

Ideal Carehomes (Number One) Limited

Ebor Court

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This inspection took place on 17, 18 May and 7 June 2016 and was unannounced.

Ebor Court is a purpose built care home, which is registered to provide personal care and support for up to 64 people. At the time of our inspection the home had one vacancy. The home is spread across three floors. The Guy Fawkes Unit is on the ground floor, the Dame Judy Unit on the first floor and the George Hudson Unit on the second floor. The George Hudson Unit provided personal care, whilst the other two units specialised in providing dementia care.

The service was last inspected in December 2015, and was rated 'requires improvement' in four of the five key questions we ask: Is the service safe? Is the service effective? Is the service responsive? Is the service well-led? The service was rated 'good' in the question: Is the service caring?

At the December 2015 inspection we found that risks were not always identified or appropriate action taken in response to concerns. This was a breach of Regulation 12 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we checked to see if improvements had been made in this area. We found that risk identification measures were in place, but record keeping in relation to the registered provider's response to identified risk was not consistent; we have reported on this under Regulation 17.

At the December 2015 inspection we found that people's food and fluid intake was not always effectively monitored increasing the risk of dehydration, malnutrition and associated health complications. This was a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We checked to see if improvements had been made in this area and found that people had access to a range of food, snacks and drinks. However, record keeping in relation to food and fluid intake was poor and we have reported on this under Regulation 17.

In our last inspection we found that quality assurance processes were not robust enough in identifying concerns with the quality and support provided and in driving improvements. This was a breach of Regulation 17 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We checked to see if improvements had been made in this area and found that the registered provider's quality assurance audits had not been completed consistently since our last inspection and that, as a consequence, these processes were less robust than at our last visit. We also found that records were poorly kept. This was a continued breach of Regulation 17 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 17 (2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were systems in place to ensure people received their medication safely, however these systems were not always effective in promptly identifying when medication was out of stock, and as a consequence some people had not received their topical cream medication as prescribed. The opening

date had not always been recorded on medication with a limited shelf life once opened. This increased the risk of people receiving medication that was no longer effective. This was a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take in respect of these breaches at the back of the full version of this report.

The registered provider is required to have a registered manager as a condition of registration. The previous registered manager had left the service since our December 2015 inspection and there was no registered manager in post at the time of our inspection; as such, the registered provider was not meeting their conditions of registration. The home was being managed by an acting manager, until a new registered manager was recruited. The registered provider acknowledged that the recent changes at the home had been unsettling for staff and had also meant that they had not made as much progress on implementing the requirements from our last inspection as they had planned.

At our inspection in December 2015 we made a recommendation that the registered manager reviewed staffing levels and staff deployment over a 24 hour period to ensure they continued to meet the needs of people using the service. Before this inspection we also received further information of concern about staffing levels. When we inspected this time, we found that the registered provider had increased the staffing levels at the service and had recruited a number of new staff recently. However, there were also more people using the service, so the staffing ratios were broadly comparable. The acting manager was actively recruiting for additional staff to increase the staffing levels at the service on an evening. There was mixed feedback from staff and visitors about whether there was sufficient staff to meet people's needs, and this feedback showed us that whilst action had been taken to improve staffing, there were still outstanding concerns in this area that had not been fully resolved.

At our inspection in December 2015 we made a recommendation about recording consent to provide care and support in line with relevant guidance and legislation. We found that there was information in care files to clarify where people had a Lasting Power of Attorney (LPA) for care and welfare, and that the home sought consent to provide care in line with legislation and guidance.

There were systems in place to help staff identify and respond to any signs of abuse, to protect people using the service from harm.

We checked the recruitment records for three members of staff and found that recruitment practices were robust and appropriate checks were completed before staff started work. This meant that the registered provider was taking appropriate steps to ensure the suitability of workers.

Staff received an induction in order to carry out their roles effectively but not all staff had received regular supervision in the last six months. We found that the majority of staff were up to date with all training considered essential by the registered provider.

People using the service told us that staff were kind and caring. We observed positive and friendly interactions between staff and people using the service. People using the service told us they were treated with dignity, and staff were able describe to us how they promoted people's dignity and independence.

The registered provider completed care plans, and these contained some person centred information and preferences. However, files were difficult to follow and some information in relation to people's care was held in different places and had not always been consistently cross referenced into the care plans. Some

care plans also contained contradictory information, which meant that staff did not always have clear guidance in order to provide person centred care. The registered provider did not provide diabetes training and did not have a diabetes care policy and we have made a recommendation about this in our report.

People had opportunity to participate in activities at the home and we observed some activities taking place during our visits. Some people told us they would like more activities to be available.

People using the service were aware of how they could raise a complaint if they had one, and said they would feel comfortable doing so if needed. Relatives we spoke with said they would know how to raise a complaint, and one told us that they had recently noticed an improvement in the home's handling of concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Risks to people were not always effectively managed because risk assessment documentation did not always clearly document action needed to minimise risk.

