Hazelroyd Limited

Hazelroyd Nursing Home

Inspection report

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Date of inspection visit:
10 October 2018

Date of publication:
07 December 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 10 October 2018. At the last inspection on 28 June 2017 we rated the service as 'requires improvement'.

Following the last inspection we asked the provider to complete an action plan to show what they would do, and by when, to improve the key questions asking if the service was safe, effective, responsive and well led to at least good. The registered provider sent us an action plan, detailing how they were going to make improvements. At this inspection we checked the improvements the registered provider had made. We found sufficient improvements had been made to meet the requirements of the Regulations.

Hazelroyd Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Accommodation is provided for up to 30 people, across three floors. At the time of the inspection, there were 27 people living in the home.

There was a registered manager in post. 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.

People said they felt safe living at Hazelroyd Nursing Home and we found there were systems and processes in place for people's needs to be safely met. Staffing levels were supportive of people's individual care needs. People received their medicines on time and staff understood each person's abilities and health needs.

People were supported to have maximum control and choice over their lives and staff supported them in the least restrictive way possible. Policies and systems in the service supported this practice and staff understood legislation around people's mental capacity.

Staff had a kind and caring approach and showed respect when interacting with people and good regard for people's privacy and dignity.

People enjoyed meaningful activities and there were appropriate opportunities to engage with the activities coordinator in groups or on a one to one basis. There were many resources to support people's activities and we made a recommendation the provider extends these to include resources such as audio books, for people with impaired vision.

Systems and processes for assessing and monitoring the quality of the provision, including identifying risk, were robustly implemented. Audits were thorough and there was clear evidence of management oversight of the service. People, relatives and staff spoke highly of the registered manager and the way the service was

run.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.
Staffing levels had improved since the last inspection and there were enough staff to meet people's needs.

Systems and processes were in place to ensure risks were clearly identified and staff understood how to keep people safe.

People were supported appropriately to receive their medicines when they needed them.

Is the service effective?

Good

The service was effective.
There was clear assessment of people's needs.

Staff were suitably trained and supported to carry out their work.

There was appropriate understanding of the Mental Capacity Act legislation, supporting staff in promoting people's choices and rights.

Is the service caring?

Good

The service was caring.

Staff had a very kind, caring and compassionate approach to working with people and there was evidence of good relationships between people and staff.

People's privacy and dignity was respected.

Visitors were welcomed at any time.

Is the service responsive?

Good

The service was responsive.

There was evidence of person-centred care and staff knew each person well.

Activities were meaningful and people were purposely engaged.

People knew how to raise a complaint and they were confident any concerns would be taken seriously.

Is the service well-led?

Good

The service was well-led.

Staff had clear direction and there was evidence of strong teamwork in the home.

The registered manager was enthusiastic and committed to delivering high standards of care, with robust quality assurance systems in place.

There was evidence of partnership with other professionals to ensure the quality of people's care.

Hazelroyd Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 10 October 2018 and was unannounced. There were two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service. Their area of expertise was care for older people.

Before the inspection we reviewed information we had available about the service. The provider had completed a Provider Information Return (PIR). The PIR 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. We also reviewed safeguarding alerts and notifications submitted to us by the service. A notification is information about important events that the registered provider is legally required to send us. For example, where a person who uses the service suffers a serious injury. We took this information into account when we inspected the service. We contacted the local authority safeguarding and commissioning teams and the clinical commissioning group (CCG) who told us what they knew about the service.

We spoke with the provider, the registered manager, six staff caring for people, the cook and cleaning staff. We spoke with 14 people who used the service and seven relatives/visitors. We looked at care records for five people and records to show how the service was run.

Good

Is the service safe?

Our findings

At the last inspection the service was rated 'requires improvement' in this domain because there were not enough staff available to meet people's needs. There were improvements needed to ensure the home was clean and that thickening agents were used and stored safely. At this inspection, the provider had ensured all actions were taken and this domain was therefore rated as 'good'.

