Bupa Care Homes (HH Bradford) Limited

Crossley House

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

Our inspection of Crossley House took place on 4 June 2018 and was unannounced.

Crossley House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 58 people in a two storey, purpose-built building; the top floor specialises in providing care to people living with dementia. At the time of our inspection there were 49 people living at the home.

A registered manager was in place. 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. The registered manager had registered with the Commission in January 2018 and was supported by a newly appointed deputy manager. The home was also supported by the provider's quality manager on the day of our inspection.

People told us they felt safe living at Crossley House. Safeguarding policies and procedures were in place and staff understood how to keep people safe. Assessments were in place to mitigate risks to people's health and welfare. Accidents/incidents were mostly documented and investigated with actions taken as a result. However, we found some accidents had not been fully documented and the registered manager was taking steps to ensure this was rectified.

Medicines were mostly managed safely. Medicines checks were made and errors were reported, investigated and actions put in place to mitigate the risk of reoccurrence. We found this was put in place with an error we found during our inspection. Staff who administered medicines were appropriately trained and their competency was assessed.

The premises was well maintained, clean and light, with a number of communal areas in which people could spend their time. Infection control procedures were followed. People' were encouraged to personalise their bedrooms with their own items such as ornaments and pictures.

Staff were mostly recruited safely, had received appropriate training and sufficient staff were deployed to keep people safe. The service was working to ensure a system for regular staff supervision and annual appraisal was in place. People and their relatives said staff were kind and caring and we observed this during our inspection. Staff respected people's dignity and right to privacy and supported people to remain as independent as possible.

People enjoyed the food offered which was freshly prepared, with choices to suit people's tastes. Staff assisted people where required and mealtimes were relaxed and informal. Where people were at risk nutritionally, referrals were made to the GP or dietician and actions taken such as monitoring food/fluid

intake and providing dietary supplements.

People's needs were assessed prior to coming to live at Crossley House to ensure these needs could be supported by the service. Plans of care were drawn up and reviewed and updated regularly to ensure these remained relevant. The service worked with a range of health and social care professionals to meet people's health care needs.

We saw staff sought people's consent when providing care and support. The service was compliant with the legal requirements of the Mental Capacity Act 2005.

A range of activities was on offer for people if they chose to take part. These were tailored to people's interests, including one to one activities where people preferred these. People and their relatives were complementary about the activities co-ordinator, who was enthusiastic and was developing ideas to include more dementia friendly activities.

Complaints were taken seriously at the service. Where a complaint was made, a full investigation took place, including ensuring the person who raised the complaint was kept informed throughout.

A range of checks were in place to ensure the quality and smooth running of the service. These included regular staff and service user meetings and annual quality surveys. Actions were taken as a result of these, showing people were involved in the service.

The management team were committed to service improvement. People, relatives and most staff were complementary about the leadership of Crossley House.

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.

Safeguarding procedures were in place. Staff were trained and understood how to recognise and report signs of abuse.

Risk assessments were in place. However, some incidents had not been recorded to allow effective analysis and risk mitigation of people's falls risks.

Medicines were mostly managed safely.

Is the service effective?

Good

The service was effective.

People's consent was sought and the service was acting within the legal requirements of the Mental Capacity Act 2015.

Staff training was up to date and equipped staff with the required skills to provide people with safe and effective care and support.

People's health care needs were supported with access to a range of health and social care professionals.

Is the service caring?

Good

The service was caring.

It was clear staff knew people well. Staff supported people in a compassionate and caring manner.

People and their relatives praised staff and told us staff respected their privacy and dignity.

People's independence was supported and encouraged.

Is the service responsive?

Good

The service was responsive.

A range of activities was available, tailored to people's

preferences.

Care plans reflected people's care and support needs.

The service was working within the requirements of the Accessible Information Standard.

Is the service well-led?

Good

The service was well led.

People and their relatives praised the support and the management of the home. People knew who the registered manager was.

People's opinions about the quality of the service were sought and actions taken as a result of these.

A range of quality checks were in place to ensure the smooth running of the service.

