Care Quality Commission

Bupa Care Homes (CFHCare) Limited

West Ridings Residential and Nursing Home

Inspection report

Lingwell Gate Lane
Lofthouse Gate
Wakefield
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Tel:
Website:

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Ratings

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

Overall summary

We carried out this inspection on 16 and 17 November 2015. The inspection was unannounced.

Prior to this inspection we had made a focused inspection of the Kingsdale unit on 30 September and 2 October 2015. The Kingsdale unit discharged all patients following the inspection and the registered provider closed the unit on 13 November 2015.West Ridings Residential and Nursing Home is a multi-unit site providing care for up to a maximum of 180 people. The service has six units and provides care and support for people with nursing and residential needs including people who are living with dementia. On the day of our visit there were only five units open and 117 people living at the home.

The service did not have had a registered manager in post at the time of our inspection, although there was a

Summary of findings

manager who had been in post since August 2015 and had applied for registration. 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. There had been a high turnover of managers at the service which had impacted upon the consistency of quality. The new manager had begun to make some improvements to the service and feedback from people, staff and relatives was positive. It was not possible due to the manager's limited length of time in post to see how the improvements noted were being embedded and sustained.

Staff engaged in some safe practice and knew individual risks to people. However, not all equipment was suitable or safe for people to use and staff were not all competent in moving and handling.

There had been a high number of falls on the Kingsdale unit which had recently closed, some of which had resulted in serious injuries to people. There had been no management investigations into these incidents and no analysis or monitoring of accidents and incidents on the unit.

Staffing levels were acceptable overall although there were variations in staff visibility across the units.

Staff were kind and caring in their approach and engaged positively with people overall. Staff took time to involve people, although where people could not verbally communicate, staff sometimes lacked skills in communication.

Care plans up to date, although variable in quality across the units and up to date. There was little evidence people had been involved in discussions about their care and there were some inconsistencies in the information recorded.

There were limited activities to engage people in meaningful and personally interesting activities that incorporated individual interests. The environment for those people living with dementia was not always supportive of their needs.

Systems with which to monitor and evaluate the quality of the provision had improved since the last inspection, although they varied in consistency and rigour.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service.

This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures"

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?

Inadequate

The service was not always safe.

Not all staff understood safeguarding procedures and how to ensure people were protected from abuse.

Staffing levels had improved since the last inspection, although these were variable across the service.

Equipment was not always used appropriately and some equipment was not safe, such as wheelchairs.

Is the service effective?

Requires improvement

The service was not always effective.

Not all staff had knowledge of the Mental Capacity Act (2005) and how this legislation impacted upon people they cared for.

The effectiveness of some training was not always monitored or robust, such as moving and handling.

People enjoyed good food and drinks in the service.

Is the service caring?

Good

The service was caring.

Staff were kind and caring in their approach and they were discreet when managing people's personal care to ensure their dignity and privacy was protected.

Staff took time to engage with people using appropriate eye contact, facial expression and tone of voice.

Is the service responsive?

Requires improvement

The service was not always responsive.

Some care plans were up to date and person centred, but this was variable throughout the service and people were not all involved in discussions about their care.

There were variable activities; some units had activities taking place whilst in other units there was little for people to do.

People knew how to complain and felt the manager and staff were approachable. Not in main body of report

Is the service well-led?

Inadequate

The service was not always well led.

Summary of findings

Systems and processes to monitor and evaluate the quality of the provision were beginning to be developed although were not yet embedded in practice.

There was an improvement in staff morale and staff reported a more cohesive way of working within teams to help drive improvement.

Staff had clear direction in the way they worked and were confident in their role.

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.

There were six adult social care inspectors and two specialist professional advisors, who specialised in governance and occupational therapy. Prior to our inspection we reviewed information from notifications and used the information from our focused inspection in October 2015 to inform the inspection plan.

