Bupa Care Homes (CFHCare) Limited

West Ridings Care Home

Inspection report

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17 November 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on 16 and 17 November 2016. The inspection was unannounced, which meant no-one at the service would know we were visiting. The inspection was prompted in part by notification of serious injuries to two people. These incidents may be subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incidents. However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of falls and the seeking of medical treatment. This inspection examined those risks.

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 five units open and 113 people who used the service.

The service had a registered manager in post at the time of our inspection. 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 had a secure understanding of safeguarding and whistleblowing procedures.

Staff's knowledge of how to use equipment had improved since the last inspection and individual risk assessments for people were much more detailed to ensure staff had clear instructions for moving and handling people safely. People were appropriately assessed for equipment and the provider had taken steps to ensure equipment was suitable for people's needs.

Accidents and incidents were recorded and analysed to good effect to evaluate and share where lessons may be learned and practice may be improved.

Staffing levels were sufficient to meet people's needs and there was a reduction in the use of agency staff and staff being called from one unit to cover staff absence in another unit. Where a hostess was deployed this was positive and supportive of people's dietary needs.

Systems were more robustly in place than at the last inspection to assess and monitor the competency of staff.

Training had improved and was more specific for staff to be effective and work safely, such as moving and handling. Staff knowledge of what was meant by people's mental capacity and deprivation of liberty and processes they may need to follow where a person lacked capacity had been enhanced through training.

Staff were very caring and respectful in their interactions with people. People's privacy and dignity was

promoted well.

Assessment of people's needs in care records was clearly documented.

There were many meaningful and interesting activities that supported people's interests. The environment throughout the site had continued to improve since the last inspection and was more welcoming and homely.

There was more rigorous and regular quality monitoring throughout the site and the registered manager had a clear oversight of the strengths and areas to improve. Communication between units had improved which resulted in more cohesive teamwork at all levels.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found there was significant improvement to take the provider out of special measures.

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.
Risk assessments were in place and detailed, although there was some conflicting information in records seen on the Calderdale unit.

Two serious incidents had occurred since the last inspection, although information from accidents and incidents was shared with staff to encourage future learning and develop safer practices.

Equipment for people was suitable and available to meet their individual needs.

Is the service effective?

Good

The service was effective.

Staff training was more robust and staff competence was routinely checked to ensure they had the necessary skills and knowledge, particularly with moving and handling.

Staff understood how to support people where they may lack mental capacity.

People enjoyed the meals and there were regular opportunities for people to have drinks and snacks. Special diets were known and managed well by staff.

Is the service caring?

Good

The service was caring.

There were many sensitive, caring and compassionate interactions with people throughout the whole service.

People's privacy, dignity and independence was promoted well.

Staff understood people's needs and promoted their rights.

Is the service responsive?

Good

The service was responsive.

There were many activities to enable people to be purposefully engaged according to their interests.

Care was person-centred and staff understood people's individual needs.

Complaints were acknowledged, responded to and recorded adequately.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were improved systems to assess and monitor the quality of the provision, although there were some weaknesses in the oversight and management of risk on the Calderdale unit.

New systems were in place to identify and share lessons to be learned from serious incidents and to improve practice as a result of these.

Communication had improved across the site and there was a clear structure for sharing information.

West Ridings Care 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 on 16 and 17 November 2016 and was unannounced, which meant no-one at the service would know we were visiting.

The inspection was prompted in part by notification of serious injuries to two people. These incidents may be subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incidents. However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of falls and the seeking of medical treatment. This inspection examined those risks.

Five adult social care inspectors carried out the inspection. Prior to the inspection we reviewed information from notifications, liaised with local partner agencies including the local authority and the Clinical Commissioning Group (CCG).

We spoke with 25 people using the service, eight of their relatives/friends, two visiting professionals and 14 staff. We carried out observations of people's care and reviewed 16 care records. We looked at documentation relating to the running of the home.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe. One person said:" I definitely am safe in here". Another person said: "Course I'm safe, no worries about that". Relatives we spoke with said their family members were safe at West Ridings. One relative said: "I do feel my [family member] is safe, yes. I wouldn't want them anywhere they weren't safe". Another relative said: "It's safer for my [family member] to be here than in their own home, that's for sure, and there's peace of mind".