Recruitment processes were robust and appropriate checks were completed before staff started work.

There were mixed views about whether sufficient staff were available to meet people's needs.

Systems in place to ensure that people received their medication safely were not always effective, which increased the risk of people not receiving their prescribed medication.

Requires Improvement ●

Is the service effective?

The service was not always effective.

There were a range of food and drinks available, but people's food and fluid intake was not always effectively recorded. Action taken in relation to weight loss was not consistently recorded.

Staff received an induction and on-going refresher training in order to carry out their roles. Consent to care was sought in line with legislation and guidance.

People were supported to access health care services, but records did not always evidence that advice given by healthcare professionals was followed, in order for people to maintain good health.

Requires Improvement ●

Is the service caring?

The service was caring.

People told us that staff were caring and they had positive relationships with the staff who supported them.

Good ●

We saw that staff supported people using the service to make day to day decisions.

People we spoke with felt that care staff respected their privacy and dignity.

Is the service responsive?

The service was not always responsive.

Peoples' needs were assessed and care plans were in place. However care files did not always contain clear information to ensure that care was responsive to people's needs, and not all care files were up to date.

People were provided with support to take part in social and purposeful activities, but there were mixed views on whether there was sufficient stimulation for all people using the service.

The registered provider had a system in place to manage and respond to complaints and concerns.

Requires Improvement ●

Is the service well-led?

The service was not well led.

There was no registered manager in post, which is a condition of registration.

The registered provider had quality assurance systems in place, but these were not being followed and the registered provider had not fully addressed all the concerns we raised in our last inspection.

There was poor record keeping in relation to people's care and a lack of recorded evidence about action taken to minimise risk and respond to people's needs.

Inadequate ●

Ebor Court

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17, 18 May and 7 June 2016 and was unannounced.

The inspection was carried out by two Adult Social Care Inspectors and an Inspection manager who attended for one day.

This inspection was carried out to check that improvements to meet legal requirements, planned by the registered provider after our December 2015 inspection, had been made. Prior to the inspection we had also received some information of concern about the service, which we looked at as part of this inspection. Before the inspection we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also sought relevant information from City of York Council's safeguarding and commissioning teams.

As part of this inspection we spoke with six people who used the service, seven care staff, a cook, an activities executive, the deputy manager, the acting manager, the front of house manager, the regional director and the nominated individual for the registered provider. We also spoke with four visiting healthcare professionals and three relatives of people using the service. We looked at fifteen people's care records and/or monitoring documentation, three care staff recruitment files, seven care staff induction and training files and a selection of records used to monitor the quality of the service. We also carried out a tour of the premises and made observations throughout our visits of how people were being supported within the home.

Is the service safe?

Our findings

People who used the service told us they felt safe. Comments included "I feel safe living here" and "I feel safe." A relative of someone using the service told us, "I feel comfortable that they are safe."

At our December 2015 inspection we found that risks were not always identified or appropriate action taken in response to concerns. This was a breach of Regulation 12 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we checked to see if improvements had been made in this area.

We found that the registered provider completed assessments to identify potential risks to people using the service and care staff. We reviewed care files of people living at the home and saw that there was a range of risk assessments in place, such as risk assessments for managing medication and falls. Staff used the Malnutrition Universal Screening Tool (MUST) to identify people at risk of malnutrition and a Waterlow risk assessment to identify the level of risk of developing pressure sores. However, we found that not all risk assessments had been reviewed monthly in line with the registered provider's policy and saw examples where risk assessments had not been reviewed since February 2016. By not regularly updating these risk assessment tools, we could not be certain that staff would identify if people's needs changed and take appropriate action to manage risks. The acting manager advised us that they were aware that the care files on one floor of the home in particular had not all been reviewed recently, and that they and the deputy manager were currently in the process of identifying all files overdue for review, and that these files would be reviewed as a priority.

We saw some examples where risks had been identified and risk reduction measures had been implemented. However, we found that record keeping in relation to action taken in response to identified risk was still inconsistent. One person whose file we reviewed, was identified as being at high risk of falls. After having had two falls, the care plan indicated that a referral to the GP was required to discuss the falls. Although the person did see a GP the following month there was no evidence in the file to confirm that this had been to discuss the falls or that any further action had been taken in relation to falls prevention. When we spoke with the acting manager and deputy manager about this they confirmed that the person's falls had been discussed with the GP, but had not been recorded properly.

Another person's file stated that a visiting healthcare professional had requested that staff monitor the person's skin integrity, due to a skin tear. There was however, no reference in the person's skin assessment about them having a skin tear. There were some care plan entries which indicated the person had been repositioned and that dressings were being used, but there was no short term care plan in their file to ensure there was clear instruction to staff on how to support the person with their wound care.

As these issues primarily relate to poor record keeping we have reported on them under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in the 'well-led' section of this report.

The registered provider had a system for recording accidents and incidents, in order to keep staff and people using the service safe. We saw records of health and safety and environmental checks, including the gas safety certificate, electrical certificate, fire alarm tests, emergency lighting check, fire alarm and fire extinguisher checks, nurse call tests, hoisting equipment checks and portable appliance tests.

