Maria Mallaband Limited

Water Royd Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Water Royd Nursing Home, known to people, their relatives and staff as Water Royd, on 20 February 2018. The inspection was unannounced.

Water Royd is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Water Royd accommodates 62 people across three separate units, each of which had separate adapted facilities. One of the units specialises in providing care for people living with dementia. There were 53 people living at the Water Royd, with a further two people being admitted on the day of our inspection.

Water Royd was last inspected in September 2015. At that time we rated the service as Good in all five key questions and therefore, Good overall.

At the time of our inspection the home had a registered manager in place. A registered manager is a person who has registered with CQC 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.

People were not protected against the risks associated with the administration of medicines as this was not always carried in a safe way. Topical creams prescribed for people on one floor were recorded as administered by staff without checking this was the case. One person had not received one of their medicines for five days.

People told us they felt safe living in the home and we saw there were systems and processes in place to protect people from the risk of harm. The management team and staff knew what to do to keep people safe. Individual risks had been assessed and identified as part of the support and care planning process.

People told us they were happy living at Water Royd and we saw respectful interactions between staff and people who used the service. We saw staff respected people's privacy and dignity and the home had a 'dignity champion' who helped ensure staff did this.

We found the home was well maintained, clean and tidy. People's bedrooms had been personalised and communal areas were comfortable and homely. The decor was dementia friendly with pictures and signage which helped support people living with dementia to navigate their way around the home.

Recruitment processes were robust. We saw there were sufficient numbers of staff on duty to ensure people's needs were met. Staff had received training and supervision to ensure people received effective care.

People's care plans contained sufficient person-centred information to guide staff in how to support them. The registered manager was in the process of updating each person's electronic care plan to included further individual information. The home had a 'digital champion' who supported staff members with the electronic care plans and any future developments.

Records showed people had regular access to healthcare professionals to help meet their wider health needs. People's nutritional needs were met and menus we saw offered variety and choice.

People enjoyed the different activities available and we saw most people engaged with activities in a positive way.

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

A complaints procedure was in place. We saw the complaints process was well-managed and people and their family members told us they would raise any concerns with the registered manager.

The home had good management and leadership. The registered manager was visible working with the team, monitoring and supporting the staff to ensure people received the care and support they needed.

People and their relatives had opportunities to comment on the quality of service and influence service delivery. We found some of the quality assurance systems were working well, whereas others needed to be improved to ensure people receive a consistent quality service.

We found one breach of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Medicines were not always well managed.

People told us they felt safe and staff we spoke with knew what to do if they witnessed abuse. Risks to people had been assessed and managed.

Sufficient numbers of staff were deployed to meet people's needs. Effective recruitment procedures were in place. The home was clean and tidy.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills they needed to support people safely. Staff had the opportunity to attend supervision.

The service was compliant with the Mental Capacity Act 2005. Adaptations had been made to the home to make it dementia friendly.

People's nutritional needs were met and they attended regular healthcare appointments.

Is the service caring?

Good

The service was caring.

People told us they were happy living at Water Royd and felt they were well cared for.

We saw people were treated with dignity and respect.

People and their relatives were involved in planning their care and treatment.

Is the service responsive?

Good

The service was responsive.

People's care plans were person-centred. We saw they were in the process of being updated.

Activities and trips out were on offer if people wished to take part.

Complaints were well-managed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to monitor the quality of the service were not always effective.

The management team within the service were available to give guidance to staff and had an 'open door' policy.

People who used the service, their relatives and staff were asked to feed back about the service.

Water Royd Nursing Home

Detailed findings

Background to this inspection

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

A comprehensive inspection took place on 20 February 2018 and was unannounced. The inspection team consisted of three adult social care inspectors, one bank inspector, a trainee adult social care inspector and two experts 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.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Prior to our inspection we reviewed all the information we held about the service. This included any statutory notifications that had been sent to us. We contacted the local authority commissioning and contracts department, safeguarding, infection control and Healthwatch to assist us in planning the inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all the information received from third parties to fully inform our approach to inspecting this service.

There were 53 people living at the Water Royd Nursing Home at the start of this inspection and a further two people were admitted the same day. We spoke with 11 people, some of whom were living with dementia, 11 family members, seven care staff, four domestic and kitchen staff, the chef, the activity co-ordinator, the deputy manager and the registered manager. We also spoke with three healthcare professionals during our inspection.