People told us they felt safe and their relatives agreed. One relative said, "Yes, [my family member] is safe. They're very good here. [my family member] is prone to falling but they have all sorts of things in place [They have] been here two years, and only had two or three falls in that time. When [they were] in their own home they were falling often."

We saw when people's assessment indicated risk, detailed, person specific care plans were in place. These were all reviewed each month, using a resident of the day schedule. Some were reviewed more frequently, if there were changes or when applicable, for example when a person had a wound. Risk assessments were comprehensive, detailed and reviewed. They included risk of pressure ulcers, mobility, falls, malnutrition, medication and personal specific risks such as bedrails, choking and scalding.

Staff recruitment procedures were in place to ensure potential staff were suitably vetted before working with people in the home. The service ensured there were sufficient numbers of suitable staff to support people to stay safe and meet their needs by carrying out dependency assessments every month. Staff said there were enough staff to care safely for everyone living in the home. Staffing numbers had increased in the previous year. On the day we visited there was a nurse and six carers on duty in the morning as well as domestic, kitchen, maintenance staff and the manager of the service. Relatives told us there were usually enough staff. One said, "There seem to be enough staff on during the day. Sunday seems a bit sparse" and another said, "There are enough staff – I've never seen evidence that there aren't. I visit every two weeks."

Clear procedures were in place and known by staff to ensure people were safeguarded against abuse. Staff understood the signs to be aware of and how to report any concerns, and they were confident to use safeguarding and whistleblowing procedures to ensure people were safe.

People's records were accurate, complete, legible, up-to-date, and securely stored in a locked office. Care staff had access to records so they could obtain information to support people to stay safe.

The service's role in relation to medicines was clearly defined and described in relevant, up to date policies and procedures. The policy referred to current professional guidance about the management of medicines. Nurses administered all medicines and had received training provided by the service, been assessed as competent by the manager and signed to show they had read the policies of the service. They also had access to information about medicines from an up-to-date British National Formulary (BNF) and patient information leaflets for each medicine prescribed for people living in the home.

Medicines were available when people needed them, stored securely and temperatures of the room and

refrigerator were monitored to ensure they were within safe limits. Controlled drugs (CDs) are prescribed medicines that are often used to treat severe pain and they have additional safety precautions and requirements. There are legal requirements for the storage, administration, records and disposal of CDs. These are set out in the Misuse of Drugs Act Regulations 2001 (as amended). The service complied with these requirements. CDs were stored in a separate wall mounted metal cabinet and recorded in a ledger. We saw two signatures for each entry. We checked the remaining count of two items and it matched the expected count.

Medicines were administered safely. We saw the nurse wore a red 'do not disturb' tabard to reduce interruptions, prepared a trolley with measuring cups, teaspoons, glasses and a jug of water and washed their hands. The nurse used their handover sheet to check any new information or changes for each person and ticked names when medicines had been administered. This meant at the end of the round, they were able to check at a glance that everyone had received their medicines. People were offered medicines when they were ready for them, with time critical medicines being offered at the prescribed time. The nurse checked each person was ready before checking medicines using the medicines administration record (MAR).

The nurse greeted each person and offered their medicines in the way they preferred them, as described on their MAR. They stayed with each person until they had taken their medicines and signed the MAR only after they were administered. MAR charts included a recent photograph of each person, details of allergies and resuscitation status.

Some people had been prescribed medicines for use 'when required' (PRN). When medicines had been prescribed PRN, the nurse asked people if they wanted the medicine before preparing it. When the PRN medicine was a laxative, they checked records of bowel movements before offering the medicine if appropriate. There were protocols in place for each person's PRN medicines which included information about how the person liked to take, or was assisted to take their medicines. They did not include information about how each person communicated but the nurse knew people well and understood these needs which were documented in care plans. Protocols included directions to staff about how many doses of how frequently doses could be given before informing people's GPs.

