Calsa Care Limited

Vicarage Court Care Home

Inspection report

Vicarage Gardens
Featherstone
Pontefract.
WF7 6NH
Tel: 01977 708368
Website: www.theoldvicaragecare.co.uk

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Ratings

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

Overall summary

The inspection of Vicarage Court Care Home took place on 15 and 18 June 2015 and was unannounced. The previous inspection had taken place in September 2014 and found the service was not meeting specific regulations. We issued warning notices for the registered provider to take immediate action in regards to the care and welfare of people, and assessing and monitoring the quality of service provision. We requested action plans for the other areas of non-compliance. This inspection was to follow up on areas of progress following this previous inspection.

Vicarage Court provides care and accommodation in three separate units, for people who require nursing care, people living with dementia and people who require personal care. On the day of our inspection there were 57 people living at Vicarage Court, 21 were receiving nursing care, 19 were living in the unit supporting people with dementia and 17 were receiving support for personal care.

People and relatives told us they felt safe. We found staff had a good understanding of the principles of protecting people from abuse and were aware of the importance of

Summary of findings

recording. We saw that accidents and incidents were dealt with appropriately and records were kept. We saw detailed risk assessments and resulting action plans ensuring that people were supported in the most appropriate manner. However, we found that the registered manager was not notifying us of such situations as required under law. We referred the registered manager to our guidelines and they agreed to remedy this with immediate effect.

We found the service to be suitably staffed on both days of our inspection and that medicines were handled safely and in accordance with NICE guidelines.

Staff had received an induction, supervision and training and feedback from other professionals was positive. We found that people were offered nutritious meals but there was poor practice in regards to how mealtimes were facilitated. People were not enabled to make choices such as which drink or meal to have. There was also a lack of best interest decision making for people in the service who were deemed to lack capacity.

Some staff were caring but we found others were not aware of how to support someone with dementia effectively. This was observed during activity times and mealtimes. We observed some activities were carried out in a way which did not always respect the needs of the individual, particularly those living with dementia and staff sometimes appeared disinterested.

There were improvements in the care records since our last inspection which aimed to be person-centred. Since the last inspection there had been an increase and focus on the activity programme. However, we witnessed that individual engagement was sometimes poor between staff and a person unless it related to a specific care task.

There was a registered manager in post on the day 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.

We found that the use of audits for care records and medicines were detailed as were the checks on the premises, health and safety and infection control. The service also had in place a variety of mechanisms in securing feedback about its quality of care and this had been recognised in specific awards. However, we found that as people were not being supported to make choices there was a lack of understanding by the service as to how best care for people who were living with dementia.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People and relatives told us they felt safe. Staff had an understanding of what constituted safeguarding and how to report this. However, we found it was not being reported correctly to the commission as required by the registered manager.

We found staffing levels to be appropriate to meet people's needs and medicines were administered safely.

Is the service effective?

Requires improvement

The service was not always effective.

Staff received induction, supervision and training. Although generally we saw little understanding of how some of this training was translated into practice, there were some good examples by particular staff members.

Staff did not always offer people choice, and although we saw that appropriate requests for DoLS had been made, there was a lack of understanding by some staff as to how to support people with dementia appropriately. We could find no evidence of best interest decision making.

Some people were supported to eat and drink and action was taken where additional health needs were identified.

Is the service caring?

Requires improvement

The service was not always caring.

We observed some positive interactions with people from some staff but others were more task-focused in their approach. This was particularly evident at meal times.

Staff demonstrated how they supported someone with dignity and respect when dealing with individual tasks for people in terms of physical care needs but this was less evident when staff were with people but not directly involved in a physical care task with a person

Is the service responsive?

Requires improvement

The service was not always responsive.

We saw that care records were person-centred and had improved from our previous inspection. However, people's needs were not always met in a person-centred way.

There was evidence of a full activities programme with a wide spectrum.

Complaints were handled in a timely and responsive manner.

Summary of findings

Is the service well-led?

The service was not always well led.

Relatives and staff felt the home was well managed and that the registered manager and owners were available.

We found the home to be run in a clinical manner so that basic care needs were met but that people's choices and wishes were not always respected.

The home was pro-active in seeking people's views and sought to act on any concerns.

We found an auditing system was in place but was not yet fully embedded or effective. It focused on the completion of paperwork rather than the quality of care being delivered.

Requires improvement

Vicarage Court 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.

The inspection took place on 15 and 18 June 2015 and was unannounced.

The inspection team comprised seven adult social care inspectors and one specialist advisor over the two day period. The specialist advisor had a background in nursing of older people and people with dementia.

Prior to the inspection we reviewed information from notifications received by the Care Quality Commission regarding safeguarding incidents and other concerns. We had not requested a Provider Information Return (PIR) as the inspection was in response to previous concerns identified. 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.

We spoke with ten people who use the service and seven relatives. We also interviewed twelve staff including seven carers, two nurses, the registered manager and the provider. We also spoke with a community nurse who visited the service on one of the days of our inspection. We used a Short Observational Framework for Inspection (SOFI) to assess the impact of the service on people who struggled with communication. This is a means of helping us to understand the experience of people who could not initiate conversation with us.

We also looked at nine care records including risk assessments, three staff personnel files and documents relating to quality and assessment of the service provision including maintenance audits, care record and medication audits, health and safety logs and infection control audits.

Requires improvement

Is the service safe?