We observed care interactions in the communal lounges and observed the lunchtime meal on each unit. We reviewed documents and records that related to people's care and support and the management of the service. We looked at six people's care plans in detail and a further three care plans for specific information.

We also sampled people's medication administration records.

Requires Improvement

Is the service safe?

Our findings

The arrangements in place for the storage of medicines were satisfactory. The room in which the medicines were stored was tidy; temperatures of the medication rooms and fridges were recorded twice daily to ensure they were within the recommended limits.

Medication administration was recorded via an electronic system which displayed a photograph of the person. Once the system was ticked to indicate the medicine had been administered, the person's photograph changed colour to show the record was completed. We observed staff who administered medicines did so in a friendly manner; they spoke at eye level with people and offered reassurance. We saw staff who were responsible for the administration of medicines had their competency assessed. Records showed staff had completed the administration of medication training.

We saw covert medicines were managed appropriately and the administration of controlled drugs which are liable to misuse to be safe. Covert medication is the administration of any medicine in a disguised form.

We found a prescribed medicine for one person had been discontinued by the memory team. The person had been prescribed a medicine for anxiety by the memory clinic, which was last, received it on 15 February 2018. The registered manager confirmed the person's medicine ran out on 15 February 2018 which meant there was a five day period when they had not received it, although, staff had contacted the memory team to check if they medication was still required. The GP had been asked to visit due to the person's raised levels of anxiety; the staff stated the person's level of anxiety needed to be addressed. Before the end of our inspection the person's prescription had been submitted to the pharmacy for dispensing.

We found medication administration records for people's prescribed creams were not always completed appropriately or in a timely way. Records showed creams on the upper floor were applied by care staff and records were ticked on the electronic system by the nurse on duty prior to them checking if care staff had actually applied the creams. We noted body maps on the upper floor to show staff where to apply people's creams were not completed. We spoke with one staff member and asked how they knew where to apply the cream for one person; they said, "[They've] got dry legs. I just know." Following our inspection the registered manager told us people's creams that were prescribed were applied at the correct times, although, the nurse and senior staff member did not communicate with each other when creams were applied. They also stated, on the topical medication administration record staff documented creams had been applied.

We saw the process for recording cream application in place on the ground floor was not the same as the upper floor. The senior staff member checked with care staff if the creams had been applied prior to ticking the electronic system.

We saw the records care staff signed to say they had applied prescribed creams were not always completed. For example, we saw two people's records showed signatures were missing on 17, 18 and 19 February 2018. This meant the system to manage the applications of creams was not robust.

We concluded the management of medicines was not always carried out in a safe way. This is a breach of Regulation 12 (1) and (2) (g) (Safe care and treatment); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people had personal emergency evacuation plans (PEEP) in place so staff were aware of the level of support people required should the building need to be evacuated in an emergency. We saw risk assessments had been carried out to cover people's care and health and safety issues. These included malnutrition, mobility, choking, sleep, and skin integrity. This helped ensure people were supported to take positive risks as part of their daily lifestyle with the minimum necessary restrictions.

The registered manager told us they had worked hard to reduce people's risk of falls. They said they had worked in partnership with the falls team, completed analyses of falls and identified obstacles within the dementia unit that people may fall off or trip over, which were then removed. The registered manager said they used equipment, such as sensor mats, to also support people with their mobility. One nurse told us, "We don't have many falls because we are careful. When we do have them we document them and follow up to reduce the risk of them happening again." Another staff member told us, "If someone is assessed as high risk of falls, we'll put sensors in place and write a risk assessment." This meant the service identified and managed risks relating to the health, welfare and safety of people who used the service.

We found fire safety arrangements were satisfactory. The home had a fire risk assessment and records showed fire safety equipment was tested monthly and fire evacuation procedures were practiced. We saw the last fire drill was carried out in December 2017. There were clear directions for fire exits and the exits were kept clear and clutter free. Staff had received fire awareness training.

We checked records for the maintenance and upkeep of the home's building, utilities and facilities, for example, the gas supply, moving and handling equipment, and water temperatures. All checks and testing had been done as required. This meant the registered manager ensured risks to people posed by the building were minimised.