Crossley House

Detailed findings

Background to this inspection

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

This inspection took place on 4 June 2018 and was unannounced. The membership of the inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience used on this occasion had experience of caring for older people and people with dementia.

We used a variety of methods to gather information about people's experiences at the service. During the inspection, we spoke with 14 people and six relatives of people who used the service. We observed care and support and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at elements of five people's care records, medication records and other records relating to the management of the service including staff recruitment and training records and policies and procedures. We looked around the home including some people's bedrooms. We also spoke with the registered manager, seven care staff, the quality manager, the chef, the activities co-ordinator, the maintenance person and three visiting health and social care professionals.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and contacting the local authority safeguarding and contracts teams. The provider had also completed a provider information return (PIR) and returned it to us in a timely manner. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Crossley House. Comments included, "Oh yes, I am certainly safe and comfortable here", "This is my home; I certainly do feel safe", "I have a lot of friends here - I am safe and comfortable" and "Absolutely, at all times." Relatives we spoke with commented they felt reassured that their loved ones were safe at Crossley House. One relative commented, "We live away from Bradford - we have full reassurance that my relative is happy and safe." A second relative told us, "Our relative is extremely happy here – we do feel [relative] is safe. We went on holiday and came back - [relative] was extremely happy."

Safeguarding policies were in place. Staff told us they had received safeguarding training and understood how to recognise and report signs of abuse. They all said they were confident people were safe living in the home and had not witnessed anything of concern. We found safeguarding procedures had been followed to keep people safe, including referring to the local authority safeguarding unit and investigations undertaken.

Medicines were mostly managed safely. People told us they received their medicines correctly and on time. Medicines were administered by senior care workers who had received training in medicine administration. Their competency to administer medicines had been recently assessed to ensure they continued to have the skills to give medicines safely.

Medicines were stored safely and securely. We looked at a sample of medicine administration records (MARs) and found them to be well completed. We checked the stock levels of medicines and found the number in stock matched with what records stated should be present. This gave us assurance people were receiving their medicines as prescribed.

Where medicines had to be given at specific times or intervals, for example weekly or every 72 hours, we saw these generally were consistently given. However, we found an instance where a weekly medicine important to a person's health had been omitted in error. The unit manager took immediate action to contact the GP to check if any adverse effect could have been caused, an incident form was completed and the registered manager put immediate actions in place to mitigate the risk of reoccurrence. Arrangements were in place for the application and recording of topical medicines such as creams.

Risks to people's health and safety were assessed and a range of risk assessments and care plans maintained for each person. These included risks associated with their care which included smoking, manual handling, skin integrity and nutrition. These were subject to regular review and evaluation. We saw staff following plans of care to ensure people were kept safe.

The registered manager told us they had several vacancies and were using agency staff, particularly at night, to provide cover. The registered manager told us the service was commitment to 25% over-recruitment of staff to help reduce agency staff and the impact of any further staff leaving. The staff we spoke with said they thought there were enough staff on duty to ensure people's needs were met. The registered manager told us

they tried to ensure 10 care staff were always on duty during the day and six at night. We looked at rotas for a three-week period in May 2018. We saw these levels were largely maintained although on five out of 20 days there were only nine staff on during the day.

Overall, staff were recruited safely. New staff were required to complete an application form, prove their identity, provide references and undertake a Disclosure and Baring Service (DBS) check before starting work. In one case, where we found a poor reference had been received, the registered manager explained to us the steps they had taken to investigate this which were satisfactory. However, this needed recording in the staff file to better evidence the actions taken. From our discussions with the registered manager, we had confidence this would take place.

Incidents and accidents were recorded and subject to monthly analysis. A falls toolkit was used to analyse for any trends, including for particular residents and the time and location of any falls. A report demonstrated trends had been investigated and action taken to help keep people safe. However, when looking at care records we saw one person had experienced two falls in May 2018. Neither of these was recorded as an incident or included on the falls analysis. This meant the monthly analysis was not an accurate reflection of all the incidents which had occurred that month. We spoke with the registered manager who immediately took actions to mitigate the risk of reoccurrence. For example, a themed supervision was already planned for all staff to go through a new incident/near miss report form and a falls check list was to be introduced to prompt all staff to ensure they report and record falls as required in all. In addition, they told us they would ask at the daily senior staff meeting, handovers and check during their daily walk rounds about any falls and if these had been documented appropriately.