We spoke with the local authority commissioners and safeguarding teams before the inspection. We spoke with 30 people who used the service and 12 relatives during our visit. We spoke with the registered manager, the regional manager, clinical services managers and 14 staff. We observed how people were cared for, inspected the premises and reviewed care records for 18 people. We also reviewed documentation to show how the service was run.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. Comments included: "I feel I am safe as I can be. I fall sometimes but I know there's someone there for me", "It's a safe place", "I've always got my zimmer with me" and "There's lots of people about to watch out for me".

We saw staff encouraged people to be aware of their own safety. For example, staff reminded people to use their walking aids. When one person put too much food in their mouth and began to choke, staff were quick to respond. Staff were aware of individual risks to people, although we found some risk assessments lacked meaningful instruction as to how people's safety could be minimised.

Staff on four of the five units we inspected had a good understanding of safeguarding procedures and how to identify and report concerns. Not all the staff we spoke with on the Airedale Unit were confident about safeguarding or what to do if they had concerns.

Staffing levels were appropriate for the needs of the people overall, although the dependency needs of some people on the Airedale unit meant staff had to work in pairs to provide assistance, which left some people having to wait. At times on the Airedale unit we saw staff were not visible in the communal areas and people waited a long time for lunch to be served. We noted that staffing levels had improved since our focused inspection of the Kingsdale unit, as staff had been redeployed from the Kingsdale unit to other units. The manager told us staffing levels were maintained with four floating staff and considered there was adequate staffing across the site. Some staff we spoke with told us they thought staffing levels had improved since the previous inspection, although other staff considered their unit did not have enough staff. For example, staff reported on one unit there had been no domestic staff so they had been involved in cleaning as well as care tasks. However, staff reported improvements to staffing since the arrival of the new manager.

People's walking aids were labelled individually and hoists and lifting equipment had been checked and serviced regularly. Staff were aware of which walking aids belonged to which person and demonstrated they knew people's physical abilities and individual risks.

We found some equipment that was not safe to be used and in poor quality in relation to maintenance and infection control. For example, wheelchairs that belonged to the organisation were all visibly dirty and had damaged frames, loose nuts and bolts, brake failure, damaged or missing footplates, damaged seats and damaged lap-straps. Such items had previously belonged to residents no longer at the service, but had not been returned to the NHS wheelchair service. We noted that after pointing out unsafe parts on wheelchairs, staff continued to use these.

On the Wensleydale unit we found only one of the two available hoists was working and staff told us this had been out of order for three weeks.

We observed mixed practice throughout the site with regard to moving and handling; some staff followed safe guidelines whilst others did not work in a safe way. For example, not all staff used safety lap straps on wheelchairs or engaged the brakes when wheelchairs stopped.

Air flow pressure relieving cushions were available; however they could only be used on chairs located near to a small quantity of sockets, restricting people's choice of where to sit and these were not used with dining chairs at lunchtime. It was unclear how frequently each person was assessed for the appropriateness of each cushion; staff said it 'could be once a month or every three months'. On one unit we saw an ordinary cushion had been placed over an air relieving cushion which meant the pressure relieving action would not be in use.

On the Calderdale unit we saw a range of specialist seating but it was not clear who had been assessed for this seating or why it was being used. On the Swaledale unit a range of specialist seats were available, some of which were in need of repair and cleaning. This meant that they posed a risk of infection and a potential hazard to those with poor skin integrity.

We observed one person being hoisted and staff showed us the person had their own sling. We saw the sling was not positioned correctly and mentioned this to staff, who lowered the person and then had to make three further attempts to get the sling in the correct position for safety.

We saw a member of staff attempt to assist a person from sitting to standing, but the member of staff did not position their hands in a safe way and it was only when another member of staff came to assist that the manoeuvre was carried out safely.

Inadequate

Is the service safe?

On one unit there was a set of chair risers that were broken but still being used to raise a high backed chair. We discussed this safety risk with the unit manager who agreed to remove these for safety.