We saw pressure-relieving cushions and foam mattresses were checked on a monthly basis and air flow mattress were checked daily to ensure people's pressure area care was well managed. The checks confirmed air flow mattresses were set at the correct pressure for the individual, although settings were not recorded in people's care plans.

Information was securely stored but available to relevant staff when required, such as care plans and other confidential records. One staff member told us data protection was important. They said, "If it is confidential, we lock it away and log off laptops." This meant measures were in place to ensure the safe storage of information.

People and relatives we spoke with told us they felt safe in the home and they had as much or as little support as they needed. Comments included, "My [relative's] a nurse and [they] chose this place because [they] felt it was safe for me", "It's perfect here, [my relative's] been here [number] years and I have peace of mind [they are] very safe" and "I am impressed with how safe they keep my [relative], much better than at home."

Staff we spoke with had a good understanding of safeguarding adults, could identify types of abuse and knew what to do if they witnessed any incidents. One staff member told us, "We know people well, so if we spot any changes with someone and we think they might have been abused we safeguard. We'll document what we have seen and we report it." Another staff member said, "Any signs of abuse, like someone being

upset or withdrawn, bruising or marks, I would speak with the individual for as long as they wanted to talk, listening to them. I would then go straight and tell the manager, she would definitely do something. It's never happened, but I am sure they would respond if it did. I can take it higher too." All the staff we spoke with told us they had received safeguarding training and the training records we looked at confirmed this. The registered manager told us they had reduced the number of safeguarding incidents within the home by working in partnership with people's social workers and had implemented a tool which provided early indicators of people's health and well-being. This meant appropriate action would be taken if staff had concerns people were at risk of abuse or harm.

The registered provider had an equality and human rights policy which outlined staff and management duties in ensuring people were treated equally, with respect as individuals and protected from discrimination. This helped to keep people safe and challenge any discriminatory practice.

People and relatives we spoke with thought there were sufficient staff in the week, but less at weekends. All said there was no impact on their care and their needs were met. One person said, "If I need help I can have it with the ring of a bell no problem." Another person told us, "They are very busy but will chat if they have time." A third person said, "They seem OK for staff and they always remember my tablets and they come every day to clean." One relative said, "There are staff on all the time", and added, "There seems to be enough staff." A healthcare professional told us, "Staffing levels are good and some staff have worked here a long time."

Staff we spoke with told us there were enough staff on each shift. Comments included, "You've got to care about people to do this job. We have enough staff", "It's got better here recently, on the whole more relaxed as we all know what we are doing. We are busy though" and "Sometimes there is not enough staff if staff have gone sick, but that can't be planned. If it can be planned, then there are always enough staff. Sometimes, we can sit and enjoy a cuppa with people, which his important."

We found staffing levels were sufficient to meet the needs of people who used the service and records we saw supported this. We observed on several occasions people's sensors sounding, and saw staff responded quickly to make sure people were safe. We heard call bells were attended to in a timely way and saw staff were present in the lounge and dining areas throughout our visit. People told us staff responded quickly if they rang their call bell.

We looked at recruitment records for five staff members, three care assistants, one domestic assistant and one kitchen assistant. All records contained an application form, interview records and two references. We saw relevant checks had been completed, which included a disclosure and barring service check (DBS) and proof of identification and right to work in the UK. The DBS is a national agency that holds information about criminal records. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people.

We looked around the home and found the premises to be clean, tidy, clutter free and warm. Staff demonstrated good knowledge and awareness of their responsibilities for infection prevention and control. One staff member described the infection control training they had received and explained what they would do in the event of an outbreak being identified. There were up to date infection control policies and procedures in place. We noted the kitchen had been inspected by environmental health and had been given a '5 star' rating, which is the highest possible.

The management team learned lessons when things went wrong. We saw monthly analysis was carried out in response to accidents and incidents and weight management, identifying patterns and trends which the

registered manager then addressed through action planning. The registered manager said they shared information with staff to prevent any further issues.

Good

Is the service effective?

Our findings

People and their relatives told us they thought staff had the skills and abilities to look after them. Everyone spoke positively about the attitude of the staff.

