Londesborough Court Limited

William Wilberforce

Inspection report

West Green
Pocklington
York
North Yorkshire
YO42 2NH

Tel: 01759302294

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09 July 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 2, 5 and 9 July 2018 and was unannounced.

William Wilberforce is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

William Wilberforce provides accommodation and support to a maximum of 64 people some of whom may be younger or older adults that may have physical disabilities and/or living with dementia. At the time of our inspection there were 55 people using the service. The home is purpose built with all rooms being en-suite over three floors. Rooms on the ground floor have access to a small patio. People living with dementia live in various areas within the home. However, on the ground floor some people are living with dementia that may require higher levels of support and supervision from staff. A large safe garden is available for residents to access freely and parking is available on site. The home is located on the outskirts of Pocklington in East Yorkshire.

There was a registered manager in post at the time of this inspection. However, they were unable to be present during this inspection. We were supported by the deputy manager and director in their absence. 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.

Risk assessments associated with people's care and support had been completed.

People did not always receive consistent person centred care and support to meet their individual needs, and preferences.

People received their medicines as prescribed and these were stored safely. However, medicines for pain relief were not always monitored to check their effectiveness.

Staffing levels were seen to be sufficient to meet people's needs.

A variety of quality assurance systems were in place and identified areas that required improvements to be made. Records showed actions plans had been implemented to ensure improvements were made throughout the service. However, the systems in place did not identify some of the issues we raised during this inspection.

We also identified one breach of the Care Quality Commission Registration Regulations 2009. This related to the failure to notify us of other events and incidents which had occurred at the service which the provider is

legally required to inform us of. We will deal with the notification issue outside of this inspection process.

Systems were in place to protect people from avoidable harm and abuse. Staff had good knowledge of the types of abuse and how to report them.

Recruitment included pre-employment checks to ensure people were of a suitable character to work in a care home environment.

Robust systems and processes ensured the safe management of infection prevention and control.

Staff adhered to the Mental Capacity Act and asked for people's consent before carrying out care and support tasks. For people who lacked capacity to make decisions for themselves best interest decisions were arranged with health professionals and relatives input.

Staff received refresher training relevant to their role and senior managers provided additional support during observational practice. Health professionals had delivered some specialised training in dementia to support staff in managing behaviours positively. Supervisions were regularly completed and encouraged reflective practices.

Staff encouraged people to be as independent as they could be and knew people's levels of independence to be able to support them appropriately.

People told us they felt staff were caring, helpful and kind to them. They felt staff respected their wishes and that their privacy and dignity was maintained.

Policies were in place to support staff in promoting equality and recognising people's diverse needs.

Regular activities were arranged within the service including barbecues, entertainment and films shown at the in-house cinema. Relatives were encouraged to attend all events and activities.

Systems were in place for people or their relatives to raise a complaint if they wished to do so. Information was readily available and included in the service user handbook.

The provider sought feedback from people and their relatives to improve the service. Records showed that changes had been made as a result of suggestions made by both relatives and people living at the service.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains safe.

Rotas were completed by senior staff to ensure staff knowledge and skill mix was sufficient to meet people's needs.

Risk assessments were in place and included some information to guide staff when managing risks to people.

Medicines were managed safely and people received their medicines as prescribed. However, medicines for pain relief required further monitoring.

Infection prevention and control measures were robust and systems were in place to promote best practice.

Is the service effective?

Good

The service remains effective.

We received mixed feedback from people about the food. The provider had plans to improve the dining experience and was in the process of changing from precooked to fresh home cooked food throughout the service.

Staff received an induction to the service and shadowed an experienced member of staff until they were deemed competent to work alone.

People told us that staff asked for their consent prior to carrying out any care and support. We observed this was happening in practice.

Records showed that staff supported people to access appointments to support their health and welfare when needed.

Is the service caring?

Good

The service remains caring.

People described staff as helpful, conscientious and kind.

Staff could tell us about each person's level of independence and promoted their privacy and dignity at all times.

We observed many positive interactions between staff, people living at the service and their relatives.