We found that prior to the appointment of the new manager and the closure of the Kingsdale unit, accidents and incidents were not appropriately recorded or monitored to establish if trends or patterns occurred. Where we had been informed of people sustaining serious injuries, there had been no further investigations completed to establish root cause or identify future learning. There were no adequate risk assessments for people's individual safety or for the premises. Where errors in practice had been highlighted, no robust systems were put in place to prevent a reoccurrence. For example, we were told about an incident of poor moving and handling that had resulted in a serious injury to a person, yet a further member of staff had made a similar error.

We discussed with the manager whether there had been any investigation into the serious injuries that had occurred on the Kingsdale unit and we were told this had still not been done. The manager explained that it was difficult to do this retrospectively due to there being a previous manager at the time of the incidents but who was no longer on site.

The above examples show the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12 Safe Care and treatment as care was not provided safely for people.

We found no concerns with the safety of medicines on the whole, although we noted minor points on some of the units. For example, on the Wharfedale unit, there was only one set of keys for two drug trolleys, so one could not be locked until staff obtained the keys to lock it. On the Airedale unit, staff did not record medicines as they went along and did not always watch people taking their medicine. In other units we saw medicine administration records (MARs) were completed correctly and people reported receiving their medication on time. There were effective protocols for giving medication 'as and when required' (PRN) and staff checked with people whether they needed any pain relief.

We observed premises and in particular bathrooms to be clean with no malodours. Staff used personal protective equipment which we saw was in good supply throughout the site. Staff we spoke with understood how to minimise the spread of infection through appropriate routine cleaning procedures and hand washing, although some equipment was not clean, such as the communal wheelchairs.

Requires improvement

Is the service effective?

Our findings

People and their relatives told us staff had the necessary skills to do their job well. One relative said: "They [the staff] are so good with my [family member] and I really think they understand". Another relative said: "Staff seem to just know what to do with my [family member]. It's not an easy job but they do it well". One person said: "They know what to do and they do it".

Staff told us they felt supported by their manager to do their work and they had regular supervision meetings. The manager told us supervision had previously been 'ad hoc' but there were now systems in place to ensure this happened on a more regular basis. Staff reported feeling clearer about their roles than previously and felt they could discuss their competence with the manager at any time.

Staff knowledge and skills were updated through regular opportunities for training. Staff we spoke with said they felt training was ongoing and they had regular updates to their skills and knowledge for their role. Staff told us they had been given sufficient induction to understand their role and this included shadowing more experienced staff and some experiential learning, such as with the hoist.

We saw the service compliance report showed most staff received mandatory training and where individual staff needed training this was booked and monitored centrally. The home had a trainer responsible for in-house training and the manager told us that where more specialist training was required this was done through specialists, such as district nurses, or in hub training off site. We found the effectiveness of some of the training, such as moving and handling, was not always robust.

There was varied knowledge among the staff team as a whole. Some staff had completed training in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) and they were aware of how this impacted upon their work. However, not all staff had sufficient awareness of this and how to support people effectively. The registered manager was aware of their responsibilities in ensuring the rights of people were protected and was working closely with the local authority to ensure appropriate safeguards were in place.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff demonstrated appropriate understanding of the need to gain people's consent for care and support. For example, staff asked people before assisting them with aspects of their care and people's privacy and dignity was maintained well. Staff we spoke with told us where people could not communicate verbally they used non-verbal cues to establish consent. For example, staff said they used gestures and observed facial expressions to help understand and interpret people's choices.

We saw people received adequate food and drinks for their needs. Mealtimes were organised with staff on hand to support people if necessary. Staff we spoke with understood people's particular dietary requirements and we saw from people's care records that where particular diets were needed, these were provided and people's health was monitored accordingly, such as those with diabetes. People we spoke with were complimentary about the food and said they enjoyed their meals. One person said: "They know what I like and I can have all my favourites". Another person said: "The food is always nice here". Another person said: "I'm never without summat to eat". Relatives we spoke with said they thought their family members' dietary needs were appropriately catered for. One relative said their family member had gained weight and staff monitored this well. We saw on the Airedale unit there was limited choice for people, although people reported a good variation of meals on the whole throughout the site. On the Swaledale unit staff took extra care to ascertain the meal choices of people and there was a flexible approach to make adjustments where people changed their mind.