Staff understood the action to take to ensure people were protected from harm and they knew the safeguarding and whistleblowing procedures, which were accessible around the home.

Staff we spoke with said they would confidently raise concerns with managers to ensure people were safe. One member of staff said, "We've got a duty of care" and if they found any concerns they would 'take it higher'.
Staff were able to describe the steps they would take to prevent and identify pressure care concerns. Where people had sustained skins tears we found action taken for the person was detailed, although there was limited information about any investigation into the cause or whether particular equipment had been checked.
Procedures were in place for staff to support people with emergency evacuation and we saw personal emergency evacuation plans (PEEPS) identified people's level of mobility and the support they needed to evacuate safely, including the equipment and method needed.

The registered manager told us they were confident many systems and processes had been established since the last inspection to learn from previous incidents and ensure people's safety. We found high priority had been given to meeting the requirements of the regulations in relation to safe care and treatment.

We found the registered manager had a much better overview of the risks in each unit than at previous inspections. This was because there was improved communication around risk identification and management in each unit and across the site. Most risk assessments for individuals were clearly detailed to give staff precise instructions, such as for the use of bedrails and for moving and handling people safely and these were known by staff. Where people were at high risk of falls there were detailed records of how this was monitored, although not all falls on the Calderdale unit were recorded on the falls log.

Staff we spoke with said they checked for environmental factors when considering people's risks of falls, although we noted on the Calderdale unit, where there had been a high incidence of falls, some people had no shoes or slippers on and were wearing only socks. One member of staff we spoke with said people sometimes removed their own slippers and shoes.

People were individually assessed to use equipment and there was a wide range of equipment available to meet their needs. Additional seating had been obtained to support people's needs, although we noted on the Calderdale unit one person had poor posture as their chair was too low for them and the table was positioned to their left, which was not suitable to meet their needs.

Equipment to support people with moving and handling had been obtained so that slings were for personal use and not shared with others. Staff knew how to use equipment and most people's risk assessments and care plans had sufficient detail to give staff clear instructions for moving and handling people in the safest way. Where hoists were used to support people, details of the hoist and the type of sling were included in the person's care plan. However, we noted some discrepancies on the Calderdale unit on one person's care plan for moving and handling; the mobility plan identified a large sling, yet the risk assessment stated a medium sling. Also on the Calderdale unit, where one person's mobility was variable this was not clearly documented. For example, on days when they did not need the hoist, there was no clear detail as to how they needed assistance. We discussed this with staff who said they would re-write the care plan.

We observed improved practice with moving and handling; staff supported people safely with clear explanations and reassurance so people felt safe. For example, we saw when staff were going to move one person who used a wheelchair, they sat and spoke with them at face to face level, discussing what they needed to do and how they could do this before they moved the person. They ensured the person had their feet on the footplates and explained why and made sure the chair the person was moving to was prepared with the pressure cushion in place.

Staff we spoke with said their competence in using equipment was regularly checked by managers. Unit managers said there was more detailed information for staff to know how to use equipment safely and there was clearer accountability for incidents and accidents on each unit, with better communication and governance in place.

We saw accidents were recorded in more detail with an account of the action taken by staff to ensure people received appropriate attention and treatment. Soon after the last inspection there had been two incidents in which people did not receive prompt medical attention and had suffered harm. The registered provider had significantly improved their procedures to ensure clearly documented decisions following further lessons learned from these two incidents and we found there was much more robust recording implemented since these occurred. Furthermore, there was discussion and information sharing between all the units to enable other staff to consider how practice could be improved following incidents and accidents.

Prior to the inspection the registered manager had notified us of some temporary staff shortages on two occasions and they had shown the measures taken to minimise the risks and ensure continuity of care for people. They assured us staff shortages were 'not the norm'. Staffing levels were observed to be adequate to support people who used the service. Movement of care staff between units to cover staff absence had reduced, as had the number of agency staff.

