member described how they would provide choice for a person who was frail and had dementia. "I get two tops out and ask which one they like best. I make sure

Good

Is the service caring?

they're looking nice and presentable". Of another person they said "He's always been a gentleman, he's been a man that likes a shirt collar, jumper, trousers and shoes to match. He's always shaved, his hair's always combed"

We spoke with one person's key worker and they explained that they had gradually got to know the person and what their preferences were. One carer we spoke with described the people that they were key worker for and how they adapted activities to suit the person's needs and abilities. When we spoke with staff about their key worker role and what this involved, staff said that it meant ensuring that people's wardrobes were tidy and checking that they had enough toiletries. One staff member explained that although they were not one person's key worker they had agreed to accompany them to a family wedding.

We saw evidence of good relationships between staff and people throughout the home. Staff used appropriate touch, smiley facial expressions and good eye contact when they communicated with them and they were kind and patient. We heard appropriate banter and it was evident through staff's interaction with people they knew them well. For example, staff engaged with people in conversations about their families and what people used to do for work.

On the Calderdale Unit we saw the atmosphere was calm and relaxed, people looked well cared for, and their privacy and dignity was promoted well. Staff interaction was positive and kind and staff were skilled at involving people and giving explanations to them about their care. We saw staff on the Calderdale unit were sensitive to the needs of people living with dementia and staff used skilful interaction when people showed signs of being agitated or upset.

We observed people in all units wearing clean clothes and personal care appeared to have received attention. However, on the Calderdale unit we observed one person who appeared to be poorly groomed and whose trousers were regularly falling down. This happened on several occasions, meaning that the person's clothing may have been inappropriate, ill-fitting or poorly maintained. We discussed this with staff as there was potential for the person's dignity to be compromised.

We saw in the main lounge/dining area there were no curtains which prevented the room from feeling homely and made it feel stark; we discussed this with the unit manager and the acting manager, who said they would take steps to address this. We also noted one person's bedroom did not have many personal effects and there was nothing to reflect their interests or individual homely style. We raised our concerns about this with the staff who agreed to consider how to improve this.

One member of staff asked a person if they were comfortable and when found out they weren't got a cushion to help support the person. Later that afternoon they curled the person's hair as the hairdresser had been unable to attend that day.

One person called out while they were in the lounge and a staff member responded promptly. They knelt down so they could speak to the person face to face, and held and stroked their hand to calm them. Staff asked what the matter was and made various discreet suggestions to find out what the person wanted.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people about how they were involved in making decisions about their care and support. One person on the Calderdale unit said they had freedom to decide when they got up. They told us: "They more or less leave you to your own time." We spoke with this person about whether they were able to have a bath or a shower whenever they wanted. They told us: "They're not very up and coming with baths, they have a machine to lift you and fish you out. Not enough people want to help". Another person on The Wensleydale unit told us: "I think you can have a bath once or twice a week."

On the Wharfedale unit people described problems with receiving assistance and care when they needed it. One person told us: "You have to ask continuously – it's all down to the number of staff. They do care but they just don't have enough people to get around to doing things." Another told us: "We're supposed to have a bath once a week, but you have to natter away at them to get one. There are people here who probably hardly ever get one."

We spoke to people and their relatives about their involvement in care planning. One relative told us: "I think they know [my family member] as a person, we're all involved in their care." Relatives told us they were involved in care planning and reviews of care where their family member had difficulty making decisions. No one expressed any concerns about lack of involvement in their care or a failure to consult people.

Staff we spoke with described person-centred care and gave examples of how they provided this. One member of staff told us how one person they cared for did not like running water in their shower and so staff turned the water off and on to minimise the person's distress, and carried out this task as quickly as they could.

We had a mixed response when we asked people about activities. Not all people we spoke with were happy with the activities. For example on Wharfedale unit one person told us: "It feels like only a place to stay and sleep. There is no entertainment – no nothing. It's very rare we have a singer." Another person told us: "There is an activities lady but 'she doesn't do what we like." One person told us their first impression of what there was to do in the home. They said "Nothing. It's always like this". Another person said "I think that there are things arranged for us to do, but I can't say what. I'm never bored though." Another person on the unit said: "We are short of things to do. We used to play bingo and dominoes but we don't any more. We got a new activities co-ordinator but [they are] more interested in writing notes than anything else."