Our findings

We spoke with three people who told us they felt safe living at Vicarage Court. One told us "I like living here. I feel safe". Another told us "I feel safe". We also asked relatives their views and one advised us their relative was "Certainly safe. The staff are very, very nice. I'm very impressed". Another relative said "Up to now they have been pretty good. Yes, they are safe". A further relative said "They wouldn't be here if they weren't safe. They've been here four years…I never worry about them being uncared for".

We spoke with two staff who told us people were safe in the home. One member of staff told us of a recent safeguarding incident between two people living in the home and how they had escalated this to the registered manager. We were told this had been referred to the local authority safeguarding team. We did not find any record of this incident which happened in June 2015 in the care plan apart from a record in the completed professionals section and we had not received a notification about this.

We asked the staff member what actions had been in place to reduce the likelihood of this situation happening again. They told us the people residing in the home were under observation every fifteen minutes and staff were very conscious of where each person was. The staff member told us "observation is key". Although we did not find any written record that these observations were taking place, two staff members told us about them. This meant that there was a possibility that key information could be missed as there was no record being made of what action was taking place.

This incident had not been reported to the Care Quality Commission as required. We asked the registered manager for the safeguarding records and were advised that 'touch wood', we have not had any incidents since January 2015". The Care Quality Commission had received notification of five safeguarding incidents since September 2014, one was In December, one in January 2015 and three in February 2015. These were reported correctly and appropriate action taken. This shows a discrepancy between the registered manager's knowledge and what the home were reporting.

However, when we looked at the accident and incidents file we found records of four incidents between people living in the home for May 2015, three of which were safeguarding in nature. Only one was noted as having been referred to the local authority safeguarding team. There had been no further notifications. This was contrary to the home's own safeguarding policy. The registered manager told us that 'we'd wait and see how serious it is before referring to CQC'. This is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18 Notifications. Providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services. We informed the registered manager of this requirement who agreed to remedy it with immediate effect.

In addition, we sampled accident and incident records between March and May 2015, we discovered there had been many falls, some of which had resulted in skin tears or visits to hospital. In March 2015 there had been 43 accidents of which 40 were falls. One person had fallen seven times in that month and five of the accidents had resulted in people going to hospital. In April there had been 31 recorded incidents, five requiring hospital or paramedic attention. In May 2015 there were a similar number (32) with two requiring hospital visits. We scrutinised the May 2015 monthly analysis sheet which detailed each fall including injury and treatment details. Of the 32 falls recorded, eleven resulted in an injury such as bruising or a skin tear. Analysis had taken place to determine if there was a particular trend such as specific time or place.

We were confident that staff had a good understanding of how incidents such as falls should be recorded and what action should be taken to prevent falls from happening. Falls risk assessments were updated and action taken to reduce risks. However, these were not reported to CQC as required and many of the completed sheets indicated that this was not applicable. This is a further breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18 Notifications because when a person is injured as a result of fall CQC should be notified.

During the inspection one person had a fall which required an immediate response from staff. We observed staff providing a reassuring response, holding the person's hand and providing a cushion to support their head. A nurse was requested and completed a body check and an ambulance was called. A further member of staff made the area around the person more accessible as they had fallen at the back of some chairs. Staff were patient and encouraging, and eventually the person was able to lift themselves off the floor with assistance of three staff to support them while they got their balance. The person later went to hospital to

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be checked. They displayed reluctance to go but were given clear explanations as to the necessity of this. In this instance we saw staff showing their understanding of seeking someone's consent despite the person having limited capacity due to having dementia.

We spoke with a member of staff who told us they had just completed the Skills Network training booklet. They could describe the signs of abuse such as bruising, personality changes, and failing to change someone if they had been incontinent. They told us they had seen no instances of this but had seen an instance of one person agitating another person using the service. This had been diffused by separating the people. They told us they "would complete an incident form and tell the manager who would refer it through to Social Care Direct". Social Care Direct is the referral point at the local authority for any safeguarding referrals.

Four further members of staff we spoke with all demonstrated awareness of the signs of abuse and what procedure they needed to follow if they had a concern about a person using the service. One staff member told us they "would report any skin breaks" and another said they "would report all falls". A further staff member said "If you can't provide a safe place it needs reporting".

We found evidence of comprehensive risk assessments including those for falls, moving and handling, pressure ulcer care and nutrition using the Malnutrition Universal Screening Tool (MUST). This provides an indication as to whether someone requires specific support with eating and drinking. We saw where one person had been referred for nutritional advice and provided with fluid thickener and fortified drinks.

The risk assessments were regularly reviewed and updated, and care plans were developed to mitigate these risks. There was evidence of responding to risk scores, seeking advice and implementing that advice to achieve change. In one record we saw that someone had been identified as at risk of developing pressure ulcers. Appropriate equipment had been provided and the pressure relieving mattress for the profiling bed had been correctly set. The moving and handling assessments included a section on 'safe system of work', which clearly identified the staffing and equipment needs when supporting a person living in the home needed to be moved.

The staff we spoke with told us they felt staffing levels were good. One staff member told us staffing levels would be increased if the dependency levels changed to meet the increased needs of people who used the service. Another member of staff told us that recent increases in staffing levels on the unit made a big difference. They said everyone worked as a team and they hardly ever worked with agency staff. A different member of staff said "Another pair of hands for each shift would make a difference". A further member of staff said "Perhaps more staff would be beneficial, particularly on the morning shift" but did reiterate that all staff worked 'as a team'.