Staff training records showed staff had completed a range of training courses. These included dementia awareness, first aid, food safety, and infection control. The registered manager had a mechanism to monitor training completed and identify what was due. The registered manager told us some staff had completed moving and handling and fire awareness 'train the trainer' sessions so they could provide training to other staff. One staff member told us, "There's lots of training, so we have the skills we need. Some of it is e-learning and some is a course in the home. We often talk about situations and what we could do. We share our knowledge and experience of people with new staff. We answer their questions and talk to them." This ensured people continued to be cared for by staff who had maintained their skills.

We looked at staff files and saw records showed a detailed induction process, signed by the new staff member and their supervisor when each part was completed. In addition there were initial training records and renewal dates for training, where applicable, and confirmation of competency checks on staff members.

During our inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. Staff confirmed they received supervision where they could discuss any issues on a one-to-one basis. Staff files evidenced each member of staff had received individual supervision and or a personal learning and development portfolio (PLDP) discussion. One staff member told us all the care staff had monthly PLDP meetings and staff could say how they felt they were doing and what training they would like. Staff also confirmed they received regular appraisals. This meant staff received the training, supervision and appraisal they needed to provide people with effective care.

People we spoke with were complimentary about the quality and quantity of food offered. One person told us, "I like the meals in here, I didn't eat at home, I am a rubbish cook." Another person said, "I like my bed and can have my breakfast in bed if I want to, better than a hotel." One relative said, "I have been impressed with the meals, they are excellent."

We observed staff giving out meals in accordance with a list of choices people had made the previous day. All people received their requested meal. One person refused the meal they had ordered and asked for an alternative. We saw this was brought by staff which they also refused. Staff then made the person a sandwich of their choice. For breakfast in each dining room we saw people were able to choose which cereal they would like from see through dispensers, along with a variety of cooked breakfast items.

We observed the lunch time meal in the dining rooms, although people were able to choose where wanted to eat their meal. Food was nicely presented and the tables were set with tablecloths, condiments, cutlery, napkins and flowers, and had menus on the tables. We saw staff encouraged people to eat and asked if they needed assistance to cut their food. People were not rushed and enjoyed their meals.

New lunch meal times had been implemented which allowed more time to ensure food was prepared well for each floor. We saw snacks and drinks were available throughout the day; the afternoon tea trolley had tea, coffee or squash, carrot sticks, homemade cake, biscuits, crisps and fresh fruit.

One staff member told us, "When new people come we go and meet them, we find out about any special diets they have as well as what they like and don't like." We noted one person's care plan we looked at stated they were vegetarian and an appropriate meal was served to them.

Staff we spoke with told us people enjoyed the food. One staff member told us "People are enjoying the new menu. At tea time people are definitely enjoying more of the food." This meant people's nutritional and hydration needs were met.

Staff told us they had daily handover meetings at the beginning of each shift which included discussion about people's current health and care needs. We saw a copy of the handover notes, which provided information about each person for the staff coming on the next shift. Staff worked well together as a team, helping each other in order to make sure people's care needs were met

Care plans we looked at showed people had been seen by a range of health care professionals including doctors, district nurses and chiropodists. One person told us, "My feet have never felt so good; I have the chiropodist every few weeks." Other comments included, "They always inform us about what is going on if [our relative's] been 'out of sorts" and "Staff responded quickly, [name of person] had an inflamed foot and UTI's (urine infections), they responded quickly."

In the registered provider's 'a guide to our services' it stated other visiting services include tissue viability nurses, epilepsy nurses, dieticians, community psychiatric nurses, continence nurses, Macmillan nurses and physiotherapists. The registered manager told us the dentist and GP attend the home when needed and the chiropodist visited every six weeks.

One staff member told us they had developed a close working relationship with visiting healthcare professionals and worked with them to support people's care and well-being. Other staff comments included, "If we think someone needs to see their doctor we go to the nurses. They check out our concern and then ring for the GP if they need to" and "We have lots of GP and district nurse visits." This meant people received appropriate healthcare support when needed.

The registered manager had made adaptations to the home, especially for people living with dementia. Water Royd had a homely feel with nicely decorated small lounge areas which had a focal point, for example, a fire place. We saw people's bedrooms were personalised with pictures, ornaments and photographs of family members. One person had their own bedding in their room. One staff member told us, "Rooms are decorated for each person and we trim up for festivities, like Christmas, Easter and we've just done Valentine's." This helped make people's rooms comfortable and homely. Each bedroom had an ensuite toilet.