Some people were prescribed topical creams or lotions, either PRN or regular applications. Non-medical creams such as barrier creams or emollients were applied by carers in people's bedrooms during personal care. Protocols were in place for these but were not always detailed to include where to apply and why they were needed. Body maps were not used to provide pictorial information about where to apply different creams. When specific frequencies were recorded, the topical MAR had not always been signed. We spoke with the nurse who said these were checked at the end of each month and audited by the manager. The nurse and carers thought creams and lotions were applied correctly but not always signed for. The registered manager gave assurances these matters would be addressed to ensure recording was consistent.

One person received medicine in a patch format once a week. The site of application was not recorded although the manager showed us evidence the service was about to implement body maps to record application sites.

One person needed their medicine covertly (hidden, such as in food) but no details were available on the MAR of how medicines should be disguised. Neither a mental capacity assessment nor best interest meeting had taken place about the person's capacity to make the decision to refuse medicines, as described in the policy of the service. However, the person had previously had a DoLS in place and one had been applied for by the service which included a statement the person needed to be given medicines covertly. The registered

manager assured us they would address this matter in line with their continuing updating of the care records, which we saw was in progress.

Medicines were disposed of safely. Medicines no longer required were listed in a returns book, stored in a sealed container and kept in a locked room until collected by the pharmacy.

People were protected from infections that could affect both staff and people using services. Arrangements were in place for making sure that premises were kept clean and hygienic. We observed the premises were clean with no malodours on the day we visited. The kitchens were clean and a schedule was in place for deep cleaning all areas, including people's bedrooms which were deep cleaned once a month as part of a 'resident of the day' scheme.

Staff understood their roles and responsibilities in relation to hygiene. One member of staff described opportunities for handwashing and we saw laminated posters encouraging staff to wash their hands appropriately. Supplies of personal protective equipment (PPE) was available in locations on each floor of the home and was used when delivering personal care. Washbasins in toilets, bathrooms and the kitchen all had soap dispensers with hand-washing soap and paper towels and bins with foot- pedal operated lids. Care staff described the process of disposing of continence pads safely in yellow 'clinical waste' bins. Soiled linen and clothing was separated from other laundry and washed separately. When people had been assessed as needing to use a hoist or standing aid, individual slings had been provided and were laundered appropriately.

When a person had an infection that put others at risk of cross-infection, information was handed over to staff on each shift and recorded on a handover sheet. PPE was available outside the person's bedroom and non-essential visitors discouraged from entering the person's room.

Three hoists were used by staff to help people stand or transfer from bed to chair, to use a toilet or shower. These had been serviced annually and staff said they had received training. Some staff received updated training on the day we visited. Carers said they had been trained to check slings and belts for wear and tear each time they used them, and would report to the manager if they were found to be defective.

The premises and equipment were maintained safely. A maintenance employee checked a book each day where staff wrote issues that needed attention. The manager said they regularly checked this and discussed prioritising work when necessary. They followed a weekly, monthly and annual schedule of safety checks as well as attending to day-to-day maintenance. The manager maintained a schedule of annual safety checks and required certification carried out by external professionals. Where safety inspections had shown issues or suggested future improvements, details had been transferred to an action plan.

A fire safety certificate had been issued to the service within the previous year and fire safety checks took place each week. These included equipment such as evacuation sheets and fire extinguishers as well as signage, emergency lighting and fire alarm system. Records showed all staff had received fire safety training. We saw break-glass fire points and extinguishers on each floor or the home. Extinguishers had labels indicating they had recently been serviced. Fire doors were signed and kept closed. Fire exits were clearly marked and laminated fire procedure information was displayed near fire points.

Good

Is the service effective?

Our findings

At the last inspection the service was rated 'requires improvement' in this domain because people's dietary care needs were not sufficiently recorded. At this inspection, the provider had ensured all actions were taken and this domain was therefore rated as 'good'.

Relatives told us staff cared for people skilfully. One relative said, "They take good care of [my family member]. It usually takes three of them to see to [my family member]. Another relative said, "All the care I've seen here has seemed good." Another relative told us, "When it came to the DoLS assessment, I saw the social worker's notes, and [my family member] is being well cared for from their opinion."

Staff told us they felt supported through training and supervision. Staff said they attended staff meetings where they discussed issues and concerns and ways to improve care for different people. We saw records to show staff had regular opportunities for training supervision and meetings to discuss practice. There were clear processes for induction of new staff to ensure they provided effective care.