One of the visitors we spoke with told us they thought sometimes there were not enough staff to meet people's needs. They told us that sometimes there were no staff in the lounge and people had to wait a long time to go to the toilet. However, another relative said "There seems to be enough staff. We've never been unable to find anyone. We saw eight carers on this floor last week".

We asked the registered manager how staffing levels were determined and were told that a dependency tool is used. This is reviewed two or three times a month by the unit managers who look at people's changing needs. We were told that "All care staff are permanent and are hungry for shifts". We asked how staff sickness was covered and were told that permanent staff were asked first, and agency staff were a last resort. However, where this had been necessary on the first day of inspection the same agency was used to ensure some consistency of staff provision.

The service also used bank staff on occasion who were trained to the same level as permanent staff. All staff had commenced employment as bank staff initially to ensure they were suitable and then invited to apply for a permanent post if they met the required standard. There had not been any recent starters and the home was fully staffed. We found evidence of robust recruitment checks.

We noted that call bell summons were responded to quickly. We asked how handovers between shifts were managed and were told that the nurse from the previous shift remained on duty while the incoming nurse and care staff handed over to the next shift. We saw evidence of handover sheets which were completed on a daily basis. The registered manager advised us these were shredded as soon as possible after due concerns about information

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going missing. We were assured that the information was purely there as a prompt and the information was transferred to care records where necessary. We saw evidence of this in the daily communication section.

We observed medication rounds in both the nursing and dementia units. We looked at thirteen Medication Administration Record (MAR) charts. These were completed appropriately with the necessary signatures. The service used a cassette system (Biodose) for dispensing medication, so that each dose was pre-prepared for use. Medicines for all permanent people using the service were provided on prescription sheets that had the person's photograph to aid identification and individual images of the medicine that was to be given. Where there were new or respite people, the medicine had been written by hand. As appropriate for such hand-written prescription records, there were two signatures to confirm the entries. All individual medicines had a signature confirming administration or a code for other instances e.g. 'refused' .

The files which contained people's MAR charts also referred to any allergies and how the person liked their medicine to be given. One example was "I like to be called P. If you give me my tablets one at a time, I will take them with either juice or water. You will have to check I have swallowed them as I may spit them out when I think you are not looking". We observed this person being given their medication. They were advised that this was happening and we saw it being given directly into the mouth. This method of delivery was not recorded on the MAR sheet. They were given juice to aid swallowing. The unit manager dated the administration on the MARS sheet. The unit manager was observed to count the medication and they told us this was done once a day to ensure medication was accurately recorded.

We checked stock levels against records for medicines that were not in pre-packed cassette form and also for Controlled Drugs. All were correct. Medicines were kept within appropriate secure cupboards, within a clinical area that was locked. We noted the room to be locked when not in use. There were daily records for room and drug fridge temperatures. There was a procedure and records for the appropriate disposal of unwanted medications.

We found in one record that someone was prescribed a salbutamol inhaler PRN. PRN means the medicine should be given as and when the person requires it. However, the drug was routinely given four times per day. The prescription details were confusing and we brought this to the attention of the unit manager to seek further clarification from the doctor.

We asked about the timing of medication and whether people received medication at different times than specified on the MAR charts. We were told that some people had to be given medication one hour before eating and they had sought advice from the GP to give this at 11 am rather than waking people up at 7 am to give medication before breakfast at 8 am.

Staff told us that they were provided with medication administration training both by online training and by the pharmacy. The unit manager told us they had received training regarding medicines management. They also checked the competency of the administering staff by observing them. However, this was not recorded anywhere nor was there a system for doing this. So, although we did not observe any issues with medicines management, there was no evidence to show staff remained competent once training had been completed.

There was evidence that the service were administering people's medicines appropriately. One person was identified as needing support with more difficult behaviour through the administration of lorazepam. Lorezepam is a drug used to help people with high levels of anxiety. It was clear from the records we saw that the care plan said 'to be given as a last resort'. The care plan stated other techniques including distraction and gentle reassurance by holding the person's hand were to be used first.

Requires improvement

Is the service effective?

Our findings

We asked a relative whether they felt staff were suitably skilled and were told "They are always having training. They appear very professional".

We asked staff about their induction. One staff member told us they had had one day of induction which included being shown around the home and discussing topics such as health and safety. They told us their induction included shadowing other staff for three shifts. They felt this had given them the necessary skills and training to undertake this role. Another staff member told us they had completed their induction training which had covered topics such as manual handling, the Mental Capacity Act and safeguarding. They were currently completing the Care Certificate including modules on dementia awareness, end of life care and nutrition. Other staff told us their induction comprised watching DVDs and completing questionnaire booklets which were marked.

Three members of staff we spoke with told us they had voluntarily agreed to undertake the induction training prior to starting work there. One said they had spent approximately six hours covering areas such as fire safety, health and safety, moving and handling and person-centred care. One of the nurses we spoke with had not seen the home's safeguarding policy but was aware of the key elements required in their role due to training received in a previous capacity. We later discovered that there was no quality audit around how effective this induction was and through our observations we found that staff awareness of person-centred care and how to work effectively with people living with dementia was poor

We looked at staff personnel files and found an induction checklist. This included documents to be read by a new member of staff and procedures of how to care for specific situations such as dealing with someone presenting with more challenging behaviour. There were also printed certificates outlining various courses undertaken while on induction. These included topics such as adult abuse awareness, deprivation of liberty, infection control and food hygiene. Each of these specific areas had the question sheet that staff had told us about. Although it was clear the home had a specific induction programme the depth of discussion could only have been brief as we noted that this checklist had been initialled and dated all on the same day.