At this inspection visit we saw there were enough staff to be able to respond promptly to support people. Many people who used the service, their relatives and staff reported they had no concerns about the levels of staffing available since the last inspection. For instance, the people we spoke with on the Swaledale unit and their visiting relatives told us there were enough staff to meet people's needs. One person said, "You couldn't ask for better. They answer the buzzer efficiently. You don't have to wait long." One person's relative said, "There are enough staff and they are able to spend time with people." People told us that most staff, including the nurses had been working in the service for a long time and knew people's needs and preferences well. However, one relative on the Calderdale unit told us they did not feel there were enough staff, particularly at weekends. Another relative said sometimes staff only had time 'to do the basics' and it 'depended how people were behaving as to how the staff managed'.

Staff we spoke with said there had been some improvement in the deployment of staff since the last

inspection, although they said there were staff shortages at times. For example, the medicines round sometimes had to be interrupted if staff were needed to support people with care tasks. The registered manager told us staffing numbers were sufficient because of the reduced occupancy in the home and said if people's dependency needs meant they required more staff this would be addressed. The registered manager told us senior care staff were employed to support registered nurses. They told us: "I won't run short staffed".

One unit manager (Swaledale) said that people's choices about such things as whether they wanted to get up or to have breakfast in bed were taken into account in the way staff were deployed and were a feature of the staff handover each morning. They said the registered manager was responsive regarding the staffing available in relation to the numbers of people in the unit, and their level of dependency. They said that staffing numbers could be increased quickly, if there was a need.

The registered manager told us there had been no new staff recruited since the last inspection and they were mindful to ensure any further recruitment would be robust and new staff would be thoroughly vetted. Staff's competency checks were carried out with greater regularity to ensure safe practice.

We looked at the systems in place for the receipt, storage and administration of medicines in the home. We saw medicines were stored appropriately and safely, and temperatures of storage were monitored and clearly recorded. The refrigeration temperatures were also consistently recorded for medicines that needed to be kept refrigerated. This meant medicines were kept within the temperature range recommended by their manufacturers.

The service used a monitored dosage system. This meant that most tablets were dispensed by the pharmacy in separate 28 day, 'bubble' packs. Each person's medicine record included information about any allergies they had and photographic identification.

We observed a nurse administer people's medicines on Swaledale and the unit manager on Calderdale, who was also a qualified nurse. We observed both staff members gave people their medicines safely and provided a drink for people to assist people to swallow their tablets. They took time to make sure people had taken their medicines and were patient in their approach, gently explaining and encouraging people. Where appropriate, they asked people if they had any pain and whether they required pain relief. On the Wensleydale unit we saw staff supported people living with dementia to take their medicines; they spoke with people at their line of sight to address and encourage them to take their medicines. Staff only signed the medicine record once they had seen the person take it.

There was an effective system of ordering medicines. This ensured the correct medicines were available for people. Labels were used to show when medicines had been opened, and where they had a limited lifespan, a 'do not use after' date. Medicines that were no longer required were listed and disposed of appropriately. Controlled drugs (CDs) are prescription medicines which are controlled under the Misuse of Drugs legislation, as they have a potential for abuse or addiction. We saw two staff signed the record when any CDs were denatured (rendered harmless and unfit for use). However, we saw records where only one staff member signed to say they had disposed of other medicines. We discussed this with the registered manager who agreed that it would be best practice for two staff to be present when medicines were destroyed.

Information about medicines was available along with a copy of the relevant policies and procedures. The staff we spoke with had received appropriate training. They confirmed that when they started administering and managing people's medicines, and periodically after that, they were assessed to make sure they were competent. We saw that there was an up to date record kept of all staff who administered medicines.

There were a small number of people who were given their medicines covertly and we looked at the records of one person who was given their medicines in food. There was evidence that the decision being was made in the person's best interests, and with the involvement of people who were close to the person, such as their close relatives. There was evidence that the person's GP had been involved, and detailed guidance had been provided by a pharmacist. The pharmacists had provided guidance on issues such as which medicines could be safely crushed, and the effects of mixing them with food or drink. Other options, such as liquid medicines had been considered.