Personal information was stored securely and the provider was complaint with the new changes in data protection laws.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always contain sufficient detail to encourage a person-centred approach.

People were not always offered choices and support from consistent staff during meal times.

Regular activity schedules were in place and staff asked people for their feedback to plan future events.

Complaints policy and procedures were available for people and their relatives should they need them.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had not always informed CQC of important events happening within the service.

Some records were not completed at the time that care and support was delivered to people, making it difficult to ensure records were accurate.

Person centred care and support was not always consistently delivered to all the people living at the home.

Some audits identified areas that required improvements and action plans were put in place. However, they failed to identify some of the issues raised during this inspection.

The management team had built links with external agencies and improved working relationships with health professionals to improve outcomes for people.

William Wilberforce

Detailed findings

Background to this inspection

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

This was a comprehensive inspection. The inspection took place on 2, 5 and 9 July 2018. The inspection was unannounced.

On the first date the inspection team consisted of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The last two dates were attended by one adult social care inspector.

We requested feedback about the service from the local authority commissioning and safeguarding teams. 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.

During the inspection, we spoke with nine people receiving a service, one visiting relative and one visiting health professional. We spoke with three care assistants, four senior care assistants, the lifestyle and well-being facilitator, the cook, head of hotel services, head of public relations and lifestyle and the director of Londesborough Health Care Group. The provider name was in the process of changing and the director advised they would inform our registrations team once this process had been completed. We were unable to speak with the registered manager as they were on annual leave at the time of this inspection.

We reviewed a range of records which included care plans and daily records for five people and five staff files. We checked staff training and supervision records and observed medicines administration. We looked at records involved with maintaining and improving the quality and safety of the service which included audits and other checks. After the inspection we received feedback from three health professionals.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

Records showed that safeguarding incidents and other accidents or incidents had been managed effectively to maintain people's safety. The accidents and incidents log showed some incidents were of a safeguarding nature. These had not been identified as safeguarding referrals and actions taken to refer to other external agencies had not been recorded. The incidents had not resulted in any injury or harm to people. This has been addressed in the well-led section of this report.

We found staff were attentive to people's needs in communal areas. At times, staff presence was not always visible throughout the home. We received mixed feedback from people living at the service about staffing levels. People's comments included, "On the whole yes, sometimes they are short of staff if people have gone off sick" and "I don't think they have enough staff all of the time" and "Yes, they are in attendance in case I fall." We spoke with two health care professionals who told us they felt staffing levels appeared to be ok.

The provider told us they calculated staffing ratios using a dependency tool which took people's needs into account. Senior staff allocated rotas and were aware of how to manage appropriate skill mix and experience to meet the varying needs of people. All the staff we spoke with felt that there were sufficient staffing levels to meet people's needs. Supervision records showed that staff discussed working arrangements and one member of staff had asked to reduce their shifts which was accommodated. We observed that overall people were dealt with in a timely way and could take things at their own pace.

Systems were in place for the safe management of medicines. People received their medicines as prescribed. Senior staff were responsible for administering and managing medicines, all these staff had a level three qualification in health and social care, received annual medicines refresher training and competency checks. This practice supported staff to manage and administer people's medicines safely. Staff had a list of dates for when people's six-monthly medicine reviews were due and any concerns were discussed with the GP during weekly visits. However, 'as and when required' medicines for pain relief were not always being monitored to ensure they were effective in managing people's pain. Some prescribed creams had 'as directed' labels on them. This meant that we could not be sure they had been administered correctly as there was no guidance available from the prescriber. The provider put measures in place to ensure medicines for pain relief were monitored for their effectiveness. They told us they would contact the GP to ensure labels for creams specified the area they were to be applied on the body.