Staff told us they received regular supervision which was every three months. One of these sessions had been an appraisal. We looked at the supervision matrix and found most staff had received supervision within the past six weeks. In the staff files we found a 'record of supervision' which was a pre-printed sheet giving details about a local health organisation. Although this sharing of information was useful there was no record of any other discussions around staff's performance under this category.

We did find records of performance reviews which had set objectives. These were under the headings of care, people, business management and finance. They did incorporate more personalised aims. Areas for development were noted with action plans in place.

Staff also told us they received ongoing training which was appropriate for their role.. One staff member told us they had started their NVQ level two which was helping them gain a better understanding of people's conditions. Nurses we spoke with indicated they were supported in accessing training beyond the mandatory and statutory requirements. Other staff said the registered provider was keen on training and told us that they were always being offered videos to watch.

There were certificates in staff files indicating that staff had access to ongoing training. We looked at the training matrix and found that training was up to date for the majority of staff. The matrix identified when renewal training was required and the registered manager informed us they were aware of the actions needed.

We spoke with one person using the service who said "They never let me go out of the garden. They say you'll fall and hurt yourself. I've had the freedom to walk. I've said get the manager here. The manager has physically stopped me from leaving". We looked in this person's file to see that it referred to the person lacking capacity but there were no mental capacity assessments or best interest decisions in the file. It did also state in the file that the person did not go out unsupervised. While this may have been a perceived best interest decision as there was no recording to this extent it meant that the rights of this person were not always protected and that decisions may not have been made in their best interests in accordance with the Mental Capacity Act 2005.

There was evidence in other files of the use of mental capacity assessments within care records and consent was

sought in relation to the use of bed rails and photography. However, there was no evidence of best interest decision-making. One member of staff told us that when assessing someone's capacity, they would "Ask the person questions to gain their understanding".

Within the care records there was a yes/no question sheet with questions around whether a person was able to choose what to eat and drink, and when. In one file it was answered the person could make food choices but could not choose when to eat. In the same file it indicated the person could not self- administer their medicine or manage their financial affairs. There was no further detail. The capacity assessment had been undertaken as required under the two stage test but there was no best interest decision evident.

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.

We asked staff their understanding of DoLS. One senior member of staff told us "protecting vulnerable people from what could be a threatening outside world". They did acknowledge they had yet to receive training on DoLS. This is not an accurate reflection of the purpose of DoLS which is actually to ensure people are not unnecessarily restricted in their movements, and if they are, that due process in line with the legal requirements of MCA has been followed to ensure that the restriction is made in their best interests.

In the lounge area in the dementia unit two people were assisted to eat, while three were waiting for lunch. One person was given sandwiches. We asked why, and were told, "They did not want lunch". This person was sitting in their nightclothes in the lounge area having got up late (we were told this was their choice). A member of staff went to get a dressing gown for the person at our request as we felt their dignity had been compromised. We later checked this person's care records and found limited best interest decision making which stated that staff made choices about what the person should wear but we feel from this instance that this decision was not in their best interests.

These examples demonstrate a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations as the home were not documenting how decisions were being made for people who lacked capacity in accordance with the required legislation.

We were told that all people except one in the dementia unit would be eligible for a DoLS assessment and they were in the process of requesting these. We saw that these applications were submitted. The registered manager told us they were considering all the people in the other areas of the home to see if any further applications should be made.

We asked people what the food was like and one person said "It's edible". Another said "It's a bit iffy but it's edible. It's hard when you're catering for so many". We observed one person helping themselves to a drink from the drinks machine in the lounge.

We spoke with a relative who told us they thought the food was good and nutritious. Their relative required a soft pureed diet and they told us the pureed food had been put into moulds to resemble the original food. They felt the food looked appetising. The registered manager also told us that the use of the moulds meant food was measured, enabling more effective nutritional monitoring.

We spoke with one relative who told us their relative was unable to ask for food or drinks and relied on staff asking them. In some cases, where less experienced (new staff) had been on shift, the visitors noticed drinks and food had been left on the table next to their relative untouched . This meant they had been unable to eat or drink the food left for them.

In the dementia unit we saw a jug of juice was available for people to use. However, none of the people had a cup or glass with which to get a drink and relied on staff to do this for them. This meant they had to wait until staff offered them a drink. We spoke to a staff member about this and they told us they 'would offer drinks on a regular basis' but people's intake was not routinely monitored.

We were told staff weighed people monthly and this was evidenced in care plans. Some people's dietary intake was recorded on food charts and these people were weighed weekly. However, there did not appear to be a consistent

recording of fluid intake, especially on the nursing unit and therefore the systems may not be able to identify people potentially at risk of dehydration, particularly people living with dementia.

One family member told us and we observed, that the dosage of dietary supplement given was not always recorded on the persons chart. The relative told us, "It has to be recorded at the correct dose. If they get too much they won't eat their dinner because they are bloated." This could mean that the person was more at risk of poor nutrition and hydration.