We found the home to be clean and tidy. Infection control audits were undertaken by the service to check that standards were maintained. During the inspection, we saw staff adhered to good hygiene practices. Substances hazardous to health, such as cleaning products and disinfectants were stored in separate locked cupboards, out of the reach of people who lived at the home.

The service was safely maintained. Checks were undertaken on the fire, water, gas and electrical systems to help ensure they were safe. Personal emergency evacuation plans (PEEPS) were in place and held in the office so these were immediately available should the need arise. We looked around the building and found key safety features such as window restrictors were installed and checked to protect against the risk of falls. Flooring was level and well maintained.

Good

Is the service effective?

Our findings

People's needs were assessed and placements offered if the service could fulfil these needs. We saw reassessments took place where appropriate to determine if the service remained suitable and actions taken as a result of these.

People and their relatives said staff were supportive and understood what care and support was required. Comments included, "The staff are supportive towards my relative at all times", "They are genuine – very caring; they are there for me" and "Staff are very good. They are helpful – they listen to me."

The service had access to a range of support staff who worked throughout the provider to ensure it kept up-to-date with the latest best practice and guidance. For example, they had access to clinical skills and dementia specialists who provided training and guidance to staff. The provider had also worked with Bradford university to develop bespoke dementia care training for staff.

Staff received a range of training and support relevant to their role. We looked at the training matrix which showed the overall compliance with training was 93.6% with most training therefore being up-to-date. Staff told us the training had given them the confidence to provide effective care and support. The service had sought out further training delivered by local health professionals. For example, end of life care was being provided to staff soon. The management team conducted training needs analysis of the workforce and had recently identified some staff needed to improve their understanding of the Mental Capacity Act (MCA) and person-centred care planning, so additional training had been commissioned.

New staff received a full induction to the service. This included a four-day classroom based induction followed by a period of shadowing in the home to allow new staff to become familiar with people who used the service and their individual needs.

The registered manager told us that staff supervision and appraisal had not been taking place as regularly as it should have been. Records showed that only eight staff had received a supervision since 1 February 2018. We saw arrangements were in place to address this with the senior care workers to assist bringing these up-to-date.

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). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of their liberty.

We found the service was acting within the legal framework of the MCA and DoLS. Where people lacked capacity to make decisions relating to their care, and the service thought it was depriving them of their liberty or was likely to do so, applications were made to the supervisory body. At the time of the inspection, one authorised DoLS was in place with the others awaiting assessment by the supervisory body. We saw evidence the service had recently asked them for an update on the current situation.

We saw evidence of people's consent being sought during our observations and our review of people's care records. Where staff were unsure about people's capacity to make decisions, their capacity was assessed. For example, we saw a capacity assessment had taken place for one person who liked to walk independently with aids. The assessment had concluded the person had the capacity to understand the risk of falls and the outcome was that the person was able to maintain their independence in mobilising.

People had access to a range of suitably nutritious food. At each meal there were a number of choices available. Alternatives could be made for people based on their individual needs and requirements. A system was in place to advise the kitchen of people who required special diets so these were consistently provided.

We observed the lunchtime meal and found staff were around to assist people where required, although at breakfast time, only one staff member was present in some of the dining rooms. There was a friendly, unhurried and inclusive atmosphere and staff encouraged people to eat what they had chosen from the menu. For example, we saw the activities co-ordinator joined people in the downstairs dining room at lunchtime and chatted with them as they ate. We observed staff knew people's nutritional likes and dislikes and their choice of drinks, although they still asked the person what they would prefer. Drink and snacks were available throughout the day and homemade cakes provided in the afternoon.