Assessments and plans of care included current evidence based guidelines to support staff to achieve effective outcomes. For example, people had been assessed using the Waterlow score for risk of developing pressure ulcers. Depending of the degree of risk, care plans followed guidelines including the use of pressure relief mattresses, cushions and regular repositioning. One person had a pressure ulcer when they arrived to live at the home which had healed due to effective care. People were involved in planning their care, and support was sought from external health professionals when appropriate. A person with high risk of pressure ulcers had been unhappy with two hourly position changes overnight. Staff had discussed the risks to the person's skin and benefits of restful sleep with the person and a specialist tissue viability nurse (TVN). A decision was made to assist the person to reposition every four hours overnight, which the person agreed with.

When people had been assessed as needing to use a hoist or standing aid, individual slings had been provided of the required size by a specialist therapist. The size of sling and pressure relief mattress settings was recorded in files in people's bedrooms. Nurses and carers said they had read care plans as well as a summary of care provided in people's bedroom file. This was called a 'one stop profile' and included social information about the person, mobility, ability and equipment, whether they had variable mental capacity and diet and fluid preferences. This meant care staff could quickly check information when delivering care to people in their bedrooms and promoted effective care. The 'one stop profile' had been introduced in response to a discussion the manager had with an agency nurse about the difficulty of retaining relevant information about all the people living in the home. Records showed regular visits from GPs, podiatrists, opticians, and specialist nurses.

We reviewed records for a person who had arrived unexpectedly at the home the previous day. The manager had conducted a pre-admission assessment but was awaiting delivery of equipment necessary to deliver effective care before accepting the person. Initial risk assessments had been carried out for nutrition, choking, continence, mobility and bedrails. Staff had completed a full skin check and recorded this check on

a body map. Staff had recorded care delivered overnight in daily care records.

People's dietary needs were well met. There were three options for lunch and the cook tried to cater for specific requests for food, and knew all the people very well and their food preferences.

Some people required a vegetarian diet. There was a poster displayed in the kitchen with details of who had diabetes and how this was managed, such as insulin, tablets, or by diet. Another poster listed details of thickening agent for people who needed this adding to their drinks. There were also two files in the kitchen, a diet notification book and an individualised catering plan. The diet notification book had an individual sheet for each resident, with guidance on what sort of food they liked or disliked. The individualised catering plan listed food preparation, such as if the food needed to be pureed and what strategies staff could use if people refused food, such as trying again later.

When we first arrived, the cook was just putting toppings on fresh cupcakes for people, for their morning and afternoon snack breaks. They told us these were baked every second day. We saw afternoon snacks being taken up to people's rooms on individual trays. Smoothie bases had been made up and put in the fridge to be made up with appropriate thickeners for individuals in the afternoon. People told us, and we saw there were plenty of drinks available when people wanted them.

People were offered choices at mealtimes and when at risk of malnutrition or dehydration, records had been maintained. The service had a system in place to ensure people received support when they needed it, to eat and drink. As care staff took trays to people's bedrooms, the cook ticked people's name off a list and wrote the name of the staff who had supported each person. This ensured everyone received their meal and support if needed.

People told us they enjoyed the food on the whole, although one or two people said it was not always to their liking. We saw the cook tried to accommodate people's requests when they wanted something that was not on the menu. One person said, "The food's alright for me. I was trying to lose some weight, but I can't." We saw the cook discussing healthy eating strategies and making every effort to support the person's goals. One person told us, "I don't really like the food. It's not what they serve, it's just it's not prepared how I would do it. I eat what they get me, and some days it's better than others. It was macaroni and cheese the other day, but I didn't see any cheese." and another person said, "The food's very nice, but I'm not hungry. I keep feeling sick, so I don't want to eat. "We saw this person had refused lunch and staff came in and checked on them before going off duty. The member of staff expressed concern and suggested the person might like chicken soup as they knew the person enjoyed that.