We conducted a Short Observational Framework for Inspection (SOFI) in the dining room in the dementia unit. Although we observed staff interactions for about half of the time, these interactions were limited to giving and taking away plates, and putting drinks in front of people. One member of staff said to someone "You were hotpot – do you remember?" before placing their meal in front of them. We did not think this was an appropriate question given the person had dementia and looked confused at the comment.

People were given time to eat at their own pace apart from one person who we saw was given their dessert while still eating their first course. This was put to the side of their plate and left to go cold as they finished their meal. Other people's desserts were given without any explanation of what it was. Another member of staff put cups of tea in front of people, again without asking if this was people's preferred drink saying to one person "There you go darling". We were told by staff that people were offered choice the day before. People said 'thank you' at the end of their meal but this was not acknowledged by staff who were focused on clearing away the plates.

We observed the afternoon tea round in the dementia unit. The trolley had a very large teapot and some plastic beakers/cups. There was no other choice of drinks available on the trolley and no sugar to add to the tea. We saw staff poured tea and placed it in front of people, without comment or consultation.

We asked the member of staff what people liked to drink and why there was only tea. The member of staff said: "We give them all tea, it's what they usually like to have. People can have a choice – it's all in the cupboard if you want to see". We asked how people knew there was a choice if it was not offered or in view. The member of staff told us: "We give them all a cup of tea and if they don't drink it we know they don't like it so offer something else". We remarked there was no sugar and asked staff how they knew who liked sugar and who did not. Staff said only one person liked sugar, yet this was not available. Once we had commented about people's choices, staff began to ask people if they would like lemonade or juice. At teatime we saw one person had a can of beer with their meal.

In the residential unit we found that meals were again pre-plated and delivered individually which took over nine minutes in total. One person left before dessert saying they did not want one. They were asked if they would like anything saving for them. Drinks were only available after people had started eating and in some cases nearly finished their meals.

We observed staff asking people if they required support with their meals. Where support was accepted the staff member sat next to the person. We saw staff were focused on the person and assisted at an appropriate pace. Outside of the formal dining areas people were also supported. Staff spoke to them in a kind and reassuring way ensuring they had eye contact with the person. They advised the person they were eating beef casserole, potatoes and beans. They persuaded one person to eat more of their meal. The person responded saying "It's lovely. Yummy yummy". We heard one carer saying to the person "Do you want some more flower?" to encourage them to eat more. One carer engaged with a person who used the service by saying "Look what I've got for you" before presenting the pudding. We found the intonation of the latter comment to be disrespectful in an adult to adult exchange.

We saw that one person who needed help to eat and drink, and was at risk of choking, was supported to sit in an upright position to eat their meal which was of a soft consistency in line with their requirements.

We spoke with a visiting community nurse who said "If I ask the staff to do something it gets done". There was evidence in care records that external support was accessed as often as required. We saw in one record that a nutritional screening and risk assessment had been completed about weight loss and as a result they were referred to the GP for a swallowing assessment. The registered manager also stressed that anyone at nutritional risk was referred to the dietician. The information from them was then shared with the head cook who was given the appropriate dietary advice.

Requires improvement

Is the service effective?

The registered provider had made some improvements to the physical layout of the building. In the unit for people living with dementia the environment had the dignity tree on the wall which promoted good conversations, murals and textured pictures on the wall. They had also put a fireplace in the communal lounge to make the area more homely. Pictures on the wall represented themes from the 1960s and there was also a menu board display with pictures of the day's menu. People's artwork was displayed in the small conservatory.

There was also a small enclosed courtyard area off one of the corridors and we were told this was open all the time for people to use. However, we saw this used by staff as a smoking area. There was a washing line for people to use inside and we saw socks pegged on this. However, underneath was a chair and this could have posed a risk that people could harm themselves on the washing line if getting up from this chair as people with dementia can sometimes have visual difficulties.

We observed one person walking up and down the corridor looking for a toilet but unable to find an available one. This meant they passed urine as they walked along. This was dealt with promptly by a member of staff who took the person to their room to change. But we felt if staff had anticipated this person's needs and offered to assist them in finding a toilet this may not have happened. The floor was also then wet and it created a falls hazard.

Requires improvement

Is the service caring?

Our findings

We spoke with people using the service. They told us "I recommend living here. It's the ideal place to stay in the circumstances. I can't grumble". Another person said "I think it's good but I'm not happy with everything. Individually the girls are pretty good. They do their best…I think they are caring".

Another person said "Most of them are nice". Another said "I know we are being cared for. I can always ask for a drink. They are always very good and very nice to me". Another person told us "the people who look after you are very nice".

We observed some positive interactions between the registered provider, staff and people who used the service. One person said "Staff are lovely. I'm really happy here. They're so kind and caring. If you need anything, nothing is too much trouble". Another person commented that the registered provider 'is really nice'. A further comment was, "The staff are excellent. You ask for something and it's done".

A relative told us "We can no longer take our relative home for Christmas as we could not manage the stairs but Vicarage Court put on a Christmas meal and we were all invited. We had a brilliant time". Another relative said "The staff are kind and compassionate. I am here a lot and I have never heard one of the staff use a term or anything that is nasty. They are all the same. I don't know how they do it". A further relative said the "Staff are caring. They are always welcoming. They seem to like my relative".

Another relative said "The care staff are wonderful. They have a great deal of patience. I have nothing but praise for them". They went to say "Staff are always very positive, helpful and pleasant. They always know you and you are treated as a person".

