Advinia Care Homes Limited

West Ridings Care Home

Inspection report

Off Lingwell Gate Lane
Lofthouse
Wakefield
West Yorkshire
WF3 3JX

Tel: 01924826806

Date of inspection visit:
15 April 2021
21 April 2021

Date of publication:
05 July 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
West Ridings Care Home is a residential care home with nursing, for up to 180 people across six separate units. However, one unit, Kingsdale, has not been used since 2015. There are two units which provide nursing care, Swaledale for general nursing care, and Calderdale for people living with dementia. The Wharfedale and Airedale units provide residential personal care and the Wensleydale unit provides personal care for people living with dementia. At the time of the inspection there were 102 people using the service, although two people were in hospital.

People's experience of using this service and what we found
People said they feel safely supported overall. Relatives said they felt practice was safe. Staff understood safe ways of working, although care plans did not always provide enough guidance for staff to understand risks to individuals. People's needs were met in a timely manner during our inspection; staffing levels were adequate although deployment of staff was not always effective. Staff had a good understanding of safeguarding procedures and were encouraged and confident to raise issues of concern.Safe systems of recruitment were followed to ensure staff were suitable to work with vulnerable people, although checking of registered nurse status needed to be more robustly recorded.

Infection prevention and control practices to prevent the spread of infections were variable. The units were visibly clean throughout, with additional cleaning being completed as a result of the COVID-19 pandemic, although there was a lingering malodour in the Wensleydale unit. Whilst there were many aspects of good practice, the occasional wearing of PPE, such as face masks was not in keeping with up to date guidance. Some equipment was also in need of thorough cleaning and when we brought this to the attention of staff this was immediately addressed.

There was evidence of improving training with clear systems and processes in place to track training requirements, inform individuals and unit managers when training was due. The resident experience manager had oversight of these processes to enable staff to have the knowledge and skills to support people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Since the last inspection, the provider had taken steps to improve the unit leadership and governance by making the unit managers supernumerary, supported by Clinical Service Managers. In addition, there was a new Regional Director coming into post. There was a clear governance structure at corporate level, but improvements were needed to assure quality at the level of each individual unit.

Accidents and incidents were reviewed to ensure appropriate action had been taken and there was a clear

process to trigger further investigation of incidents. Analysis of incidents was completed although this needed to be more robust to show clear actions, rather than recommendations.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
The last rating for this service was requires improvement (published 27/01/2021).

At this inspection the provider was in breach of regulation 12, Safe care and treatment. This was because there were weaknesses in the identification and management of some risks. Although new systems and processes were being introduced to improve the quality and safety of the care provided, these were not yet embedded in practice. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections, although there were encouraging signs of improving quality.

Why we inspected
This inspection was prompted in part due to concerns received about infection prevention and control, staffing levels, medicines, managing risk and the management and governance of the service. A decision was made for us to inspect and examine those risks. We found evidence during this inspection that people were at risk of harm from some of these concerns, however we did not find evidence that harm had occurred.

This report only covers our findings in relation to the key questions Safe and Well-led which contain those requirements and concerns. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained the same as requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement, although improvements were in progress and being developed. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for West Ridings Care Home on our website at www.cqc.org.uk.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority and CCG to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

West Ridings Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

The service previously had a manager registered with the Care Quality Commission, however they had left the service in September 2020. A new home manager is in post with support from the regional support manager until such time as their registration with CQC is complete. Once registered, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by four inspectors, a medicines inspector, specialist advisor specialising in governance 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 care service.

Service and service type
West Ridings Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced. Inspection activity started on 13 April 2021 and ended on 3 June 2021. We visited the home on 15 April 2021 and 21 April 2021.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and health commissioners. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 17 people who used the service about their experience of the care provided. We spoke with six relatives on the telephone. We spoke with the management team as well as 10 members of care staff, the domestic and activities staff. We reviewed a range of records during and after our visit to the home. This included six people's care records and five electronic medicine records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training and supervision data, staff rotas, premises safety checks, quality assurance records and audits.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and assurance about safety needed improving. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risk assessments were sometimes conflicting or inaccurate, and at times lacked sufficient detail for staff to understand how to support people safely. For example, one person's moving and handling care plan stated they needed a large body sling, but this was not correct for their petite size. Where there was a risk of constipation, this was not always clearly monitored. There was some contradictory recording around mobility needs and guidance for staff. For example, records stated 'staff to assist as and when' but this was not clear enough information for staff to understand how to support the person safely.