On the Wensleydale unit a visitor told us: "I'm not sure there's that much going on to engage people." One person described things they were involved with in the home. They said: "A lovely lady comes in and we have social things. We made wire flowers yesterday. Tomorrow I think we've Scottish dancers coming – that will interest me because I used to like dancing."

One person on the Airedale unit said: "There's not much going on to join in with, but it doesn't bother me. I like my puzzles and I like to read and just chat, so I don't need organised things." Another person said: "If I am bored I say so, and they ask me what I want to do. That's how it goes." One person spoke about about trips out with a member of staff. They said "The member of staff takes me into Wakefield – we might go for a coffee or a look round the shops. We go maybe once a fortnight, but they will always ask me if I want to go. It's my say-so." We saw a decoration of flowers on a person's door around their name. When asked about it, the person advised us this had been completed with the support of the activity co-ordinator and they had enjoyed doing this.

On the Calderdale unit, the television was on but there was no-one watching it and there were few activities in the morning, although we noted this improved during the afternoon. We observed the unit manager on the Calderdale unit engage with a person who was not communicative. They brought the person a basket containing strings of beads and other familiar items to explore. Interaction was positive; staff smiled and offered encouragement. The staff on the Calderdale unit had recently developed a sensory room which created a relaxing environment for people and included an aromatherapy diffuser, music and lighting.

The activities coordinator described the range of activities available and they were aware of the personal history of people who lived in the service. On the day of the inspection we saw that people were having manicures. However, on the Wensleydale unit we saw a member of activities staff attempted to attend to a person's fingernails without their consent, and the person appeared to not want this. We discussed this with staff and saw they

Is the service responsive?

intervened to attend to the person's needs. We were told relatives came in to help with activities such as the greenhouse and summer house when the weather was warmer. One person liked gardening and was a market gardener and so enjoyed having hanging baskets outside their room where they can see them from the window. We saw that there were notices up in the unit about activities and forthcoming social events.

Staff we spoke with described activities in the home. "We have a hairdresser Monday and Tuesday. We make a list or family ask us. There are activities every morning after breakfast and the coordinator leaves just before lunch. She does hand massages, quizzes and games, reading stories, watch old movies, have a drink and a chat. Chair exercises for physio. Activities are very popular. The afternoons are generally visiting time. It gets very busy."

Care staff described the interests that people had and what they liked doing. We saw that there were monthly programmes of events, and some trips out. Some people had been Christmas shopping and to a pantomime. One person who enjoyed singing had been supported to go to church for the last two Sundays prior to the inspection.

Staff said: "There have been a lot of improvements in the last 7-8 months. Everything is now more coordinated. Every shift know what we expect of them and what they are supposed to do and who is responsible for what. If they have any problems whatsoever, they ask openly. One of the improvements is that we have the activities coordinator every day. Communication is better between staff and relatives. They feel more involved in their relatives' care. We try to have a good relationship". We saw when families came to visit, staff were observed to know their names and the relatives knew the names of the staff.

We observed a member of staff speaking with a person as they prepared to take them to the hairdresser in their wheelchair. The member of staff knew about the person's life and could encourage them to have conversations about their childhood which they clearly enjoyed. A visitor told us: "They made an effort to get to know [my relative] as a person when they were admitted. They do know about their past life – [my relative] used to be a runner and they know all about that." Another relative told me "They took time to get to know [my relative] as a person, to understand them."

We observed people in one lounge undertaking silk painting with guidance and support from the activity co-ordinator where required. This generated discussion between residents and visitors alike and was clearly enjoyed. The activity on the timetable was 'play your cards right' but the co-ordinator stated that residents had requested to do some painting instead. The equipment had been provided by a local arts group in Wakefield.

There were different choices of music played throughout the day ranging from easy listening to classical, and this was after consultation with the residents who were able to decide. Magazines and newspapers were also readily available.

We observed the atmosphere in the Swaledale unit lounge to be very relaxed and positive. There was a lot of friendly banter between residents, staff and visitors which demonstrated they felt comfortable with each other and knew each other well. The host knew all the relatives' preferences for drinks this further demonstrated evidence of positive relationships between the home and the relatives.

We reviewed a range of care plans. These showed that on initial admission people's preferences had been noted; where English was noted not to be a person's first language, communication was adapted to ensure people's preferences were known. Documentation to support how people's care needs were met was in place. For example, risk assessments were up to date, turning and standing charts were observed for people; the charts documented that care had been provided in the stated time scales. However we observed that daily notes within care records were more task focused rather than personal interests and activities.