Risk assessments had been completed for identified risks and referrals made to the falls team, speech and language therapists and the GP when appropriate. One person had chosen to drink alcohol during meal times. This had been discussed with their GP due to risks associated with their health conditions. It was agreed with the person's consent that the alcohol would be diluted with lemonade as recommended by the GP. This had been clearly recorded in their risk assessment. Two people whose files we reviewed had a risk assessment in place for falls. Part of the steps for staff to take stated, referral to multi-disciplinary team wherever possible or as required. This did not provide sufficient guidance for staff to be aware of when they needed to escalate for further support. The provider took immediate steps during the inspection to update

these risk assessments to ensure clear guidelines were in place for staff to follow.

Environmental risk assessments were in place and included guidance on managing hot weather conditions and the associated risks of sun burn to people. The garden area had shaded places available for people and staff regularly checked fluids were on offer for people. However, we did notice some people were sat in the sun for long periods of time which was their choice. Staff assured us they offered sun creams and encouraged their use or alternatively people were asked to return inside to prevent issues such as sun stroke.

People told us they felt safe living at the home and that staff were kind and helpful. One person said, "I have used the call bell once and they [staff] came quickly." A second person told us, " With me staying here my daughter can go on holiday with an easy mind." Staff had completed safeguarding training and knew about potential types of abuse and how to report them. One member of staff told us, "I would report to the manager, make sure the resident was safe and report to CQC. The director is a nurse so we have additional support if needed."

Initial assessments were completed before people stayed at the service. These were often completed by the person or their designated relative and the service offered their support to assist in completing them if needed. This information enabled staff to assess whether they could meet that persons needs or required additional information from other health professionals prior to accepting an admission.

The provider ensured safe recruitment practices were in place. Staff files recorded pre-employment information such as references, photographic proof of identity and disclosure and barring service (DBS) checks. The DBS enables organisations to make safer recruitment decisions by identifying candidates who may be unsuitable to work in a care home environment.

Individual emergency evacuation procedures were in place which detailed the support people required to safely evacuate the home in the event of an emergency. This included differences in cognition during day and night times. Regular fire drills were held to ensure staff were aware of their responsibilities.

Maintenance records showed regular checks had been completed such as, servicing of equipment such as passenger lifts and hoists. Utilities for gas and electrics had current certificates to show they had been inspected.

Prevention and control of infections was managed extremely well. Audits were in line with best practice and management had implemented thorough policies and procedures to support staff. Personal protective equipment, such as gloves and aprons was available at all times and staff used these when necessary.

Good

Is the service effective?

Our findings

We observed meals being served at different intervals in three dining areas, as well as serving people in their rooms. The director advised this was to accommodate people's preferences and needs. For example, those people more independent had chosen to eat with their friends at a later time in the bistro café. People living with a dementia had their own smaller dining area. The food looked appetising."

The provider told us that normally people chose their food prior to the dining experience and that staff were trained to ask people whether they still wanted the same meals or an alternative. Precooked meals were provided from an external catering company. The provider was in the process of gradually changing so that they were cooking freshly made meals of people's choosing. The cook told us that during the recent changes they had been baking cakes for snacks and offered tasting sessions so that people could give their feedback on whether they enjoyed them. During the inspection, there was a barbeque in the garden area that was well attended by staff and people living at the service.

People and their relatives told us they thought staff had the skills and experience needed to provide effective care and support. One person said, "They [staff] know what they are doing" and a second person advised, "I have no complaints about the staff." One relative told us, "The staff are wonderful." All the staff we spoke with felt supported by the management team.

New staff completed an induction to the home, which included introductions to people living at the service, colleagues, policies and procedures and training to understand the providers philosophy and standards expected in the role. One senior member of staff advised, "We have recently completed 'React to red' training to support with care around pressure sores, learning the importance of nutrition and hydration, infection control and observations. If we notice someone has a poor appetite we offer milkshakes, fresh fruits, cream, full fat milk and some people receive prescribed supplements to support with their nutrition and hydration. Same with falls, we have received training and know to refer a person to the falls team through the GP if they have two - three falls within a short period of time."