Requires improvement

Is the service effective?

We found people's health care needs were met and staff referred to other professionals where necessary. One relative told us where their family member needed physiotherapy this was facilitated and their family member was able to regain their independence.

Where people were living with dementia, we saw the environment was not always supportive of their needs. We were told the colour scheme had been chosen with relatives rather than with people and on one unit we saw a large picture of an old telephone box on a door that did not open, which may have caused confusion to some people. We saw whilst people's names were outside their doors, all the doors were the same, which again may not be supportive to a person living with dementia.

We noted not all the bathroom facilities may be suitable for all the people in the units. For example, there was a mixture of standard height toilets and extra height toilets but we did not see any other assistive toileting equipment with which to promote people's independence and support them effectively.

Good

Is the service caring?

Our findings

People said they felt well cared for in all the units. One person said “The staff are really kind and caring here” and another said: “They care”. Another person said: “It needs the right person to do this job and they care about what they do” and a further person said “They look after me well”. One relative said “The staff are so kind” and another relative said “Staff are lovely”. One relative described the service as ‘very caring’. One person said they were new to the home and had been made to feel very welcome, and that staff had taken the time to explain the routine of the day and where everything was.

We saw there were many caring exchanges between staff and the people they cared for. Staff expressed care and concern for people, listened to them and used appropriate gestures, such as hand holding. Staff used smiles and friendly facial expressions when communicating with people. For example, when people had been to the hairdressers, staff complimented them on their appearance.

Staff were discreet and respected people’s privacy when offering assistance, such as with personal hygiene. On the Airedale unit we observed kind and thoughtful communication between staff and people; staff introduced themselves, knocked before entering rooms and asked before carrying out any care interventions. Where people needed extra reassurance, such as with moving and handling procedures, staff made sure this happened. We heard staff spoke respectfully with people and referred to people by their preferred names and frequently asked people if they were feeling alright. On some occasions, however, staff had a patronising tone and spoke at people rather than with them. When assisting people on a one to one basis with meals, staff chatted with people and explained what each spoonful of the food was, although we noted not all staff engaged fully with the person they assisted and on occasion there was no exchange and staff appeared distracted.

At times we noted visiting professionals spoke loudly about a person in their presence and in communal areas, rather than with them or in a more private area. Staff did not challenge this. We also noted that from the driveway/car park, visitors could see directly into people’s rooms and on one occasion a commode was seen from outside, which meant that people’s privacy and dignity may not always have been preserved.

Where people were unable to communicate verbally with us the SOFI observations we carried out illustrated good engagement between staff and people with many positive interactions taking place.

Staff read people’s care plans and knew people well. Some of the staff we spoke with understood there were certain triggers that may upset some people and they knew how to minimise risks of behaviour that challenged others or the service. Staff told us they knew what people’s individual preferences were because they took time to get to know them.

Requires improvement

Is the service responsive?

Our findings

People who could speak with us told us there were not enough activities and sometimes they did not have enough to do. One person said “This is all that happens, not a lot”. We saw variable levels of activity throughout the inspection and on some units there was more activity than on others. On the Wensleydale unit there was a singer, bowling, balloons and bubbles as well as reminiscence books available to people. However, on other units there was little to engage people in a meaningful way.

We saw many occasions where people sat passively in their chairs with little to occupy them. Some people, particularly on the Swaledale unit, were nursed in bed but with little to do. Staff we spoke with said they did not feel there were enough activities for people.