● Where people were at high risk of falls, staff understood this and made sure they had easy access to equipment, such as walking aids. Falls diaries were used, but these were not consistently completed.

●Risks to people's health in relation to their food and fluid intake were not sufficiently monitored. On the Swaledale unit there were no systems in place to ensure people had eaten their meals/been offered a drink and there was a risk some people may have gone without.

● Where people were at risk of weight loss there was a lack of close monitoring of actions, such as offering snacks.

● People said they were safely supported overall. Relatives said they felt practice was safe. One relative told us, "I am reassured [my person] is safe, much safer than when they lived at home. I have peace of mind." Another relative said, "The staff are always there and they understand [my person] is at risk of falling. They [staff] take really good care of [person]."

Using medicines safely

● There were clear, comprehensive medicine policies and procedures, although these were not always followed. Medicines were not always given at the right time and PRN (as needed) medicines were not safely managed on the Wensleydale unit.

● The electronic medicines administration record (eMAR) system was not programmed to prevent unsafe intervals between doses.

● There was a lack of organisation of medicines ordering on the Wensleydale, Calderdale and Swaledale units.

● Medicines were mostly stored securely, although with the exception of controlled drugs (CDs) on the Swaledale unit, where the CD cabinet did not meet the Misuse of Drugs safe custody regulations.

● Staff interaction was positive when supporting people with medicines, with explanation about what their medicine was for. People said they were supported well; one person said their medicines were given "as regular as clockwork" and one relative said, "They know [my person's] medicine and when they need it."

Preventing and controlling infection

● Infection prevention and control practices needed to be more rigorous. Some wet wipes had dried out and there was a lack of hygienic storage of slings. Personal belongings were left in a bath on the Calderdale unit. Taps in wash hand basins were difficult to operate and required them to be continuously pushed down for water to come out; this prevented people from easily washing their hands.

● Although most staff used PPE effectively and safely, some staff occasionally wore their face masks incorrectly, or touched them without replacing them.

● The premises were visibly clean and well ventilated, although we noted a lingering malodour on the Wensleydale unit. Regular cleaning regimes took place on each unit and cleaning staff understood their responsibilities in helping to prevent the spread of infection. Furniture was positioned to encourage social distancing.

● Some equipment was not clean and oversight of the quality of the cleaning needed to be more thorough. For example, where equipment was labelled 'clean' and dated, this had not been done. Staff attended to this immediately when we raised it with them.

● Staff had received infection prevention and control training, although not all staff were clear about isolation procedures on people's return from hospital.

The weaknesses in assessing and monitoring individual risks, using medicines safely and preventing the spread of infection meant there was evidence of a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Staff had a good understanding of safeguarding procedures and were confident to raise issues of concern. Staff were encouraged to speak up if they had any concerns.

● Staff knew the potential signs of abuse and what to do to report any abuse. Staff noticed when situations had the potential to escalate and they took action to redirect people's attention.

● Where accidents and incidents occurred there was a clear process to trigger a root cause analysis (RCA) investigation and to identify learning from past events. The RCAs identified recommendations although clear actions were not always specified.

Staffing and recruitment

● People did not have to wait for the support they needed and there was adequate staffing overall, although at times, deployment of staff was not effective. For example, several staff took their breaks at the same time which impacted on staffing levels on the Calderdale unit.

● Some staff we spoke with said they felt there were not enough staff to provide quality support to people, and their time was spent completing care tasks. Lunchtime in particular was very task focused. Although there was an activities staff member, they were deployed throughout the whole site, so individual time with people was limited.

● People said staff were often too busy to spend time with them. One person said, "They're far too busy to spend time with me." However, most people said staff came quickly if needed.