There was some guidance for staff about how to administer the person's medicines in food. However, this was limited, and only referred to their breakfast dose. The guidance did not include information about the medicines the person was prescribed at other times of the day. There was no guidance about methods staff should use to monitor and record whether the person received the full dose of their medicines, and any risks to other people who used the service had not been taken into consideration. □

There was guidance for staff for people's ointments and creams. This included a body map to show where these should be applied.
As required (PRN) medicines included protocols for staff, with guidance on the maximum dose that people should take in a 24 hour period. This guidance included indications for use, such as 'for pain'. In some cases this included details of how people who relied on non-verbal communication usually expressed pain. However, this level of detail was not always included in people's protocols or in their care plans. On the Calderdale unit it was evident that audits often highlighted the need to provide protocols regarding people's PRN medicines, as repeatedly, these were not put in place in a timely way.

There were checklists that staff completed when they had finished administering people's medicines, to make sure they had considered aspects such as whether they had had completed the correct records if anyone had refused their medicines, or if there were enough medicines available for the next 48 hours. Regular audits were undertaken to make sure staff had appropriately followed all policies and procedures regarding the management of people's medicines. Any errors and omissions in administering or recording medicines found were noted and, remedial action was taken. We did note that the monthly audit format included space for action plan and for actions to be signed off when completed. However, the weekly audit format did not provide this, which made it difficult to monitor if actions highlighted in the weekly audit had been completed.

There were also systems to ensure that any learning regarding medication errors was shared throughout the service to help to improve practice and prevent similar events in the future. For instance, the regular clinical walk round checklist included reference to any medication errors to ensure they were discussed by the nurses. However, this was not provided in the format for the weekly clinical risk meeting.

The units were visibly clean and smelled clean and fresh throughout. Infection control procedures and prevention measures were robustly in place and the staff we spoke with and observed had a good understanding of the risks and how to minimise the spread of infection. There were good stocks of personal protective equipment (PPE) and we saw staff used this appropriately. One staff member told us they were an infection control buddy. This meant they showed new staff practical methods of preventing the spread of infection in the unit.

Good

Is the service effective?

Our findings

People and relatives told us staff had the necessary skills for the work they did. One person said: "The care staff are good lasses. They come through the night, open the door and see you're alright". Another person said: "They do know their job, they know how to deal with me I'm sure of that".

We spoke with the home's trainer and one of the clinical service managers (CSM) about the training. The home's trainer told us training had improved to ensure a safe system of work with regard to moving and handling. They said the practical moving and handling training was specific to people's needs and training was evaluated at the end of each session. The training included how to complete the moving and handling care plan and information about different types of slings. They told us documentation covered all the equipment people needed, such as bath seats, stand-aids, lap belts, handling belts and wheelchairs. Staff were shown how to check equipment each time it is used and the importance of this was emphasised during training. The trainer and the CSM told us unsafe moving and handling techniques would not be tolerated and staff's competence was regularly assessed.

Staff said they enjoyed the training they did. One staff member told us they had received training in all of the core subjects during their induction. They said, "We have our own trainer. He gave us moving and handling training, and showed us how to do it safely." Staff we spoke with said they felt more confident with safe moving and handling procedures in relation to people's individual needs. Another member of staff said they had a thorough induction which comprised four days training, some of which was face to face and some e-learning. They had then shadowed experienced staff for two weeks and said, "The first few months was always well supported". Another member of staff said they had done five days training and had 'really enjoyed it'. They said training showed them how to use equipment, which they found 'really useful'.

Staff told us they received regular supervision and had meetings with their manager to discuss their work and their development. Some staff told us they felt supported to undertake further training to enhance their role, although some staff felt there were fewer opportunities within the organisation for professional development, other than updating refresher training as required.

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).

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 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.

Staff we spoke with understood the legislation around people's mental capacity and human rights. One member of staff said this was 'to protect and empower people' and they understood the requirements of the MCA. Care staff told us they assumed people had capacity unless they had concerns, in which case they would refer to their line manager so this could be assessed further.

One unit manager (Swaledale) told us that no one had a DoLS in place, although a DoLS application had been made for one person and they awaited the outcome. We saw a best interest decision had been made about one person having bedrails to stop them from falling out of bed. This had involved family members and other appropriate professionals involved in the person's care.

Care records showed where best interest decisions had been made with people and other relevant parties, for specific decisions around the use of equipment such as wheelchairs and sensor mats. It was not always clear from care records, where people's family had power of attorney to make decisions on their behalf.