We saw the corridor in the dementia unit had been decorated to create a 'street' affect, with shops, a bus stop and people's bedroom doors were painted different colours and made to look like front doors. There was a dementia café which people living on this unit were able to access. Everyone living in the home was able to access a secure garden area if they wished to.

Water Royd had a 'sensory' room that people were able to use as a tranquil and quiet space. An outdoors, garden feel had been created in this room which include seating areas, a small pond, with a water effect and

a pet tortoise. We saw people had planted fruit and vegetable seeds in small containers which were beginning to grow to add to the outdoor feel. This showed decoration and other adaptations to the premises had been made help to meet people's needs and promote their independence.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw information on a staff area display board which gave an explanation of the MCA and DoLS. The registered manager and staff had a good understanding of the MCA and the DoLS application process. Comments included, "It is about people making their own decisions and if not, having a best interest meeting to make the decision for them", "It is about people being able to decide things for themselves", and, "Someone who lacks capacity can't make some decisions themselves." Staff we spoke with confirmed they had received MCA and DoLS training.

We saw DoLS applications had been completed following a mental capacity assessment and had been submitted to the local authority. We saw some DoLS applications had been granted and the service had followed up those which they were awaiting approval for.

The care plans we looked at contained appropriate and person specific mental capacity assessments which would ensure the rights of people who lacked the mental capacity to make decisions were respected. This meant the service was compliant with the MCA.

We saw examples whereby people's care and support was delivered in line with legislation and evidence based guidance. The registered manager told us they worked with, for example, the National Institute for Health and Care Excellence for the management of medicine and LOLER (Lifting Operations and Lifting Equipment Regulations 1998) regulations, We also saw they used a tool called 'PINCH ME' (pain, infections, nutrition, constipation, hydration, medication and environment), which identified where people required further review of the care and support needs. This evidenced the registered manager used national guidelines to inform care and support practice at the home.

Good

Is the service caring?

Our findings

People who used the service spoke positively about the staff and their caring attitude. One person told us, "I like it in here; I can have all my own pictures on the wall." Another person said, "I have had the same carers all the time really, I'm fortunate, they couldn't have been nicer."

Relatives we spoke with said, "My [relative] came in here because [they were] lonely and depressed. Now [they go] to the sing along on a Wednesday. They even got [them] up singing last week", "I can't praise them enough. My [relative] had lovely clean laundry all put away tidy", "Friends told us it was good and it is, very good", "Staff always talk when passing" and "I have no issues, no worries it lifted a weight when [my relative] came here."

During our inspection we observed positive interactions between staff and people who used the service. Staff were caring and approachable, chatting to the people as they supported them. We observed one staff member bent down and held one person's hand while clearing away a cup. The staff member asked the person if they were OK and if they wanted lunch in their room or in the dining room. Staff spoke clearly when communicating with people and care was taken not to overload the people with too much information. Staff knew people by name and conversations indicated they knew what people liked, and about their life history. There was a relaxed atmosphere in the home.

People's care was tailored to meet their individual preferences and needs. People looked well cared for. We saw they were smart and clean in their appearance which was achieved through good standards of care. We saw people were wearing shoes or slippers.

A healthcare professional told us, "If I had a relative, this home would be the first on the list."

We saw staff at the home had received written compliments from family members. For example, 'I would just like to say a massive thank you for caring for [name of person], whilst [they were] in your care, much appreciated', 'Just to say many thanks for taking such good care of [my relative], it was only a short time but we know [they were] in good hands' and 'To all the wonderful staff and thank you for the compassionate care given.'

Care plans we sampled reflected the involvement of the person or their family members in their development. One relative told us, "We have regular meetings about my [relative's] care." A number of relatives called into the home during our inspection; we saw they were welcomed and staff clearly knew them well. This meant people and/or their relatives were involved in their care planning.

People told us they were treated with respect and their privacy and dignity was taken care of. Their relatives agreed. One relative said, "Best place by far, they treated [my relative] with dignity."

We spoke with a staff member who acted as the dignity champion. They said their role included speaking with people to address any concerns, for example, if items of clothing not been returned from the laundry.