Some staff had completed a National Vocational Qualification or equivalent in Health and Social Care to level two and/or three. All staff completed training courses alongside their induction and spent time shadowing more experienced members of staff before working alone. The provider set monthly meetings to support new staff through their six-month probationary period and ensured feedback was gathered to improve future inductions. Training included; safeguarding, moving and handling, understanding challenging behaviour, active listening and first aid and resuscitation. Following initial training staff were expected to complete the care certificate. More experienced staff mentored new staff and were available to provide guidance. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

One health professional advised, "There are some gaps in the staff's understanding and skills in managing people with Dementia. However, they have accepted training as offered by the team and the manager has

informed me that she is planning further, more in depth training for staff. The staff team are less able to work positively with people who have more complex needs, but they acknowledge this." Further work has been completed recently to support staff in this area and has been included in the well-led section of this report.

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 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. The provider was following the MCA. Records showed that when staff were concerned about people's capacity to make informed decisions, assessments had been carried out and meetings held to make decisions in people's best interests.

Where restrictions were needed to keep people safe, applications for DoLS had been submitted to the local authority for further assessment and approval.

A health professional advised, "The staff give an indication of what they think in line with the mental capacity act and I have felt every time they have been correct. I have no concerns in this area."

People told us staff always asked for their consent before carrying out any care or support for them. One person said, "They [staff] ask if I need help with a showering or if I need help putting my slippers on." We observed staff knocking on people's bedroom doors before entering and assisting people to the dining area and back to their rooms if needed.

People were involved in decisions to maintain their health and wellbeing. This included the initial assessment which was completed prior to moving into the home, where people were unable to complete themselves they had asked their relative to complete on their behalf. This information was discussed with people and formed part of the care planning process so that staff had information about people's support needs. Some care records included a "patient passport" providing personal details such as their preferred name and important contacts. The provider told us they were in the process of becoming paperless and so future patient passports would be printed off the system with a list of medicines to take with them. This promoted consistency of care when transferring between health services.

The provider worked in partnership with health professionals to ensure people's immediate needs were supported. One health professional told us, "I only deal with three senior carers during my visits and they appear to have had adequate training. Staff always act on the advice I give to them." However, one health professional raised concerns that the seating was not always appropriate in that it did not offer support to promote good posture for people. During our inspection we did see some chairs that were available and supported good posture. Records showed staff were consulting with health professionals when their needs changed and this included discussions in terms of better seating and sleeping arrangements. The deputy manager assured us this was an area they would be monitoring alongside health professionals visiting the service to ensure people's needs were being met.

People confirmed they could access services to maintain their health and records showed regular visits by the chiropodist, GP and the district nurses. Records showed communications with a variety of health

professionals and this information was transferred into care plans to ensure they were up to date. During the inspection we observed a chiropodist visiting several people in the home, district nurses and a GP.

The design and adaptations within the premises were suitable for those that were more independent. Each area of the home had a street sign to assist people to find their rooms and move independently within the home. Books were available in the library and different items were displayed around the home such as, old style music players and a writing bureau. Corridors were wide to enable wheelchair access.

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. One person said, "The staff are excellent." A second person told us, "The staff are wonderful."

We observed care interactions around the home. Staff were conscientious, always polite and sensitive to people's needs. People were comfortable in the presence of staff, although one person told us, "They [staff] don't have enough time to chat with us." We did observe staff interacting with people, but during busy periods such as meal times staff did look extremely busy.

Staff were knowledgeable about ways they could promote people's independence. They told us some people could do more than others and were knowledgeable about people's needs. One person said, "They encourage me to remain independent, some things I can do myself."

People were allocated a keyworker who had overall responsibility to ensure their needs were met. We observed staff explaining information to people before supporting them to mobilise. Staff were professional and always smiling. One health professional provided feedback, "Communication between staff could be improved. The senior carers seem to be much more informed than the other staff." We found this was the case during inspection. However, this was an area the provider was looking to improve. All staff received a thorough induction to the service and were introduced to people they would be caring for. Regular meetings were held to provide updates to staff and additional training from the deputy manager. Where staff's first language was not English, the provider had systems in place to support them to recognise the English culture and gave appropriate examples of words to use and short phrases.