We found the records for MCA were misleading; for example a capacity assessment was done for all decisions on the front page and there was a list of decisions on the second page, sometimes lacking capacity and sometimes variable. We discussed this with the registered manager who agreed this information would be made clearer.

We saw continued improvement from the last inspections in the environment for people, particularly for people living with dementia in the Wensleydale unit and further improvements were ongoing, with a homely feel to the units. Staff were enthusiastic about the improvements made.

All units were clean and nicely decorated. The bedrooms and shared areas were light and airy and, chairs were arranged in clusters in the downstairs lounges, so people had a choice of where to sit. There were areas where people were spending time with their visitors. The signs, such as those for people's rooms, toilets and bathrooms were clear and people had 'memory boxes' by their bedroom door for pictures and other items that they liked and identified with. This helped people to identify their rooms. There was a large, easy to read calendar displayed in the lounge in Swaledale. There were pictures and memorabilia, as well as the artwork people had produced displayed throughout Swaledale and Calderdale units. The service was suitable for people who used wheelchairs and there were adaptations such as handrails, which helped to meet people's needs and promote their independence.

The tissue viability nurse told us the staff followed the guidance provided by them, as an external professional, and the standard of care provided was good, which prevented people from developing pressure sores. The unit manager from the nursing unit told us that it was exceptionally rare for anyone to develop a pressure sore in the unit and that it had been a long time since that had happened. They said this was because all staff were very vigilant about repositioning people, which provided a very good standard of preventative pressure care, together with ensuring the correct equipment, including good quality mattresses were in place. They added that staff placed a lot of emphasis on making sure people had good hydration and a good diet, and referrals to external healthcare professionals were made in a timely way.

People enjoyed the food and mealtimes were sociable occasions; tables were set appropriately for meals with flowers, napkins and condiments. People were supported individually with their meals where necessary and staff interaction was attentive and person centred. Where people sat to the tables we saw they were

supported and assisted as required. Choices were promoted well and people were offered an alternative if they did not want what was on the menu. We saw the food service was efficient so that people did not have to wait very long. Second helpings were offered where people had good appetites and where people needed encouragement staff did this in a respectful way. We noticed the pureed food for some people was not visually appetising.
Specialist equipment, such as adapted cutlery and plate guards was provided where people needed support to retain their independence.

Staff knew people's preferences, such as who preferred smaller portions, or who did not like a particular food. One person asked for toast instead of dessert and staff made this straight away. People's comments included: "I enjoyed that very much", "Lovely, thank you", "Grand, that was" and "I'm full up til tomorrow". One person told us: "The food here is top notch. I've put weight on since I moved here". We heard one person singing happily after they had eaten their main course and they chose to eat dessert in the lounge, which staff facilitated. We saw the cook visited the units and checked people's preferences and satisfaction with the meals, particularly where a catering alert identified they were at risk of weight loss.

People's dietary needs were recorded on their care plans, along with appropriate risk assessments to support their nutrition and hydration. Where people required special diets, there was detailed information about the consistency of their food and drinks along with advice and strategies for their nutritional support. Weight management was recorded in people's care plans with evidence of regular weight checks and additional care plans where there were concerns. We saw people's diet and fluid intake was recorded where there were concerns. However, on the Calderdale unit we found these records were not updated in a timely way and staff relied on their memory some hours after people had been offered food and drink, to record what they had, which questioned the accuracy of this monitoring.

Snacks and drinks were regularly offered and we saw fresh fruit was accessible to people in the units. We saw the hostess asked people's preferences, although they told us they knew what people liked but it was important to offer choices. We found there was a lack of clarity on the Calderdale unit regarding how much thickener one person required in their drink to support them with their swallowing and information recorded was inconsistent.

One unit manager told us a dietician had helped the cooks devise recipes for high calorie shakes for people, as an alternative to prescribed dietary supplements. They said these were lovely and included flavours like Pina Colada.