On the Calderdale unit we looked at two care plans and found these had sufficient general detail which was easy to locate. However, there was a lack of detail about the variance in people's preferences, such as what time they liked to get up. For people who had difficulty communicating verbally, there was clear information for staff about how to understand individual non-verbal cues. Individual risk assessments were reviewed monthly or as people's needs changed. People's end of life wishes had been discussed with them where appropriate.

On the Airedale and Kingsdale units we saw care plans that did not clearly show how people had made choices or how

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Is the service responsive?

their care had been provided. Information was basic and lacked clarity. For example people's moving and handling risk assessment detailed equipment needed but not method used. Daily logs contained only basic information relating to tasks. One person we had been speaking with on the Airedale unit was clearly low in mood and very tearful. They said: "People don't come and talk to you – they're not interested. Staff are nice but they can't be bothered to just talk". We checked the person's care plan and nothing was recorded about their low mood and there was no referral for further help or support.

We spoke with the acting manager who confirmed the organisation was in the process of obtaining new documentation, which when implemented was intended to improve care records and make them more person-centred and detailed. Although we acknowledged this was work being undertaken, records still lacked detail for staff to respond fully to people's needs. This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 20, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the Swaledale unit we looked at two care plans and found them to be completed and up to date. The daily records were mostly task-centred linked to the individual's personal care plan and were completed twice daily. There were records of end of life decisions and regular reviews of care plans. It was not clear whether these had included the person's or their relative's views. However, there were separate records of contact with family members and an outline of what these contacts had been for. This also included any other professionals involved in that person's care such as a GP or a nurse. There was indication that recommendations from the SALT team had been carried out and we observed this in practise as people were assisted with meals.

We spoke with the acting manager who confirmed the organisation was in the process of obtaining new documentation, which when implemented was intended to improve care records and make them more person-centred and detailed.

Staff we spoke with told us that the needs of people were reviewed if there was a change. One member of staff gave an example of a person who had been reassessed for a specialist chair as there was a concern that they might slip out of a standard chair. We were told that other professional staff, such as occupational therapists, were involved in assessments for equipment, such as hoists.

We spoke with people and visitors about their experiences of being asked for feedback about the home and raising concerns. One resident told us: "I could talk to the staff about things I'm worried about. I mainly talk to my daughter." A visitor told us "There are meetings but I haven't been to one for a while." Another visitor told us that they did not go to meetings because of the distance this would involve. They said "We would raise any issues directly with the staff" One visitor told us "Definitely no meetings. No surveys." We received conflicting opinions from visitors to the Airedale unit. All agreed that there were meetings but were inconsistent in their view on the effectiveness of these. One visitor told us "They have them, yes. I think it's a good thing." This visitor could not cite an example of something that had been raised at a meeting or any actions arising out of them. Another visitor said "They listen but nothing happens as a result. I'm forever telling them that things go missing in the laundry but nothing ever happens."

Most people were unable to tell us about meetings or surveys. One person on the Wharfedale unit said "I don't think there are any meetings for us to go to, but I'm not sure." Another person told us "There are meetings but I didn't see much value in them. We aren't really consulted in the running of the home."

People we spoke with and their relatives told us they knew how to make a complaint. One set of relatives said they did not have any need to complain but would know how to if they were unhappy. They said, "The staff are very good with her, if we find anything, we're not afraid to speak, we go down and see the manager"

Staff said they made sure people and relatives knew the procedure to follow. One staff told us where a relative had complained their family member did not have their feet on a stool, they communicated this to the team to remind all staff.

Requires Improvement

Is the service well-led?

Our findings

The service had experienced recent changes of managers and there had been a lack of a consistently strong leadership within West Ridings residential and nursing home. This had caused staff to feel unsettled and unclear about their roles and responsibilities. We saw evidence of high levels of staff turnover, absenteeism and sickness, which was disruptive to staff motivation and continuity of care for people.

The acting manager had only been in post a few weeks prior to the inspection and they acknowledged there was a lot of work to be done to improve staff morale and introduce new ways of working to make the service more personalised and empowering. The acting manager had some ideas that needed to be delivered and embedded, but acknowledged the importance of including staff in any changes and improvements.

Staff in some units spoke highly of the management team and their unit managers and we saw evidence of sharing information and lessons learned in staff meeting minutes. For example, where there had been an allegation of institutionalised practice and staff getting people up too early, this had been discussed and staff reminded that care should be focussed on people's individual needs. Staff we spoke with seemed to understand the messages given by management and had adapted practises to ensure individual preferences were considered.