The provider had systems in place which considered the work and life balance for staff and directors were considering how they could improve this area to support staff. This practice and level of consideration was reflected in discussions with staff that they felt valued by the senior managers at the home.

Staff had received training in dignity and respect and could tell us how they supported people to maintain their privacy and dignity. One member of staff advised, "I always knock before entering someone's room and ask if they are ok to have personal cares completed. I close the curtains and cover people up during personal cares."

We observed many positive interactions between staff and people living at the service. One person was walking with a frame and staff promptly offered a handkerchief as their nose was running. A second member of staff attentively stopped to chat with them and offered to take the old handkerchief away and gave them a clean one which they took and smiled. Some staff were offering reassurance to those less mobile staying in their own rooms. One member of staff told us, "[Name] likes to help me feed the birds when it's a beautiful day." We observed another member of staff singing with people as they walked around the home. This created a warm atmosphere and people were clearly enjoying those interactions. All of the residents we saw during the inspection were clean and wearing appropriate clothing.

Staff understood the importance of equality and diversity and completed training in this subject. One member of staff told us, "We had a Romanian and Polish night for both staff and people living at the service to build connections." One couple at the service had two rooms, one was utilised as a bedroom and the second room was their living room. They told us they were quite happy and didn't want for anything. Care plans recorded information that was important to people, this included any religious beliefs, interests and hobbies.

Information on advocacy services was available for people and their relatives. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

The provider told us there were no restrictions on visiting times to the home. Relatives were encouraged to get involved with activities and we observed several relatives attending the entertainment with their loved ones. One member of staff told us, "Relatives often attend the summer barbeques and enjoy the entertainment that is organised."

The provider stored information securely and had taken measures to prepare for the changes in data protection laws. One member of staff had been delegated to oversee and research the changes required and ensure all staff were informed and understood what this meant for them and people living at the service.

Requires Improvement

Is the service responsive?

Our findings

Care plans were computer based and contained people's daily routines including information about the support people required for personal care, oral hygiene, mobility needs and to maintain nutrition and hydration. These were reviewed monthly or earlier if there were changes to people's needs. The provider told us they were in the process of becoming paperless. During the inspection, information was provided in paper format and some seen on the computer systems.

Care plans did not always contain sufficient detail to promote a person-centred approach. People told us they felt involved in their care planning and that staff knew what care they needed. However, when more person-centred information had been recorded, observations showed us staff were not always supporting those people with higher dependency needs. One person's care plan advised they may try to eat food with their fingers. We observed them eating with their fingers, but none of the foods had been modified to support their independence. During the lunchtime period, we observed a second person receiving significant assistance from several different staff to eat their meals. This meant there was a lack of consistent support and encouragement for this person. A third person's care plan stated they required assistance to wash and dress. The actions for staff to take advised to ensure the person had everything required to wash and dress. There was no specific information detailed about the level of support required to promote their independence or details of how the person wanted to be supported by staff. In addition, one person's prescribed creams for washing and for their skin condition had recently changed, but these had not been changed in the care plan.

Care plans were not always in place for specific conditions such as, dementia, stroke and diabetes. However, the provider had ensured information was available for staff to read about different health conditions. This did not always promote person centred care planning. Care plans did not specify how conditions such as a dementia affected individuals and how they would like to be supported. The provider acknowledged that some care plans needed reviewing to promote a more person-centred approach, and to incorporate more detailed information in line with people's choices and preferences.

People could choose where they wanted to spend their time and during mealtimes some people opted to eat in their bedrooms which staff accommodated. However, we found the dining experience was not consistent across the service. Some people were not always given a choice of what foods they would like to eat or supported in line with their care plans. A relative told us, "They are not given an option [In relation to food choices]." We observed lunch in the main dining area and although some people were asked what they would like to eat, we saw at least one person was not offered any choices. This person could not communicate verbally, but could make their wishes known to staff using non-verbal communications such as a nod of the head. However, staff made no attempt to support this person to make a decision about what they would like to eat. In addition, we saw that no alternatives were offered to this person when they refused their dessert. This showed staff were not always taking the time to deliver person centred care and did not always promote people's independence. This was an area that the hotel and hospitality manager would address and observe to ensure all staff were supporting people to make daily meal choices and offering alternatives should they refuse food.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

The annual survey completed by people living at the service and their relatives included many positive comments, including; "Staff helpful" and [Name of chef] is outstanding" and "I am impressed with William Wilberforce, it is far superior to any other residential home. It has lived up to my high expectations."