We saw evidence in people's care records of referrals to other professionals for additional advice and support. The home was working closely with the Vanguard initiative in Wakefield. This initiative has been drawn up to improve care standards in care homes by a range of measures, one being increased access to the wider multidisciplinary team and enhanced pathways to primary care. The registered manager told us the Vanguard support had been invaluable in the home and attributed some of the improvements made since the last inspection to the input from the Vanguard team working collaboratively alongside West Ridings staff. For example, they had offered support with seating assessments for people and ensuring equipment was suitable for people's individual needs.

Other professionals involved in people's care were clearly documented in care records, such as GP, district nurse, chiropodist and opticians.

Good

Is the service caring?

Our findings

The people we spoke with said the staff were caring and they felt happy and settled. One person said, "This is home." Another person told us: "It's perfect here" then said to a member of staff: "Giz a love", whilst hugging them.

The relatives we spoke with said the staff were caring. One relative said that the staff were very thoughtful of their family member's feelings, saying, "I have no concerns at all about the care here. You couldn't get any better for personal care." They added that staff were always welcoming, saying, "They [staff] are always patient with the grandchildren when they visit, and get toys out for them to play with." Another relative told us: " Staff seem to be very kind". They said staff supported their family member's dignity and told us: "There's never any food around [my family member's] mouth" and said: "Staff interact well with [people]". Another relative said: "Can't fault the caring".

When discussing maintaining people's dignity with staff, one staff member told us that they knocked on people's doors before entering and always explained and asked for their consent before providing any care. They said, "I treat people as I would my own parents." We saw staff were mindful of people's dignity during moving and handling procedures and they helped to adjust people's clothing when they were hoisted. Following day one of our visit, we left the home after dark and we noticed from the car park there was a clear view into some people's bedrooms, which had potential to compromise their privacy and dignity.

Staff demonstrated sensitivity and kindness when people felt upset or lonely. We saw one care staff approach a person who was crying and asked them what was wrong, gave reassurance and asked whether they were in any pain. The person said they did not feel well and we saw records later on which showed health observations had been carried out and a doctor's visit requested. We saw another member of staff supported a person to have a drink and stroked their hand. When staff supported people to move around the room, they did this with patience at an appropriate pace.

We saw one member of staff passed a telephone message to a person from their relative and there was a calm and caring exchange of information. Another member of staff held the hand of a person who said: "I'm not quite with it this morning" and gave them reassurance about their well being.

Staff respected people and were polite in their interactions with them. For example, we saw a member of staff had to briefly leave a person they were supporting with their meal; when they returned they apologised.

People told us that their religious beliefs were respected and one person said they had organised prayers themselves, with staff, for Remembrance Sunday. They said there had been no visiting minister from the Church of England for a while, but a new vicar was due to start in January. They added that, in the meantime, if they wanted to go to church this would be facilitated. They also told us a Catholic minister often visited the home.

Staff were sensitive about providing end of life care. One unit manager told us a person had come to the

home for end of like care but 'perked right up' and was 'nursed back to health'. Another unit manager told us a person had 'bounced right back' from end of life care.

Some people's care plans were in need of updating, as they included outdated language and terminology when referring to people who were living with dementia.

Good

Is the service responsive?

Our findings

One person told us, "Staff here are really good, they look after me; I feel safe and cared for. I like my room, it's comfy and I have everything I need here". Another person said: "I get the paper every day. I like to know what's going on in the world". Another said: "We like bingo in here, we win lots of snacks". Another person said: "The girls here are marvellous; they look after me wonderfully well".

People's relatives said they were involved in their family member's initial assessment and in regular reviews of their care. They said staff were responsive to their family member's needs. One relative said: "Staff are amazing" and said staff did more than was required of them. Another relative gave praise for staff attitude. One relative said: "They're quick to ring me up if they've any concerns".
We saw staff responded promptly to people's call bells and there was little delay in meeting people's needs. On one occasion we saw a person requested help and a member of staff attended, but the person needed two staff so the member of staff waited with the person until their colleague came.

Staff chatted with people as they passed, and spent longer periods of time talking about local history, what music people wanted to listen to and who was coming to visit them. There was evidence of good relationships between people and staff, and friendships between people in the home.