We spoke with the activities coordinator who explained the activities that were provided, but we found these were restricted on a rotational basis around the units, with some units offering the same thing on multiple occasions throughout the week. Whilst there was specific information on people’s files, such as their interests and social histories, this was not used to construct individual or meaningful activities, such as creating personal memory boxes. There was a generic memory box which had items that may provoke forgotten memories. However, this was uninspiring and may not have had any links to anyone living in the home.

There was a lack of facilities for people to undertake activities of daily living for themselves. For example, there were no facilities for people to make their own drinks or use a bath independently. We noted that neither of the units offering dementia care, had any specialist therapy staff.

Care plans we looked at were variable. On the Wensleydale unit we found care plans were detailed and person centred, with good information for staff to be able to provide appropriate care. On other units we saw some care plans were detailed and informative, but others were less so. Where people were living with advanced dementia there were no clear instructions in care plans for staff to manage particular displays of behaviour.

We saw care plans were reviewed regularly although there was little evidence throughout the units of people’s involvement or the involvement or their relatives where appropriate, in discussions about care. We saw some inconsistencies in the recording of information and in some risk assessments, with contradictory information.

People and relatives said they would be happy to approach the staff and manager with any complaints. One relative we spoke with said they had lost confidence in management to address any complaints and matters of concern. We spoke with the manager about this and they showed us how they had tried to help resolve all complaints to the best of their ability, given that some complaints information was from before their time in post. We saw complaints were recorded and responded to.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us they thought West Ridings Residential and Nursing Home was run well. People said they knew who was in charge on each unit and they also knew there was a new manager in post for the whole site.

The manager had been in post since August 2015. Prior to this the service had been managed by a succession of managers that had not stayed for long enough to drive improvement in a consistent way. People, staff and relatives reported positive changes due to the new manager being in post. Staff told us they felt morale was improving and the new manager was approachable to be able to discuss any matters.

We looked at how accidents and incidents were reported, classified and analysed to identify trends and patterns. Of particular concern was that we had been given information prior to the inspection of the Kingsdale unit of two serious injuries to people.

The home had received intensive support from the area manager during and since the closure of the Kingsdale unit and the manager told us there had been 'lessons learned' from how the service had been managed. For example, audits on care plans and medication had begun to place, whereas they had not been done at the time of our last inspection. However, we had significant concern in relation to the serious injuries that had occurred on the Kingsdale unit. The manager confirmed no root cause analysis or investigation into these incidents had yet been carried out. This meant it was unclear what lessons had been learned from these serious events.

This illustrated that the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17 Good governance as there were ineffective systems and processes in place to ensure the quality and safety of the service provided.

We spoke with the clinical service managers who told us 'things had been much better since the new manager started'. They said the manager was visible in the service and we saw the manager was present within the units on the days of the inspection. We were told the new manager was 'open and fair' and included staff in the running of the site, which they said had not happened under previous management. We heard how the manager had an open door policy and we saw they made themselves available to people, staff and visitors.

The manager told us they informally observed staff practice to check attitudes and behaviours that might influence the quality of care, although they did not make a written record of this. The manager described a 'no blame culture' with clear procedures to follow where an incident occurred that may question staff ability.

We saw there were improved systems in place to assess and monitor the quality of the provision. However, the manager was unable to describe or give evidence about how information gathered through audits, investigations and complaints was yet used to drive the quality of the service. Where audits were carried out, action plans were drawn up but these were not always robust or monitored to ensure the identified improvements had been made or sustained. We found there were some inconsistencies in the rigour of the auditing, depending on who had taken responsibility for this. The manager told us there were plans in place to streamline the consistency of the audits.

New systems were in place to capture feedback, such as compliments. However, this system had only been in place since September 2015 and so it was not possible to assess the effectiveness of this.

The evidence we found in relation to assessing the quality of the provision suggested an improving trajectory. We discussed these improvements with the manager who agreed there were still systems that needed time to become embedded in practice.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided safely for people.

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 There were ineffective systems and processes in place to ensure the quality and safety of the service provided.