Handover meetings took place three times a day to ensure staff were informed of important changes at the start of their shift. These included; visits expected from health professionals, updates on people's well-being, any incidents or appointments that needed to be arranged. Newsletters were available monthly and included poems and upcoming events. This was also emailed to any relatives that had expressed a wish to receive copies. Relative meetings were held every six months for each area of the home. One relative had expressed a wish for a manual to inform them about important information. The provider had incorporated additional information into the resident's existing manual and renamed it to reflect that it became a joint relative's and resident's manual. Residents had monthly meetings. People had made suggestions that the cinema within the home show a mixture of entertainment on a weekly basis. Suggestions had been acted upon by management and included; black and white films, documentaries, historical films and musicals.

Activities were scheduled to take place three times a day and during the inspection we saw activities in the first and ground floor lounges. Staff told us that they spent one to one time with people to gain information about their likes and dislikes in terms of activities. People we spoke with gave mixed feedback about the activities on offer. One person advised, "The majority of the activities are upstairs but I can join in." One relative said, "There is a lack of entertainment, it doesn't always happen." On the final day of inspection, we observed musical entertainment which was well attended by relatives and people living at the service. Staff were seen asking people upstairs if they wished to attend and many were assisted to move downstairs into the lounge area to join in.

We spoke with the head of public relations and lifestyle responsible for researching and organising events. They told us, "We have monthly coffee mornings and afternoon teas. We did a special meal for the royal wedding and have organised visits from performers such as saxophonists, singers and pianists." One resident had given some feedback to the home that said, "It was delightful to see the Tour De Yorkshire passing the home." The provider told us people and their relatives had sat outside to enjoy the event, cakes, scones and drinks were available with a gazebo for shade. A member of staff said, "The cyclists and supporters gave the residents a wave as they were passing – it was lovely for everyone to feel a part of it." We discussed the mixed feedback with the director who advised that events have in the past been cancelled due to circumstances beyond their control. For example, one entertainer, although organised did not turn up on two occasions. The service did not rebook those that cancelled to minimise further disappointment amongst the people living at the service. We suggested that when this occurred people and their relatives were informed so they were aware of the circumstances surrounding the cancellation of events to avoid future misunderstandings.

None of the residents we spoke with had made a formal complaint about their care. Records showed that one complaint had been made this year, but this was in relation to finances and not the care or support provided. People felt confident about speaking to a member of staff or the manager if they had any issues to raise. The complaints policy and procedure was clearly visible in the home and documented in the service user's handbook which people received when moving into the service.

Where people had discussed their wishes and preferences for end of life care, this and any advance decisions had been documented in their care plans. One health professional told us, "During end of life care

seniors act with great compassion."

Requires Improvement

Is the service well-led?

Our findings

During this inspection the registered manager was unavailable, the director and deputy manager supported throughout the inspection process. Before the inspection, we checked and found the registered manager had notified the CQC of certain important events as part of their registration. However, during the inspection we identified some incidents that were of a safeguarding nature and had not been notified to CQC. This showed us the registered manager did not always have a clear understanding of their legal obligations as part of their registration with CQC.

This was a breach of the Care Quality Commission Registration Regulations 2009. We will deal with the notification issue outside of this inspection process.

Daily records were computer based and included information about the care and support people received each day. However, for people who required a higher level of support such as those at risk of developing pressure sores, checks such as food and fluid intake, repositioning and safety observations of their care were sometimes inputted onto the system up to four hours or more after the event. The director advised that the service reverted to using paper-based records when someone experienced significant deterioration or had reached end of life care. This was to ensure health professionals had the information they needed and save them time looking at the electronic systems. We asked on several occasions for any other paper based records in relation to the people's care plans we reviewed and were advised no other information was available. Some staff were looking after several people at a time and were expected to remember information for several records relating to different individuals. This meant that we could not be sure that some checks had been completed at the times stipulated in their care plans. We discussed this with the deputy manager and the director at the time of this inspection. We reiterated the importance of accurate and current records being maintained.