All the staff we spoke with enjoyed working at the service. One staff member told us "I really enjoy it; I like helping people and making their day better". Another member of staff said "I get a lot of job satisfaction. I like to think what I do makes their day more pleasurable".

Staff demonstrated a good knowledge of specific people they cared for in the service. They gave examples of how they liked to spend time with them talking about their past, holding their hand and escorting them around the grounds to enjoy the birdlife. Another was able to talk to us about someone who enjoyed company and liked to share a joke with them. We asked a more senior member of staff about how people are cared for and they said "They are a diverse group of staff who treat everyone as an individual. We don't approach people the same".

Our observations showed a mixed experience. We saw some staff were very caring and friendly in their interactions, talking to people and addressing them by name. Some staff spoke with people in the lounge after lunch. While assisting people to move, such as in a wheelchair, staff engaged with the person explaining what they were doing and why. Some staff appeared to know people well. One member of staff as she went off duty, came and gave people a hug and a kiss and said goodbye.

However, when staff were involved in specific tasks such as serving lunch or writing care plans there was considerably less engagement with people. After the morning Tai Chi session had finished, we saw little interaction between staff and people who used the service. At one point we saw three care staff sitting on a windowsill writing in the care plans but no staff interacting with people in the lounge. Interaction only occurred when people needed support. This was reinforced by a visitor who said "Staff always seem to be rushing around and have little time to spend with people in the lounge".

We saw one person living with dementia was upset and they thought they had lost a relative. They asked a member of staff if they had seen their relative anywhere and became more anxious when the staff member did not respond and walked away. We were later asked on two separate occasions in different parts of the home for help by people living there. Staff were present each time but did not respond until prompted by us.

This is a breach of Regulation 10 Health And Social Care Act 2008 (Regulated Activity) Regulations 2014 as people were not supported with dignity and there was no acknowledgement of their distress, or the impact it was having on them.

We observed one person seated in their chair in the main lounge and spoke with them. They said "Please stay with me, I don't like it here, I'd rather be in my own home. Nobody talks to me here". We asked them if they always sat

Requires improvement

Is the service caring?

in this chair. They said: “Yes, I always sit here. I don’t know why really, I just sit here. I don’t go anywhere else”. They said they could see the television but did not watch it “ ‘cos I just want somebody to talk to me”.

We asked staff how they support someone to make their own decisions. One member of staff told us they try and encourage people to be as independent as possible; “For example, we open the wardrobe door and ask people what do you want to put on today? Get people to participate as much as they can”.

Another member of staff said it was important they supported people with their cultural needs and supported a person to attend a religious service every week as it was important to them.

One relative we spoke with said “The care here is very good. We sometimes have niggles but we just talk to staff and they do listen to us”. They said they felt involved in their relative’s care plan and were kept informed of any changes in their relative’s condition.

We asked staff how they respected people’s privacy. They told us they would knock on people’s doors before they entered the room, waiting for a response before entering, and they would always ask for people’s consent before carrying out any personal care assistance. We noted that for people receiving support with personal care their doors were closed, and one person who needed to see the GP over lunchtime was escorted to a private room for the consultation.

We saw that when staff were using a hoist with someone they spoke to them throughout the process and discussed with them what they were doing. This helped to maintain their dignity.

Requires improvement

Is the service responsive?

Our findings

We spoke with one person living at the home who, when asked about activities, said "They have newspapers. I do gardening. I can sit out on the terrace. The sound in there (referring to the lounge) is atrocious all the time. There are a couple of quiet rooms. I want to be able to go out for a walk".

One relative we spoke with told us their relative was always doing some activity. For example, "They played bingo last week, on Thursday they were doing Tai Chi. The day before they were making a mosaic. They also do chair exercises". There was a piano on the corridor in the unit for people living with dementia which was provided for a person who used to use the service.

We spent some time observing activities in different areas of the home. One person told "I look forward to the Tai Chi class". We spoke with a member of staff who organised the gardening club and we saw there was an activity in which people took part in planting flowers in tubs. People said they enjoyed this activity and we overheard staff speaking with people about the different smells and colours of the plants. One person was reluctant to join in but were encouraged by the activities co-ordinator who said "Why don't you watch then? You don't have to join in if you don't want". This then allowed the person to participate as they felt more comfortable.

The registered provider also offered other activities such as dancing and entertainment and employed an activities co-ordinator. They told us they invited entertainers from outside the service to entertain people. On the second day of inspection, a tai chi class took place. A lot of people took part in the session and they seemed to enjoy it.

Each activity was monitored and audited to establish their popularity. If one activity was not being well attended, it would not be repeated. The activities co-ordinator told us they would ask people what their preferred activity was and would try to incorporate this into their activity planning. Around the home we noticed people's art work had been put up on display. There were activities planned for the morning, afternoon and evening seven days a week. The activities took place on both floors, this ensured all people who used the service had been given an opportunity to be included in the activity.

We observed that some of the people in the home had recently had their nails painted and manicured. They were very pleased with this and one said that they liked to try new colours. The home encouraged the use of memory books as a way of exploring people's background. One of the people we spoke with showed us their memory book. It was clear they enjoyed looking at the pictures they had put into the book. The images brought back lots of memories for the person and they took delight in sharing their stories with us.