On the Calderdale unit we noticed some people who were seated in chairs were not supported to move from their chairs. Staff attempted to encourage two people to get up to the table for lunch, but the people were reluctant and so staff did not try again. One person we observed had been in their chair from morning until afternoon; this person was vulnerable to skin breakdown and we discussed this with the nurse in charge and the Clinical Services Manager as they had not been asked to move. We found upon speaking with one member of staff they required training in understanding the care plan for this person and how to support their moving and handling needs.

People told us there were plenty of activities that they could be involved in. For instance, one person said, "Activities wise, we have good variety, including carpet bowls. Another person said: "There are things going on but I like to watch my television mostly. I like to watch [named television show] most, it's funny, makes you feel good about yourself seeing the people on there. I have visitors; I look forward to their visits". One person showed us the Christmas calendars they had been making with one activity coordinator. One relative said, "[My family member] enjoyed the singer who came recently and the manicure." Other people spoke about a German market, music, hand massages and a tea dance. Where people wished to smoke, we saw staff facilitated this in the designated areas. People we saw smoking outside were suitably dressed for the weather and had coats and blankets.

We saw the activities staff interacted with people in a meaningful way. For example, we observed people looking at pictures, engaging in conversation and joining in with games, such as dominoes and a ball game. As well as engaging people in activities in the main lounge, we saw that the activity coordinator gave time to people who were in their rooms, chatting and reading to them, to make sure they were not isolated. Where one person appeared to be confused, the activities staff noticed and said: "Do you want to sit with me?" We

saw there was a baking activity and all people were included equally. This prompted discussion and reminiscence about baking and people recalled their memories.

We saw records detailed the activity coordinator's contact with each person each week, in group and individual activities. People's individual profiles included their family tree, hobbies and preferences. The weekly activity schedule included an entertainer, 'move and groove', baking, craft corner, pampering and nail care, pulse exercise and a mobile library.

Staff were attentive to people's social needs and supported them with activities, such as completing word-searches, jigsaws and reading. One person said they needed their glasses and staff immediately went to get them. Staff told us activities had improved and they felt they had more time to sit with people and understand their social and emotional needs as well as provide physical care.

Everyone we spoke with spoke particularly highly of the hosts and hostesses, whose role it was to support people's mealtime experience. One person said, [Named host] is fantastic. So pleasant all of the time, knows everyone inside out, and knows exactly what they like." This was echoed by many people who used the service, visitors, staff and managers.

We saw there were many more resources for people to engage with and these were used well. There were photographs of the old local area displayed for people to see. We saw a board with details of the day, date and weather to help orientate people who may be confused, although we noticed not all clocks were showing the right time. We saw memory boxes were on loan from a local library to encourage people to reminisce.

Care plans were mostly detailed and evaluated regularly and there was evidence that people, or their families where appropriate, had been involved in discussions about their care. However, some care plans we saw lacked information. For example, on one person's care plan new information was documented, although the original care plan remained which may cause confusion to new staff because the care plan said they were incontinent, but other details showed they had a catheter. The catheter care plan was in place, but there was also the original plan which showed they were incontinent. Another person's care plan stated 'uses commode' yet this had not been updated to show they used continence pads. On the Calderdale unit we noted some incidents were not consistently recorded. For example, we saw a fall recorded on a person's body map, but not on the falls log. Another person's body map showed a skin tear, but no reference to this in the daily log. The registered manager told us there was to be training on care plans carried out by the admiral nurse, to support staff's understanding. An admiral nurse is a registered nurse who has significant experience of working with people with dementia.

Daily records were detailed and gave clear insight into people's presentation and how they spent their time. These were seen to give an up to date overview of people's day and provided useful information to staff as well as being available to other professionals if necessary.

Newsletters were available to people and relatives as well as information about Vanguard support and health information. Relatives told us communication from staff about their family members had not always been as regular as they would have liked and we found from records there had sometimes been delays in families being notified of incidents. However, this was being addressed and the registered manager told us this was an area they were working on, to improve communication with relatives. Resident and relative meetings showed actions taken in a 'you said, we did..' format.

People and relatives told us what they would do if they needed to complain and all said they would

approach either the unit manager or the registered manager. We discussed one complaint that had been made, about a staff member not responding to one person's buzzer in a timely or considerate way. It was clear that action had been taken to address the concern, to the complainant's satisfaction. Where complaints had been made but not yet resolved, we saw evidence of the registered manager's response and action taken to date. Some people told us where they had made a complaint they were confident the registered manager would deal with this effectively. Compliments were also recorded and shared with staff.