People told us they were happy with the food served at the home. Comments included, "Excellent – almost as good as home", "They are not stingy - they give us a lot of food", "Certain things I like - certain things I do not like. I get fish which I like" and, "The food here is good. It's lovely. I'm going to ask for seconds." We saw this person was asked if they wanted more food and this was provided. A relative commented, "I have seen the food for my relative – it is excellent. We do not need to bring anything in from outside."

People's nutritional needs were assessed. We saw where people were of low weight, the service liaised with GPs and took steps to reduce the risk such as monitoring weights more frequently, recording food intake and giving nutritional supplements. However, one person's nutritional care plan needed more detail about the measures staff had put in place to promote their nutrition and protect them from harm. We discussed this with the registered manager during feedback at the end of our inspection. They told us they would review the person's care records to ensure appropriate measures were in place. Following our inspection, the registered manager sent us information to show this had occurred.

The service liaised effectively with a range of health and social care professionals to help meet people's needs. This included GPs, district nurses, clinical psychiatric nurses and social workers. Their advice and involvement was clearly recorded in care records and used to update plans of care. We spoke with two social care professionals who told us the person they were visiting needs were met by the service. They said the person was very well supported and staff had gone above and beyond to ensure the person was comfortable within the home. A health care professional we spoke with told us the home communicated well with them, listened to and followed their advice about people's health care. We saw the service made effective use of the telemedicines system. This allowed on-line video consultations to take place with nursing staff at a local NHS trust about people's care. This system facilitated minimum disruption to people living at the service through unnecessary hospital admissions and gave a speedy response to health

concerns.

The building was suitable for its intended purpose. There were numerous communal areas where people could spend time as well as a small garden area. People were encouraged to bring items to the home to personalise their rooms, such as pictures, small items of furniture and ornaments.

Good

Is the service caring?

Our findings

People we spoke with said they were happy with the care and support they received and liked living in the home. They told us staff were kind and friendly. Comments included, "They are really caring, kind – they listen to me; they respect me", "They are so helpful and kind- always doing things for me; so understanding", "Staff are extremely caring. They are always round us – they do things with that genuine care" and "Of course – respect and dignity given at all times. Very pleasant to be around these staff."

We saw evidence people's families were able to visit the home when they wanted to and there were no restrictions on visiting. Relatives commented, "They ensure they get to know us. They are so kind and caring; we are truly blessed", "Staff are very patient. My relative can be a handful; they never complain – always willing to help" and "Wonderful. They are so caring and kind. They are always respectful to us as well. Very approachable – always keep us in the loop." Most people and/or their relatives told us they had been involved in care planning and review.

People's privacy and dignity were upheld. For example, we saw a staff member assisting a person to their room to rub a pain relieving gel on their knees in private, rather than in a communal area. Staff were able to give examples of how they ensured people were treated with dignity and respect, for example; knocking on doors and covering people during personal care. People told us staff treated them with dignity and respect. One person commented, "Very respectful. They look after me - they treat me as a person."

We saw people were supported to live as independently as possible. For example, people could get up at a time that suited them, eat their food where they wanted and take part in activities that were of interest to them. Care records demonstrated the service helped people to maintain their independence. For example, one person's care file we looked indicated they were very independent. The care and support plan focussed on checking on their welfare and prompting their own self-care with minimal restrictions on their freedom. We saw this happened during our inspection. People were kept busy and activities focused on maintaining people's confidence and independence. For example, during the inspection some people were decorating flower pots and were to be later encouraged to plant seeds in the decorated pots and care for the subsequent plants.

The home was split into four distinct units. Staff were generally assigned to the same unit to help ensure people were cared for by familiar faces and help develop good relationships between people and staff. The staff we spoke with knew people and could tell us about their needs and preferences. Information on people's past lives was recorded within care and support plans. We saw bedroom doors in the dementia room contained brief information about the person, such as their previous employment and what they enjoyed doing. This helped staff better understand the people they were caring for and helped in the provision of personalised care and support.

We saw information about advocacy services was displayed in the service and this had been explored for people who had no one to speak on their behalf.