People's needs were met by adaptation, design and decoration of the premises. Two communal lounges on the ground floor had recently been re-decorated and the manager told us people had been involved in choosing the décor from swatches and pictures. One room had a pretty, cheerful floral paper while the other was more neutral. A new wet-room shower had been installed and care staff said there were enough bathrooms, toilets and showers to meet people's needs.

People had been asked for written consent to care plans, photography, information sharing and use of bedrails. When people had cognitive impairment, mental capacity assessments had been carried out for each of these. People were asked their consent and were consulted before staff supported them with any care. People made their own decisions about routine matters, such as what to eat or wear.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

We saw mental capacity assessments were for specific decisions and were detailed. People had been helped to understand information given to them. A person living with dementia had variable capacity and assessments documented they had understood information, were able to understand and process it and communicate their answer so they had mental capacity and had consented on their own behalf. When people lacked mental capacity to decide about living in the home under continuous supervision, decisions had been made at well documented best interest meetings and DoLS were in place or had been applied for.

Staff described how they always asked people and gave choices. One member of staff said they described options and often showed people who could indicate preferences if they could not respond verbally. One member of staff said, "I talk to everyone as if they have capacity to understand, I ask them." They said even if people did not respond, they always talked to them and explained every step of care processes.

Good

Is the service caring?

Our findings

At the last inspection the service was rated 'requires improvement' in this domain because people were not consistently treated with care and respect, and their privacy and dignity was not sufficiently promoted. At this inspection, the provider had ensured all actions were taken and this domain was therefore rated as 'good'.

People told us they felt well cared for at Hazelroyd. Comments included, "The carers are very nice here", "The carers treat me very nice" and "They're brilliant, are the staff".

Relatives told us the staff cared for families as well as the people in their care. One relative said, "They are very good. They look after me too. I've had one or two flutters here. The nurse came and saw me, and put me right. Made me a sweet tea, which I don't like, but it does the trick. I'd missed breakfast. Only last week, I'd called a taxi to go home when I felt faint. I knew I couldn't stay out there, so I came back here. They made me fish, chips and mushy peas". Another relative said, "They always make me a lunch too, and plate it up so I can take it home with me."

One relative told us, "[My family member] has improved since they've been here. They seem much more alert and aware of what's going on. I put it down to the closeness of the carers here, and the attention [my family member] receives. The atmosphere also, it seems like a very relaxed place for everyone." Another relative said, "They are caring, very much so. They seem close to all the people who live here. [The activity coordinator] will give them a cuddle sometimes." Another relative said, "It's homely here. Less people live here than in some places, and it feels like they are closer here [staff and people]."

We observed many interactions between people living in the home and care staff during the day we visited. We saw people were treated with kindness, respect, and compassion. Staff showed they knew people well in the way they spoke with them and the topics they talked about. One person was complimented on the colour of their jumper by a carer who said, "You look lovely in peach, the colour really suits you." We saw staff demonstrated caring values throughout the inspection. Some staff attended a funeral of a person who had recently passed away and they spoke fondly of the person to other people in the home.

A nurse administering medicines did so patiently and didn't rush people. When staff supported people with care, this was determined by people setting their own pace. Staff treated people as individuals and took an interest in them. For example, staff asked one person how they had slept, asked another if they had enjoyed breakfast, then listened attentively to people's replies.

When a person was distressed because their friend, another person who lived at the home, had become unwell and gone to hospital we saw staff reassure them frequently and assure them the person would soon be back in the home.

An activities co-ordinator not only engaged people in activities but gave emotional support to people. A person enjoyed holding and stroking a soft toy of a cat. Another person's care plan directed staff to, 'provide

social and emotional interactions' and stated they chose to remain in their bedroom but enjoyed chatting with staff. It stated the person could demonstrate a low mood or be anxious and shout and described how staff should act to calm them.

Staff spoke about people with affection. One member of staff said different people preferred different care staff. They said of one person, "[They] make me laugh, [person] has got a very dry sense of humour and likes a joke." Staff told us they regarded the people who lived at Hazelroyd with the same respect as they would their own family members. We saw staff who attended to do training took time to sit and chat with people in the lounge before training commenced.