Requires Improvement

Is the service well-led?

Our findings

One person's relative said they felt the service was, "Excellent." They told us they felt involved and informed and they had attended relative meetings. Another relative said: "They are trying to improve things". Another relative said: "After the last CQC inspection they've made lots of effort".

The registered manager had been in post since August 2015 and their registration with CQC had recently been completed. The registered manager was visible in the service and had an overview of the quality of the service delivery. There had been some changes in one of the post holders for the clinical service managers (CSM) and the service had been temporarily without someone fulfilling this role, although a new CSM was in post at the time of the inspection. We found there had been some gaps in the notifications sent to CQC; we discussed this with the member of staff responsible for sending these and they said the omissions had occurred when there was disruption to the CSM posts, but gave assurances of consistent reporting since then.

Many staff we spoke with said the registered manager and their management team worked very hard to improve the service. For instance, one staff member told us the registered manager went around to each unit every day and there were daily handovers of information between staff. They said, "We talk a lot." One unit manager said, "We have all worked hard since the last inspection, on improving our systems of communication. Everything is more open and we are better at learning from mistakes". They told us that each unit manager had weekly meetings and the registered manager had held meetings with care staff to improve morale and reinforce good practice. Another unit manager said: "Everyone has worked hard to improve things".

We were told that there were 'champions' for areas such as medication and weight. Champions are staff members who have extra responsibility and training in a particular area. They sign up to act as a good role model, and to educate and inform all those working around them, in order to promote good practice in people's care.

One staff member told us, "I really enjoy my job. The manager is very good and I get good support." Another member of staff said: "[The registered manager] expects high standards". Another member of staff said: "The staff team is really good; we work well together and there's a lovely atmosphere". However some staff said they did not find the registered manager approachable, although felt very well supported by the unit managers.

We found the management team had made some efforts to improve the culture in the home and encourage communication. For example, the registered manager's open door policy was reinforced and there was evidence of increased transparency with regard to sharing learning from incidents and improving practice. We saw reflective discussions had taken place following incidents and lessons learned had informed plans going forward. These discussions took place at unit level and across the site. The registered manager told us they felt there had been significant improvements to governance since the last inspection and said: "I've got structure now".

We saw there had been weekly governance meetings introduced, to analyse what had happened each week, unit by unit and analyse any incidents. These were documented in a governance file on each unit. This file included all communications, such as 'take 10' meetings, health and safety issues, alerts, incidents and staff competency checks. If an incident happened on a particular unit, this was communicated via a 'West Ridings alert' to all units so that everyone could learn from what had happened, as well as group supervision meetings for staff concerned. In addition, there was a 'message of the month' with topical information, such as 'gaps in turn charts', 'seeking medical advice' and 'answering buzzers'. Staff we spoke with confirmed this and told us it helped them feel more in touch with what was happening across the whole site. We saw an example of such an incident that had been shared with all units, in relation to poor moving and handling that was addressed. Where training needs were identified, the registered manager told us 'toolbox talks' were being arranged for staff. For example, where a person had sustained a skin tear, talks were being arranged around how to support people's skin integrity.

Audits were clearly documented in most units and were identifying and reporting risk appropriately. However, there were some gaps in the practice and recording on the Calderdale unit and the identification and management of risks and quality was not always robust. For example, there were inconsistencies in the recording of risks within care records on this unit and the format for recording falls was not consistently implemented.

The registered manager told us how they had worked closely with the local authority safeguarding team to discuss recent concerns and look at ways to improve the quality of the provision and reduce risk. They said they welcomed input from other professionals, particular those from the Vanguard team and they were happy for Healthwatch Wakefield to make a visit to the home.

We noted significant improvements in the leadership and management of the home since the last inspection, with evidence of more cohesive working between all the units and a more robust oversight of the quality of care overall. The registered provider had given clear focus to addressing the issues highlighted through previous inspections, and although it was too soon to assess at this inspection whether the improvements made would be sustained, there was a real commitment and motivation from the managers and staff to continue to improve.