We looked to see how the service worked within the framework of the Equalities Act 2010. Staff had received training in equality, diversity and human rights. This helped ensure the service was responsive to the diverse needs of people who used the service and was working within the framework of the Act. Other protected characteristics are age, disability, gender, marital status, religion and sexual orientation. We also saw religious services for different faiths were held regularly. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

People's care and support records were stored in cupboards which were kept locked when not in use. This meant staff understood the importance of keeping people's confidential information safe.

Good

Is the service responsive?

Our findings

We saw evidence a comprehensive assessment of people's needs was carried out prior to admission to help the service decide whether it could meet people's needs. This was then used to create more detailed care and support plans when the person moved into the home. We looked at five people's care records and saw an appropriate range of care plans were in place which were sufficiently detailed and person centred. Care plans were subject to monthly evaluation and we saw changes were made following incidents or changes in people's needs. People told us staff knew and provided the care and support they needed. From our observations, we concluded people's plans of care were followed. For example, one person's nutritional care plan stated, 'staff to ensure that independence is promoted at mealtimes.' We saw staff gave the person time to eat their meals independently with minimal intervention.

We saw the service supported people with their end of life needs and they and/or their relatives were included with planning and managing future decisions. We saw arrangements were in place to ensure appropriate access to medicines to manage pain and other symptoms. A number of compliments had been received from relatives about the end of life care provided by the service for their loved ones. Comments included, 'I will never forget Crossley House and its staff for what you did for [name]' and 'You were all amazing...being there for a hug when needed.'

Where people's needs changed we saw prompt action was taken. For example, one person had developed a pressure sore. The service had immediately liaised with the district nursing team, ensured additional equipment was put in place, prescribed creams applied and care plans had been updated. Records showed the person's pressure sore was now healing.

People's religious needs were assessed. Religious clergy visited the home regularly and services were conducted for people of Church of England and Catholic faiths.

An activities co-ordinator worked in the home who had recently been appointed. They were very enthusiastic about their role and had many plans for activities tailored to people's preferences. One person commented, "I enjoy painting- which I can do. I get my nails painted." The activities co-ordinator told us they worked flexibly around people's wishes and preferences, such as when people wanted to go out or engage in a particular activity. For example, they told us they had recently taken a person who enjoyed horror films to an evening film showing on Friday 13th which the person had dressed up for and thoroughly enjoyed. This showed a person-centred approach to activity provision.

We looked at records which showed people engaged in a range of activities including arts and crafts, quizzes, nail panting and going out into the community. External entertainers also visited the home, for example musical fitness and a ukulele player. Photographs of activities were displayed which showed people enjoying a variety of events. The activities co-ordinator involved people as much as possible in the planning of activities. For example, they had taken a person shopping to help them to choose the decorations for an activity that people were going to engage in. There were a number of future activities planned, including World Cup and Wimbledon parties and a summer fair. Where people preferred to spend

time in their own rooms, the activities co-ordinator visited them to provide one to one companionship and meet their social care needs. However, the coordinator acknowledged it was difficult to get around everyone due to the size of the home, although people were encouraged to visit the different units where activities were taking place. Activities were being developed to include more dementia friendly activities for the dementia unit, including working with the service's dementia champions and liaising with other dementia groups such as the Alzheimer's society and the provider's dementia team.

People we spoke with were clearly fond of the activities co-ordinator and people and their relatives praised them. One person said, "[Activities co-ordinator] keeps us busy; we do something every day." Another person commented, "I like to sit on my own. [Activities co-ordinator] does come to talk to me. I prefer this way." A relative told us, "We went on holiday for five weeks. My relative had done activities [person] has never done before. It was brilliant to come back – [person] was happy and did things [person] would never have."

The service did not yet have an accessible information standard policy although we saw this was being developed by the provider. However, we saw people's communication needs were assessed, looking at if the person required information to be made available in a different format. Staff adapted communication approaches to suit these needs. For example, we saw staff spoke slowly and clearly with people and ensured they spoke face to face and at people's eye level. We saw staff used hand gestures to communicate with another person and they told us they also wrote information down if the person did not understand what they were saying. Information on display was in an accessible format such as the menu and the 'You said, we did' board.