People's social history and preferences were documented and staff were aware of these. Previous hobbies and activities had been taken into account when planning activities in the home and people were supported to express their views and be actively involved in making decisions about their care and treatment. We saw visitors were present all through the day. Some were in one of the lounges spending time with their relative, while others visited people in their room.

Care plans directed staff to ensure privacy and dignity was respected and promoted when delivering personal care. We saw staff in all roles respected people's rights.
People were well dressed and had their hair done and it was evident their personal care needs were well met. When one person had spilt breakfast on their top, they were gently invited to change it, and asked which top they would prefer.

Each month every person living in the home was 'resident of the day' on a day. Care staff were prompted to check people's clothes were in good repair and toiletries were adequately supplied.

Staff told us they enjoyed caring for people in the home. One member of staff said, one of the best things about the home was, "Good staff, all team-workers and we care. You've got to like this job to do it."

Good

Is the service responsive?

Our findings

At the last inspection the service was rated 'requires improvement' in this domain because people's care and support was not delivered in a timely manner. Care plans were not up to date and people's involvement in these was lacking. Activities were limited for people. At this inspection, the provider had ensured all actions were taken and this domain was therefore rated as 'good'.

People told us the service was responsive to their needs. One person said, "The care staff are all very nice. Some talk to me more than others. Some don't talk, just get on with it. I can't complain." And another person said, "Staff do chat when they can, when they have time."

One person told us, "[Living in a home] is not somewhere I choose to be, but I need to be looked after. I knew nobody here [locally]. I didn't realise how much it would affect me. I do keep in touch with my old friends by phone." Another person said, "Hazelroyd was recommended to me. It's very nice here. I have a nice room here too, nicely decorated."

We found clear evidence of person-centred care. Before people came to live at the home, the manager completed an assessment of their needs in order to decide if the service could meet those needs. The form included three decision options, either accept, accept with conditions such as needing equipment or staff training, or decline if the person's needs could not be met. This well-structured approach meant the manager made a clear decision based on needs and available support.

The manager told us about their response following a person being transferred to the home from hospital despite necessary equipment not being available. They reported the unsafe discharge to the hospital safeguarding team and spoke with the senior nurse on the ward the person had been discharged from. They had contacted relevant health professionals to obtain a temporary plan to provide adequate nutrition and fluids.

Assessments and care plan documentation prompted assessors and reviewers to consider people's communication needs, preferences and characteristics protected under the Equality act such as gender, religion, sexual orientation and disability. People's sexuality had been incorporated into care plans which commented on their self-image, how they liked to dress and the importance they gave to grooming or dress. One person told us staff had supported them to attend a local pride event.

Records showed people were supported to maintain religious or cultural preferences. For example, people's religion was recorded and also if they wanted to attend church or be visited by ministers of religion. One person's care assessment noted praying was important to them.

Care assessments prompted staff to invite people to discuss their end of life choices. When people did not want to discuss this subject, their decision was respected and noted. We saw 'just-in-case' medication had been prescribed and obtained for a person who was approaching end of life care. We saw staff spoke in sensitively open ways with people about when a person had recently passed away, when people asked staff

questions.

We spoke with the activities coordinator who we saw had a talent for communicating with people and engaging them in activities, either in groups or on a one to one basis. They told us the home had an open event with families and visitors every two months, where they had a singer and a buffet. They said they arranged birthday parties for people, with family and friends invited, and one person showed us the invitations to their party they were sending to their guests. The activity coordinator told us they hosted a charity fundraising coffee morning event. They said there were also events such as a pie and pea supper, to raise funds for the people to have trips out. We saw a Halloween bingo game was being organised at the time of the inspection.

We saw the activities coordinator went around first to visit people who were in bed to spend a little time with each of them. They told us one person enjoyed being read to from the Bible and they supported them in prayers. Another person enjoyed being sung to. We saw the activities coordinator engaged with one person who enjoyed perfume; they put a little of two different perfumes onto cotton wool, for the person to smell, and then asked which perfume they would like to wear. This showed people had the opportunity to enjoy personalised care according to their interests. We saw there were sensory activities for people who could not communicate easily.