Some staff we spoke with described an improving morale and a culture that was more open than previously felt. One member of care staff described a 'friendly, diverse culture' and said they were encouraged to be open, honest and put their views forward. Staff said they felt supported to question practice and confident to raise concerns. They said: "No problems here. It is a positive work place. Everyone helps each other. Everyone gets involved. It is busy in the mornings. But the carers are always talking with people". "Very friendly environment. Staff are not afraid to seek help or advice. Much more relaxed and confident. Before it was a blaming culture but it's not like that now. It is busy but I enjoy working here". "If I was concerned about staff, I would have a word with the manager first and then talk to the person. I have a good relationship with the manager. The Registered Manager is new. She has been moved from another home. We see her every day. She always asks how we are doing and do we have any problems and do we need help. She is very supportive. I feel like I can go to her. She is very approachable. It was not like that before".

The acting manager told us of their open door policy so staff could approach them to discuss any issues should they wish to. We saw evidence of regular staff meetings and manager meetings thatwere used to discuss attitudes, values and behaviours. There were some weaknesses in the documentation to record such meetings and this did not provide an audit trail to show how significant issues had been escalated.

We saw evidence of BUPA's vision in the staff induction pack and newsletters. We saw a generic BUPA policy that stated people's rights to be treated as an individual, have dignity and privacy protected and to be addressed politely. Although we saw people's rights were mostly well promoted in practice, staff we spoke with were unable to describe the vision and values of the organisation, although we saw people's rights were mostly well promoted in practice.

Staff we spoke with told us they thought communication had recently improved in that there was more openness and transparency. Staff said they felt able to contribute their views in staff meetings and they felt supported by their line managers on the whole.

Some staff on one unit were upset as the manager and deputy manager were being moved to another unit which required support. Not all staff we spoke to were clear about the rationale for this, which left them feeling unsettled.

Plans were in place to conduct annual performance appraisals. Employee records were complete and comprehensive. Regular monthly performance meetings involving all managers were in place. Staff told us the regional manager was regularly visible in the service to support the acting manager in their role. Unannounced quality manager visits were conducted to check the service was meeting people's individual needs and where improvements were needed, action plans were put in place. This showed there was some monitoring of quality taking place within the service.

The home had basic governance procedures and processes in place which were generally clear, well documented and up to date. There was a system in place for the acting manager to receive monthly reports from each unit.

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Is the service well-led?

There were weaknesses in the quality of the recording and analysis of information. The organisation was dependent upon paper systems with which we found there were problems in the quality; many hand-written data entries were illegible. Data systems were not effectively used to produce meaningful management reports. There was evidence of rudimentary audit but much of the documentation was hand-written in such a way the information was not legible and often incomplete. We did not find evidence to show the service measured and reviewed the delivery of care in a systematic way against current guidance.

Management of the service was reactive rather than proactive and focused on current issues, rather than anticipating what might happen in the future. For example, there were systems in place to analyse accidents and incidents that had occurred, yet there was little to anticipate risks and analyse near misses and there was no formal risk register. The clinical audit plan was responsive to focus on what had already gone wrong and root cause analysis was then superficial. There were no overall strategies to deal with known risk issues, such as depression or anxiety. There were no clear plans in place or evidence of forward thinking as to how the service could drive improvement.

These examples, illustrate a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance records and documentation were of a high standard, initialled and up to date. However this was not comprehensive; for example, there was no evidence of wheelchair or bedrails checks. Compliance certificates were up to date for service and maintenance provided by external contractors, such as portable appliance testing (PAT), fire alarms, burglar alarms and catering equipment.

We spoke with housekeeping staff who showed us records of audits in place to ensure the home was clean and infection control was well managed. These records were well kept, detailed and thorough.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 9 HSCA (RA) Regulations 2014 Person-centred care People's care was not always managed safely in line with their needs, such as with moving and handling and wound care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There was mixed staff knowledge and practise across the home with regard to MCA and DoLS and so people's rights were not always protected

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 People were not always protected against the risks associated with the unsafe use and management of medicines

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 Care records lacked sufficient detail for staff to respond fully to people's needs. There were weaknesses in the quality of the recording and analysis of information

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing levels did not always ensure people's needs were met in a timely way

This section is primarily information for the provider

Enforcement actions

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