We saw complaints were recorded and had been fully investigated with actions and outcomes, including correspondence and a written apology to the complainant. Many compliments had been received, praising staff, activities and the end of life care. These included, 'We can't believe the change in [person] since the staff started to care for [person]. They really can't do enough in supporting [person] and the other residents.'

Good

Is the service well-led?

Our findings

We received positive feedback about the management of the service from people, relatives and health and social care professionals. A health care professional commented, "It is a busy place to come but we have no concerns." They told us they had seen some improvements since our last inspection and would recommend Crossley House as a place to live. Relative comments included, "It did go through a difficult time. [Registered manager] seems to have stabilised the staff - there is not a lot of staff turn around", "No problem with management - they have been extremely supportive to us and my [relatives] who both have been here" and "Brilliant. [Registered manager] came in support us about an end of life meeting. She brought in sandwiches and a cup of tea - how thoughtful. I go home on a night so happy - I can leave [relative] in safe hands." One person commented, "I can speak to [registered manager] - she is nice" and another person said, "I know [registered manager's name] is the manager."

Most staff we spoke with told us they enjoyed working in the home and morale was good. They said they felt supported by the management team which included the unit managers or the registered manager. Most staff said they felt able to raise concerns with the management and would recommend the service as a place to work and as a place for a loved one to live if required. Some staff told us they thought that improvements had been made to the service. For example, one staff member said, "Much better now, lots of changes and everything is in place." However, other staff said they did not feel as supported and felt reluctant to approach the management team.

The registered manager told us they were trying to ensure all staff shared the same vision and values for the service and they felt this was gradually changing. They told us they held a clinic every Thursday where they stayed late for staff to drop into, to talk any issues through. They explained they were aware some staff were not as settled with their management style and this was an opportunity for these staff members to chat with them about their concerns. We saw they had also recently held a 'thank you to staff for your hard work' party with raffle prizes to boost staff morale and team spirit. We saw the management team were committed to continuous improvement of services to benefit people living at Crossley House.

A range of audits and checks were undertaken by the management team. A clinical board was maintained in the registered manager's office which provided an overview of people's care and support needs, such as who had a textured diet and those at high risk of falls. This helped raise awareness with the staff team. Other checks included a weekly review of people's care and support where resident care plans were reviewed to ensure they were receiving appropriate care. Actions arising from these checks were delegated to senior staff to amend care and support plans. Audits took place in a range of other areas including night checks, medicine management and infection control. The registered manager also completed a monthly report on events within the service, such as pressure sores and infections which was sent to senior management to monitor how the service was operating. Monthly provider visits took place to monitor and review the service with action plans developed from these. A quality improvement plan was in place with actions and timelines to facilitate this.

Resident meetings were held monthly. We saw evidence that any requests or actions from the previous

meeting were carried over to the following month to ensure people's feedback was acted on. There was a 'You said, we did' board on display which showed people's comments had been listened to and acted on. For example, people had asked for new carpets which were provided and a summer fair which was being planned. People were consulted about the choice of carpets and decoration which showed the service involved people in the service. People's feedback was also sought more formally through annual survey. We looked at the results of the last survey done in December 2017. Results were very positive. For example, 95% of all people were happy with the home and 100% were happy with the staff.

The service worked with other agencies such as the local authority and local NHS trusts to provide training and support to staff as well as share best practice. The service utilised the telemedicines scheme. This provides a 24 hour a day video consultation with nursing staff at a local NHS trust to help avoid unnecessary hospital admissions. The service was also working with the Alzheimer's society and Bradford University to improve dementia care provision in the home.

Staff meetings were regularly held to discuss a range of topics including service quality and improvement. Staff told us these were a useful tool to discuss concerns and share best practice. In addition, the service had an 'employee of the month' scheme to recognise the difference a particular employee had made. We saw some staff had been promoted to senior roles from within the service, recognising the contribution they made to the running of the home.