● Staffing levels were regularly reviewed and we saw dependency assessments in individuals care records. The management team told us the dependency tool was used reliably to calculate staffing levels and there were regular rota meetings to discuss any particular issues arising.

● Recruitment procedures were followed to ensure staff were suitable to work with vulnerable people. Registered nurse status was checked, although the recording of this needed to be improved.

● There was evidence of clear systems and processes in place to track training requirements, inform individuals and unit managers when training was due. The resident experience manager had oversight of these processes.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant although systems and processes were in place these were still being improved and developed further, and as such were not yet fully embedded in practice. The provider was not yet able to demonstrate sustained levels of high quality person-centred care due to the management team being new in post.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The manager understood the challenges of their role and had developed oversight of many aspects of the service provision in the short space of time since coming into post. They were enthusiastic about driving improvement and proactive when issues came to light during the inspection.
- Quality assurance systems were in place and there was a clear governance framework. Quality and risk was discussed at organisational, regional and home level. There needed to be further work to ensure more robust quality assurance at individual unit level and the manager was considering ways in which this could be improved. Where there were weaknesses in the quality of the provision highlighted during the inspection process, these were already being identified and addressed through the improving systems.
- Documentation in relation to risks and safety needed to be improved and the manager was actively seeking ways to address this. For example, where lifting equipment had been regularly checked, this was not indicated on the lifting equipment. Out of date information was recorded in the emergency evacuation files for each unit. Individual risk assessments for people were not sufficiently detailed and there were gaps in recording, such as handovers and staff allocation sheets. The manager was working with the senior management team as well as unit managers to make improvements in a shared way, rather than imposing their own ideas for change.
- Staff were clearer about their roles and responsibilities since changes to the management team. Staff gave positive feedback about the new manager and how they were supportive and involved with improving quality at West Ridings Care Home.
- The service was showing clear signs of improvement since the last inspection. Named house managers were beginning to provide more consistent leadership at unit level, and in a supernumerary way, which meant the lines of accountability were clearer.
- Improvements to morale were reported; staff overwhelmingly said communication had vastly improved and they felt much more motivated. Regular daily 'huddle' meetings were used to share and feedback key information and discuss topical issues, such as falls. A 7am walk-round by the resident experience manager had been introduced to improve communication and identify any issues from the night shift to the day shift.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Since the last inspection there had been a drive to improve the culture across the whole site. The manager

was keen to empower staff and valued their individual contribution to the work of the whole team. One member of staff said, "[The manager] gives us credit for what we know and he respects our views. We can challenge his decisions and he's firm but fair." Several staff described the manager as "a breath of fresh air" and "exactly what West Ridings needs". Staff told us the manager did not hesitate to offer practical support and help with people's care when needed.

● Staff expressed the values of the organisation and they reported feeling noticed, listened to and valued. Staff overwhelmingly said the new management team was approachable and visible. One member of staff told us, "I feel like I'm a person, whereas previous managers used to walk past without even seeing me. [The manager] will ask how I am and really care about my answer." Staff said feeling valued helped them to be better at their work.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider and management team understood their responsibilities and acted on the duty of candour. Relatives told us they were kept informed of any incidents that occurred. Where relatives had reason to raise concerns, there were appropriate and timely responses made by the manager to resolve any issues.

● Relatives told us they felt included in information about changes occurring. There was information posted within each unit for relatives and visitors, although we saw 'meet the team' photograph boards were blank.

● The rating from the last inspection was on display in the home and the manager had been proactive in introducing himself to people and relatives, arranging times to meet and get to know people. Staff commented how well the manager had got to know them and the people they cared for in a very short space of time. Some relatives said they had been introduced to the manager and he had made himself known.

Working in partnership with others

● The management team worked closely with community professionals and organisations to meet people's needs. Referrals were made in a timely way to ensure people were appropriately supported.

● The provider had placed a voluntary stop on admissions to the home in order to stabilise the management and staff team and drive quality. They were working closely with local authority partners to identify and make improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 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 There were weaknesses in assessing and monitoring individual risks, using medicines safely and preventing the spread of infection.