In the dementia unit we observed one member of staff began to engage people in an activity with an inflatable ball. The member of staff threw the ball to one person and the person tried to catch it but missed. The member of staff said 'let's try again' but then became distracted with a conversation between their two colleagues at the far end of the room. The member of staff stood still with the ball in her hands but her head turned the other way, meanwhile the person waited with their hands out to catch. The member of staff then walked away and took the ball with her with no explanation as they walked away. They left the activity to join in the staff conversation.

The member of staff returned a few minutes later, put the ball on the table away from the people and said 'Let's do something else, what about cards, can you play cards?' The member of staff then brought out a jigsaw puzzle with large pieces and put this out on a side table for a different group of people, then walked away and said 'Be back in a minute'. The staff member returned a few minutes later and sat with two people and the jigsaw, picked up one or two pieces and then lost interest and wandered away from the activity.

One person began to sing 'Show me the way to go home' and a member of staff said "Oh I like that song" but no attempt made to sing along or encourage more singing. The television was playing but none of the four people seated in the television area were watching. In another part of the lounge a member of staff put some music on, which conflicted with the sound coming from the television. Three people sat passively in one part of the dementia lounge and staff walked past them without acknowledgement.

Two people in the lounge began to argue and became verbally abusive with one another. There was only one member of staff in the lounge at this point and they did not

Is the service responsive?

notice this exchange of words. This shows the service was not being pro-active in supporting people with dementia. This could have escalated into a more serious incident fairly quickly.

One person walked in a bent over position repeatedly pressed their head against the wall. A member of staff intervened and said "C'mon, you can't walk through walls just yet". We did not see any attempt by staff to deter this person by trying to engage with them in a productive way, and on looking in their care plan, found it recorded almost daily that they mobilised frequently. There was no recording to say what staff had done to try and establish a relationship with this individual to minimise the risk of them knocking into the wall.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we did not see people being offered choices or, particularly in the unit for people living with dementia, to engage in meaningful activities to support their wellbeing. We observed that the home was run in a very clinical manner which, although meant people's daily living needs were met, people were denied choice and flexibility as to how they spent their day.

We found individual staff knew the people they cared for well when we asked specific questions about the people they were responsible for. We asked staff how they knew how people wanted to be supported. They told us they asked people what was important to them. They read the notes, observed people and learnt about their lifestyle. They liked to build relationships with people.

We asked about choice being offered to people. We were told they offered choice where possible but some things were fixed such as dinner times. However, if someone did not want their dinner at the fixed time they would always heat it up later for them in the microwave.

We found care records were comprehensive and demonstrated individualised assessment and care planning. They did contain people's preferences and dislikes including food. They were regularly reviewed and contained daily records from day and night staff. These records were factual logs such as whether the person was asleep, continent and had eaten. They were task focused rather than looking at a person's overall wellbeing. Detail was lacking as to how choices had been made in regards to food, activities undertaken and how the person had contributed to their own personal care choices.

We spoke with one relative who told us they were asked to contribute to the care plan and completed a life history for their relative. However, this was placed at the back of the care file and was not prominent. Another relative said "We get involved in the review. Seems to be more than once a year". We asked the unit manager about this and they told us they were in the process of completing "This is me" documentation which focused more on the individual.

We saw reassessments in people's files when there had been a change in need. For example, on 10 June 2015 one resident had fallen frequently and had been referred to 'My therapy' for an assessment. We asked a member of staff about pressure care. They informed us they completed a 'turn chart' indicating when someone has received pressure relief. They said "We work with district nurses who monitor people at risk. There is no one with a pressure sore at the moment. We check skin integrity at every opportunity we can". We found this was documented regularly in care records.

The activities co-ordinator was responsible for organizing and chairing the resident and relatives meetings. They told us the meetings were quite well attended by both residents and their relatives. This was confirmed by two of the relatives we spoke with. The meeting covered areas such as food, laundry and activities. The activities co-ordinator told us any issues brought up at the meeting would be addressed and any actions to resolve issues taken would be reported back at the next meeting. This was evidenced in the minutes of the meetings we saw.

We asked the registered manager about any complaints the service had received. They told us there had been two. We looked at the complaints policy, which was dated June 2015. The procedure and processes for dealing with complaints was outlined, for example acknowledge, rectify, learn from the complaint and discuss the outcome. There was also a useful complaints flowchart to show how complaints should be dealt with. We found that all complaints had been responded to in a timely manner and investigations completed where necessary. We did not find any specific evidence as to how learning had been shared with staff from such incidents.

Requires improvement

Is the service well-led?

Our findings

We asked relatives their view of the home and were told "I am impressed with the activities co-ordinator. She is the heartbeat of the place. Keeps them all going". They went on to say "We are invited to relatives' meetings. The registered manager ….is a good manager, the staff are good. The owners are good".

The community nurse visiting the home on the day of our inspection told us "The management structure has changed and the place runs really well now; much better than it used to". They went on to say "All the managers are approachable and very helpful".

Staff told us "I can come and work alongside people who are all making a contribution. It's a nice environment to be in" and "Management were supportive and listen to what staff say". Another staff member said "I would not trade this job for the world. Just to see the people being given the best care and support makes my heart sing". A further staff member said "I enjoy it. Staffing could be better but if I'm fair, it doesn't matter which area you are in. The residents are treated with compassion and get a good level of care". Staff were positive about people working together as a team and there being a happy atmosphere. They told us the vision of the home was to ensure 'everyone was happy, contented and lived as normal a life as they can'.