The provider had implemented a variety of quality assurance systems, which included monthly and daily audits. Records showed the systems in place identified some areas that required improvements to be made and actions were taken promptly to make any adjustments. However, they had failed to identify some of the concerns raised during our inspection such as inconsistency in the delivery of person centred care, staff deployment during busy periods such as mealtimes and the failure to notify all safeguarding incidents to CQC. This showed us that there was a lack of management oversight in some areas of the service. The provider's systems were at times ineffective in identifying risks and areas that required further improvements to be made.

During meal times staff did not always provide consistent support to people. Some staff were in and out regularly creating a distracting atmosphere for those people living with a dementia. For example, six people were seated and two care workers were supporting people to eat and drink. A third person was supported by their relative. During this period several staff entered the room to have discussions with other staff who were supporting residents to eat and drink. People looked distracted and staff were unable to consistently provide the level of support needed to encourage and support their needs. This showed us there was a lack of leadership and direction from senior staff around best practice for those living with a dementia and that

deployment of staff during busy periods did not create the best experience for those with higher dependency needs. This was an area of focus for the hotel and hospitality manager who had recently come into post.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The home had made several improvements since our last inspection. This had increased partnership working with external agencies and health professionals. The home was research ready and employed one member of staff as their Research Champion. Research initiatives had been discussed in June 2018 with representatives from NIHR (National Institute for Health research) and JDR (Join Dementia Research). The home also had current involvement in the INSIGHT project with York University SPRU (Social Policy Research Unit). This had led to the introduction of a one Page Profile for activities for each resident based on their interests and hobbies. The current research was in relation to isolation and loneliness for people with sight loss in care homes. In addition, the home had been proactive in changing their systems in relation to Infection Prevention and Control. They had utilised best practice guidance and tools available to them resulting in no further outbreaks occurring since the winter of 2017.

Some audits had identified numerous issues which had been discussed widely with staff and sometimes the GP to look at ways the service could better manage concerns or risks. This included medication issues which resulted in a change of pharmacy to improve working relations and practices; accepting dementia training from local dementia specialists to improve staff understanding and, awareness of how to support people effectively. The deputy manager had attended a positive approach to care training session which supported best practice when managing behaviours people may display when they are living with a dementia. They told us, "I observe staff practice and if I see that things could be done better – I support staff and intervene to use the time as a mini training session." In addition, the provider had identified and was progressing plans for additional training in dementia and Parkinson's to increase staff knowledge and skills in these areas. This helped to promote both staff understanding and the experience for people living with dementia.

Staff described the management and leadership as open and transparent. During the inspection the management team worked well with the inspection team to ensure any issues were taken on board. We were confident that the deputy manager and director would make the improvements required. One member of staff described the management as, "Friendly. You can approach them and talk about anything." A health professional that mainly dealt with senior members of staff said, "Their hearts are in the right place. The seniors do give a damn. It's nice that it's not just a good looking home."

Meetings for all staff were regularly held and actions plans put in place to ensure improvements were driven throughout the service. For example, from the seniors meeting in June 2018 an action included "Implement risk management for residents who at high risk to prevent further deterioration" a timescale of four weeks was given and who was responsible. This was detailed as ongoing in the completed/outcomes column.

Business contingency plans were in place in the event of an emergency and included; loss of electricity, flooding and adverse weather conditions. These included important contacts so that they were to hand in the event of any emergencies occurring.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person-centred care and treatment that was appropriate, met their needs and reflected their personal preferences. Regulation 9(1)(a)(b)(c)(2)(3)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality of the service did not always highlight areas that required improvements to be made. Records relating to people were not always accurately maintained. Regulation 17(1)(2)(a)(c)(f).