They also supported other staff members to ensure they respected people's dignity and addressed any staff competency issues in relation to people's dignity.

Staff spoke about the importance of ensuring privacy and dignity was respected. People were also encouraged to retain their independence. We saw one staff member had noticed a person's nose was running and they discretely, with care, asked if the person wanted help and then provided it.

One staff member said they treated people with dignity by making sure their wishes were carried out and knocked on people's bedroom doors before entering. Another staff member told us, "I always ask before I do anything and explain what I am doing in case they want something else or want something done differently. It is important to remember that while they are here this is their home now." A third staff member said, "I give people time in the bathroom on their own."

Within the registered provider's 'a guide to our services', it stated, 'There is a quiet, happy and informal atmosphere within the home in which each resident is encouraged to choose his or her own lifestyle with support from all grades of staff'. We saw in the reception of the home a rainbow heart shaped picture with the words 'love is love'. The registered provider's policies included sexuality and relationships, equality, diversity and human rights and equal opportunities.

Within the registered providers 'a guide to our services' it stated, 'There is no denominational bias within Water Royd House. Residents are encouraged to follow the religion of their choice. Visiting clergy are welcome.'

Staff supported people with whatever spirituality meant to them. People were able to attend religious services if they so wished. One person told us, "I like it here because we have church services in the coffee room." This helped to support people's spiritual, religious and lifestyles needs.

Advocacy was available to people living at Water Royd. An advocate is a person who is able to speak on another person's behalf when they may not be able to, or may need assistance in doing so for themselves. The registered manager told us three people who used the service were currently supported by an advocate. This meant people had access to independent support with decision-making if they needed it.

Good

Is the service responsive?

Our findings

We saw all the care plans and daily records were electronic with staff accessing the information through iPads and laptops. This enabled staff to update and check records quickly. Shortly before the inspection the home had moved to an upgraded version 'I-plan dynamic' which required all the care plan information to be re-entered. Staff stated this was a good thing as it gave the opportunity to review and update the information in each care plan. One staff member we spoke with told us they were the 'digital champion', they got to know everything about the care planning system to help out other staff members and problem solve. They said, "The use of handheld devices for each staff member will be introduced in the near future. Digital champions have already been trained."

People had their needs assessed before they moved into the home. Information was gathered from a variety of sources, for example, any information the person could provide, their families and any health and social care professional involved in their life. The information was then used to complete a detailed care plan giving staff the information they needed to deliver appropriate care. This helped to ensure the home was able to meet the needs of people they were planning to admit to the home.

Most care plans we saw were up to date and contained relevant information, although updating was required in some of the care plans. For example, we saw two people's 'profile sheets' had not been completed. We saw another person's care plan stated 'may refuse medicines' but there was no information as to how to encourage the person to take their medicines, or what to do if medicines were refused.

We noted it was difficult to establish if people were repositioned to reduce their pressure area risk in accordance with their care plans as information been recorded in different parts of the electronic system. The senior staff member explained some staff recorded this information on the repositioning record and sometimes on the daily living record. The senior staff member agreed this should be recorded consistently and they had already discussed with the manager, who was going to raise the issue at the next staff meeting. Records we saw evidenced people were supported to minimise their pressure area risk.

We looked at one person's care plan which had recently been updated and found this was more detailed and person centred. The registered manager told us they were aware of the areas in the peoples care plans which required further updating. They said all the care plans would be reviewed and updated by the end of March 2018 and this would include involvement of people and/or their family members.

One staff member told us. "Care plans have to be reviewed each month and then every three months they do an audit and we get a list of all the things we need to do. We need to put them into the new format now and they are going to be much more up to date and personalised. They are also trialling handhelds for care plans; we will all have one which will be much better." Another staff member told us, "When new people come here, we ask them how they want to be looked after. We look at their care plan, and if we find there are differences, we pass it on to other staff at handover so we can get the care plans right. If I thought a care plan was wrong I'd always check it out with the nurse first or a senior."

A healthcare professional told us, "Staff are aware of people's needs. They have good care plans which are computerised." This meant people's care plans contain sufficient information for staff to meet people's assessed needs.

People living in the home were offered a range of social activities. The service had an activities co-ordinator in post and we saw a programme of activities was on display. Activities included exercise, jigsaws, sing-a-longs, games, dancing and trips outs.