The home created opportunities for people to express their views. In the reception area the complaints policy was on display as well as information about other organisations that people could access. There was a 'suggestions, praise and complaints' box with forms available for people to complete and post in the box. There were some cards on display, which were for sale, that people living in the home had made. The provider also told us that the home had received the highest rating in the Wakefield and Pontefract area by carehome.uk. This website is a list of all care homes and the public have the opportunity to give the home a rating.

We were shown the results of the 'Client Satisfaction Survey' from April 2015. This showed that comments had been noted, both positive and areas where more development was needed. .Action plans had been drawn from these and the resulting changes were evidenced in minutes we saw from relatives' meetings.

The home also had regular events such as a summer fair attended by over one hundred people and live singers, opening of the home for the national care home open day and there were links with the local school whose children came and sang at Christmas and Easter.

The registered provider was keen to point out the changes that had been made since the last inspection. The registered provider highlighted the outside area and said they had made improvements to enable people to use the outdoors more with their relatives if they wished to. We did not see this being utilised by people living in the home on either day of the inspection despite the weather being good.

We saw improvements had been made to signs of people's bedroom doors, with photographs that the registered provider said had been chosen by each person. The registered provider told us they had purchased memory boxes so that important personal memorabilia could be placed inside them. These were displayed outside rooms to help a resident recognize their room. They could also be placed inside a room. Memory boxes are a tool to promote discussion around the objects within and designed to be interactive.

The registered provider showed us an activities board in the main lounge which displayed forthcoming activities. We saw additional items of interest, such as books, games, and displays accessible to people which had not been there at the last inspection. There had been some improvements to the layout of furniture in the main lounge/dining area and the dementia lounge and we saw the menu was displayed for people in picture form on the wall.

The registered provider shared with us a list of achievements and acquisitions. They were proud of their status as 'Employer of the Year 2014' as voted by Wakefield College. This was achieved as the home had worked in partnership for many years with the college, and recruited many of the staff from there. They were also keen to emphasise how much pride they took in their new nursing unit which was being supported by a strong and experienced team. Much of the focus had been improving the environment with a purpose built hair salon and general refurbishment.

We asked staff whether they thought the home was well led. One staff member told us "Yes. We are given autonomy

Requires improvement

Is the service well-led?

and power. The owners know what is going on and are approachable. The registered manager is very knowledgeable". Others told us the registered manager was 'very good' and 'accessible', and "They are clear about the standards of care". This was mirrored in the staff meeting minutes we saw where staff were given unequivocal instructions as to how to conduct themselves and follow the various procedures within the home.

A different member of staff said "I know I am listened to". They said "The owners are here six or seven days a week". Others told us "The owners are regularly involved", "They provide the things we need to do our job" and "They are very caring and know all the residents really well". Another staff member told us they felt the unit for people living with dementia had a relaxed atmosphere "and the unit manager was very forward-thinking". We asked for an example and were told that they had been instrumental in putting the dignity tree on display. This tree is a visible aid to promote good conversations and practice between people and staff.

We asked the registered manager how they ensure high quality care. They explained a nurse had recently been appointed to look at the number of audits the home were currently completing to determine their effectiveness and necessity. It was also so that any progress and change could be managed in a consistent manner. The registered provider also supported quarterly audits completed by external consultants looking at care plans and medicines records. We saw that these audits were detailed and had strict criteria by which records were assessed. We saw that where there were issues these were addressed in a timely manner and improvements sustained.

The consultants also offer support to the registered manager with any management issues. The registered manager was also encouraged to keep their practice up to date by attending different forums and reading relevant journals.

We found completed maintenance audits for all areas of the home and monthly kitchen audits. The latter saw any actions that had been highlighted as a result of the audit had been acted upon. There were also monthly bedroom audits, some of which did not have evidence that the findings of the audits had been actioned. An audit of call bells had identified seven rooms without one but there was no detail as to how this had been addressed.

Although there was evidence of staff meeting minutes these were not written in manner which promoted learning by staff as they were more a set of instructions form the registered manager. When we asked staff how they ensured good practice, they told us "We observe it. We had a dementia board for dementia week to explain all about dementia". We could not find evidence of interactive learning.

We found that although we saw some examples that indicated that the home was run efficiently in that care tasks were carried out and people had their care needs met, there was a lack of person-centred care. Staff were focused on performing key tasks such as personal care or providing lunch but did not demonstrate an awareness that this was a person's home.

The audits we saw focused on the paperwork completion rather than the effectiveness of how care was being delivered. We were told by the registered provider on numerous occasions how they felt they were "a leading home and dementia expert" but we did not always see evidence of this in relation to staff's understanding of person-centred care.

The culture within the home did not always demonstrate effective care for people living with dementia in accordance with the NICE Guidelines on Dementia 2006 which advocate the valuing of each person as an individual regardless of ability, encouraging them to be as independent as possible and using their life history to encourage participation in decision-making. Although the registered provider sought the views of relatives and health and social care professionals, there was little evidence of seeking the views of people living within the home as to the quality of care they were receiving.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services were not being enabled or supported to make choices about how to meet their daily living needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always treated with dignity and we observed on more than one occasion that people in distress were ignored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered provider was not notifying CQC of all incidents that affect the health, safety and welfare of people who use services, particularly safeguarding and serious injuries.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service was not recording best interest decisions in line with the requirements of the Mental Capacity Act 2005.