There was a range of resources available for people to use and enjoy. For example, there was a fish tank, sensory materials, colouring books and local history books with pictures of old Halifax. We recommended the provider consider how the resources could be further extended, to cater for people with sensory impairments, such as talking books for people who could not read print.

People told us on the whole they had enough to keep them occupied. Comments included, "We do nowt, just natter on. We used to play dominoes, and have fitness sessions", "I went to a lunch club, I don't go every time, on Monday. Afterwards, we went to the market", "Oh yes, there's enough to do during the day" "They have a buffet and drinks sometimes. During the day, I watch TV. I have a big TV because of my eyesight, but there's only so much TV you can take, but at least I've got it. I can't see to read now. I make the best of my time. The days seem very long", "Last Thursday, we went to Emmerdale. I enjoyed it" and "It's alright here. I stay in my room, I'm old enough to please myself. I am happy reading and doing my own thing."

One relative told us, "[The activity coordinator] does very well. There's an activity every couple of months, events with a singer and generally lunch. She has also started taking residents out. She took them to Bankfield Museum, out with families. It was a lovely day".

The manager had chosen a new call system which had recently been installed. Staff logged in by pressing a button 'attend' when in a bedroom, and again when they left. This meant the manager knew where staff were and could access information for audit purposes. The system had the capacity to attach chair and bed pressure alarms to help keep people safe.

During the inspection two people living at the home became unwell. Staff response was calm, appropriate and professional. 999 was called and each person went to hospital.

People told us they knew how to raise a complaint if they wished to. They said all staff and the management team were approachable. No concerns were raised by any of the people we spoke with or their relatives. Several of them mentioned the new manager by name, and told us there was good communication with them should they need to report any concerns.

Good

Is the service well-led?

Our findings

At the last inspection the service was rated 'requires improvement' in this domain because there were aspects of quality identified through the inspection which had not been identified by the service. At this inspection, the provider had ensured all actions were taken and this domain was therefore rated as 'good'.

There was a registered manager in post who had been running the service for a year. People, staff, relatives and other professionals told us the home was very well run.

Staff said the manager was approachable and had made a lot of positive changes in the last year. They said they had increased staffing levels and purchased new equipment. This included a new hoist and new linen skips. They had new personal protective equipment holders installed on each floor "so it's faster to get them."

People told us they thought the home was managed well and they felt it was their home. One person said, "I came for visits here before, so I could see what it was like here. I enjoy it here very much", and another person said, "The place runs well, there's a good manager here and that's important."

Relatives' comments included, "We have residents' meetings, and relatives' meetings every three months. The manager runs them, and she keeps us up to date", "I go to the relatives' meetings with (manager). We get to know her and her thinking about things", "There have been more activities since the new manager came, and she's doing some decorating of the home too. She's just had a wet room put in" and "There's two priest ladies come from St Jude's and do a service here."

We found the registered manager was enthusiastic and set very high standards in the home, leading by example. They were passionate in ensuring people received good quality care and told us they were determined to 'make this life matter' for people. Staff told us they had confidence in the registered manager and they could count on her to offer practical hands-on support with people's care, as well as guidance to support them in their role. There was clear direction for the whole staff team in a supportive culture of openness and transparency. Handover documentation was very well detailed to ensure staff understood what they were accountable for. Staff felt valued and motivated to do their work.

We found there had been proactive and prompt action taken to ensure matters identified at the last inspection had been addressed, with clear action plans in place and timescales for improvement. Systems and processes to assess and monitor the quality of the provision were robustly in place. There were good partnerships with other professionals and evidence of good communication to ensure people's needs were met.

We found the provider was visible in the service and trusted and supported the registered manager in the running of the home. The registered manager had regular visits from the provider and this enabled sufficient resources for any improvements to be made. The registered manager had had some supervision to support her professional practice, although this had not been frequent and the provider told us they were looking to

improve this in a more consistent way.