One person told us, "I have my nails done by a lady who comes in; having my nails done makes me feel better. One carer is taking me for some new shoes", and a second person said, "They all know I like my Sudoku so they have ordered me my regular paper to be delivered because it's in there." One relative we spoke with said, "There is always something going on, singers, nail painting, hairdressers. They brought [my relative] a jigsaw to [their] room."

The activity co-ordinator knew each person by name and their likes and dislikes in relation to activities. We saw they encouraged people to take part in activities, for example, by encouraging one person to show others how to use sign language and other people to take part in chair exercises. We also saw within the registered provider's 'a guide to our services' it stated, 'This home provides free WIFI. More and more people are using social media to stay in touch.'

We observed a bingo session and noted one person required support, but there was only the activity coordinator in the room. We spoke with the registered manager who told us they would look at this immediately.

Two people we spoke with told they would like some books with large print. The registered manager told us they would make books available for people to use. We saw one wall on the dementia unit had been designed to display people's art work with a gallery like feel. This meant people were occupied and had access to activities if they wished to take part.

People who used the service and relatives we spoke with told us if they had any concerns they would feel able to raise these with the registered manager. Comments included, "If I have a problem I tell my family and they talk to the manager", "If I am worried about anything I just tell them they are good like that", "I would feel ok telling her if I had a problem" and "It wouldn't worry me if I had to complain, they are all approachable."

Staff we spoke with said they were confident any concerns raised would be handled well. Comments included, "Any complaints I'd deal with what I could myself to put things right, and then report it to the nurse in charge" and "I would see I staff could deal with it at the time, as well as taking it to the deputy or the manager, I would document it."

We reviewed how the service recorded, investigated and responded to complaints. We looked at seven complaints received in 2017 and saw these had been investigated and resolved within one month of receipt, with a letter from either the registered manager or regional manager providing an explanation and apology. We saw one complaint in 2018 was still being investigated by the provider's quality assurance manager.

Details of how to make a complaint were included in the registered provider's 'a guide to our services' document and the complaints procedure was displayed in the entrance to the home. One relative told us, "I was given a leaflet when my [relative] came in for the grievance procedure, but never needed it."

We saw people's end of life wishes were recorded in their care plans. The registered manager told us they were in the process introducing a new end of life care plan as a result of them reviewing the paper version prior to this being added to the electronic system. We saw one thank you card from a family member which said, 'Difficult to put into words how grateful we are that we chose Water Royd for our [relative's] palliative care.'

The deputy manager told us the service supported people with palliative care and were considered a 'second hospice' within the area. They worked in partnership with the Macmillan nurse to support people who were approaching the end of their life. We spoke with a healthcare professional who told us, "I have provided teaching and learning on end of life care which has been embedded and implemented." A relative told us, "When [our relative] was dying they stayed with [them] until we got here and whenever we had to pop out. They are a credit to the nursing profession."

A staff member told us, "End of life gets intense, especially when we lose a long term resident who we have cared for. We had one person's [relative] who liked to come here to talk to us after [their spouse] had passed. We sat and listened to [them] and let [them] grieve." Another staff member said, "When someone passes, I make sure their room is cleaned and all laid out neat and tidy for the family, it's the last thing we can do for them. I'll put a tray in with some drinks on too so they can have a moment together if they need to." This meant people's wishes were respected when they reached the end of their life.

The Accessible Information Standard came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand, plus any communication support they need when receiving healthcare services.

At the time of the inspection the registered manager and regional manager were aware of the Accessible Information Standard. We saw a pictorial document was in the entrance to the home which provided information about accessible information and what formats and types of communication was involved. We saw people had communication care plans in place which described if they had any eyesight or hearing aids. The registered manager told us they used picture records and a board to support one person's communication needs. A staff member also said, "We have one person who is deaf, so we keep a board and pen in their room to write on for them when we are talking, so they know what is going on." This meant the home were compliant with Accessible Information Standard.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the manager was registered with the Care Quality Commission. The registered manager and deputy manager worked alongside staff overseeing the care given and providing support and guidance where needed. We saw they engaged with people living at the home and were clearly known to them.

People and relatives offered positive feedback about the management team at Water Royd. Comments included, "I can talk to the manager no problem. She is on the ball, ask her and she sorts it", "I know the manager she's about a lot", "When I had problems with my [relative's] money the manager told me what to do and who to see. She was a great help", and, "I found the manager very approachable when we had problems with the [an issue]."

One relative said, "I don't regret bringing [my relative] here for one minute. I don't worry about [them]. We can go to bed and go to sleep we know [they're] cared for. I got a good feeling as soon as we walked through the door. [My relative] is so well looked after the staff are always there I can always find someone."

Staff we spoke with told us they enjoyed working at Water Royd and described the manager as very approachable and always happy to listen. Comments included, "We have our brand values, so we all know what is expected. When there is low morale, we all cheer each other up", "The manager and deputy here give us all good support", "I can always talk to the manager, she listens and responds" and "If I am not happy about anything I can speak with management. I would talk to the nurse first. They are good management here and not hard to approach" and "They don't stay in the office, we see them. They are all up to date with everything and they keep us up to date too."

Staff said they would happy to have their own relatives in the home; one staff member said, "It is homely, and it's all about the residents, it's a home from home and how they want things to be."

The registered manager told us they had an 'open door' policy and were visible around the home. We saw the registered provider's brand visions displayed in the entrance to the home which were Caring, Compassionate, Considerate and Competent.

We noted the administration of one person's the eye drops could not be recorded on the electronic system as initially the eye drops could not be located, therefore, the staff member recorded the medicine had not been given. After the medicine round a staff member found the eye drops and said, "These must have been put in the fridge in error as did not need to be kept in the fridge." Following our inspection the registered manager stated the staff member at the time was unware of the process to reverse the decision recorded on the electronic system.

Records showed staff meetings were monthly and staff told us the meetings were inclusive. According to the November 2017 meeting minutes, discussions had included, care and staff issues, health and safety, policy awareness and 'brand' values. Staff told us they were given a say in decisions, such as when discussing new

uniforms, and were asked for their opinions on any proposed changes.

The registered manager told us they consulted with people regularly through residents' and relatives' meetings and surveys, to seek their views about the service and if there were any areas that could be improved. We looked at the minutes from the January 2018 residents' and relatives' meeting and saw discussions had included meals, staffing and activities. We saw action plans were created from the meetings and 'You Said, We Did' information was on display in the entrance the home. For example, people said, 'Could we have more shopping trips' and the registered manager had responded with 'Booked dates and arranged transport'. Relatives we spoke with said they felt they could voice their concerns if they had any. One relative said, "There are family meetings with notices and invitations and we get feedback if we don't attend." This meant the management team actively sought feedback to help improved the service provided.

Systems and procedures were in place to monitor and assess the safety and quality of the service. We saw the audit file contained a schedule setting out which audits would be completed in which month. In January 2018, audits undertaken included, safeguarding, care plans, medication, maintenance records and health and safety. Where areas for concern were identified action plans had been produced, with dates for completion set. We saw actions from previous audits had been marked as complete and dated. We also saw in January 2018 a night visit report and a dining room observation. All of these included action plans and dates for completion. This meant systems were in place to identify and address issues, however, the medication audit had not identified the concerns we found during this inspection. Following our inspection the registered manager told us medication audits were carried out on 31 January and 7 February 2018, a further medication review would have identified these areas.

The registered manager completed a 'resident at risk' tool which provided an early indication of concerns with people's pressure care, weight loss and skin tears. They said they checked these areas each week and made sure people's care plans were updated to reflect any changes. They also completed a 'walk around' of the home several times a month which looked at aspects such as infection control, maintenance and fire procedures. Action was taken if necessary. This meant people's risks were mostly appropriately managed.

During the inspection, the registered manager told us they worked in partnership with several organisations to support care provision and promote joined-up care. These included social workers, the falls team and Macmillan nurses. The registered manager said they also provided placements for students from the local college who were considering a career in the health and social care sector. This meant people had the benefit of specialist advice and support.

Notifications had been sent to CQC by the home as required by legislation. For example, homes have to notify CQC about serious injuries people sustain, allegations of abuse, incidents reported to the police or any incident which stopped the service from running.

There is a requirement for the registered provider to display the rating of their most recent inspection. We saw this was both displayed in the entrance to the home and on the registered provider's website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We concluded the management of medicines was not always carried in a safe way.