At our last inspection we noted that some beds could be split in half, in case they needed to be moved, and that the clasps joining the two halves together were missing or broken in some cases. At this inspection we found that action had been taken to address this concern, and that the two halves of the bed had been bolted together, where required, to ensure the bed base could not split and cause injury.

When we inspected in December 2015 we viewed the registered provider's business continuity plan, which contained details of arrangements in place to maintain continuity of care in the event of a major incident such as flooding or a fire. This showed us there was a system in place to keep people safe and meet their needs in the event of an emergency. We were advised that this plan had not changed since our last inspection, so we did not review the plan again on this occasion. We also viewed person emergency evacuation plans (PEEPs) in December 2015. This showed us that there were plans in place for people who would require assistance leaving the premises in the event of an emergency.

We checked the recruitment records for three members of staff. We saw that records were held of people's application forms and interviews. The registered provider sought three references, proof of identity and completed Disclosure and Barring Service (DBS) checks before people commenced work. DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. This showed us that the registered provider had systems in place to ensure only people considered suitable to work with vulnerable people had been employed.

We made a recommendation in our last inspection that the registered manager review their staffing levels and staff deployment to ensure that there were suitable numbers of staff to meet people's needs across a 24 hour period. Prior to this inspection we received information of concern about staffing levels at the service, particularly during the evening and night. The first visit of this inspection was conducted during the night shift so that we could assess how the service met people's needs at night time. We found that there were five staff on shift to support the 63 people living at the home. We looked at staff rotas which showed us that this was typical of the number of staff usually on shift on a night time. The atmosphere of the home was calm and relaxed throughout the first evening of our inspection, and people were supported to go to bed when they chose over the course of the evening. On the following two days of our inspection there were ten care staff on shift during the daytime on one of the days, and nine care staff on shift on the other day. Staff were deployed across the three floors of the home. We noted from the rotas that sometimes the staffing level varied from this, up to 12 staff on occasions and other times down to eight care staff when there was staff sickness.

We received mixed views from people regarding staffing levels. Some people using the service told us, "There are staff around" and, "I think there are enough staff; they help you with things. They might say 'just a minute' if they are in the middle of something, but it doesn't take long for them to come back." Staff told us, "Staffing is sufficient," "Staffing levels are fine," "I think there are enough staff on duty to care for the people here" and "[Staffing levels are] absolutely spot on, we've always got enough staff. If we drop down we get a member of day staff to sleep over." Another told us, "Staffing levels are okay; we manage. You can't help sickness at times, but generally it's okay."

However, other people using the service told us "The staff here have the right skills, but there's not enough

of them. I think that's why there's been a turnover of staff." Other staff told us, "The service runs with five on a night, but it would be lovely to have six. The needs of residents have changed and this needs to be taken into consideration." A relative told us, "Sometimes we struggle to find people [staff] between 8-9.30pm. Last night sensors [call bells] were going off left, right and centre." They continued, "They have got staff that care...where it doesn't work is evening times when there is a shortage of staff and it is difficult if more than one person needs help." Another relative said, "They probably need more staff; sometimes there's nobody around in the restaurant upstairs if they are supporting people in their rooms." A visiting healthcare professional told us, "I don't think there's enough staff, but they do really seem to care. On occasion I have seen people with their face still dirty from lunch when I've arrived. Staff have always sorted it as soon as they've seen it, but I think it hasn't been noticed straightaway, because there is not enough of them." Another healthcare professional told us they had concern that there were not enough staff to meet the needs of people at the home, because some of the residents had significant needs and required a level of support that they considered would be more appropriate for nursing care than a residential home.

The staffing dependency tool used by the registered provider had not changed since our last inspection. It did not provide an indication of the numbers of staff or hours needed to meet people's needs. The tool had not been completed since February 2016, and the acting manager completed this after the second day of our inspection.

The staffing dependency tool and rotas showed us that staffing had increased since our last inspection. However, there were also more people using the service so the staffing ratios were still broadly comparable. A number of new staff had been recruited since our last inspection, and several staff were temporarily 'stepping up' into senior care roles. Some newly recruited night staff were commencing their induction on 31 May 2016, and we were advised that the home would be fully staffed with overnight carers once they had completed this two week induction. There were though still other staffing vacancies. The acting manager advised us they were advertising for additional staff to enable them to increase the staffing levels at the service by an additional two staff each evening until 10pm. This would significantly improve the service's ability to be flexible and responsive to the needs of people on an evening.

Although we saw evidence to demonstrate that the registered provider had taken some action to address staffing concerns since our last inspection, comments from people who used the service, relatives and visiting professionals demonstrated that there were still concerns in this area that had not been fully addressed. We will continue to monitor this at future inspections.

The registered provider had a medication policy and procedure. Senior care staff that had responsibility for administering medication had received training on medication management. The staff we spoke with were knowledgeable about policies and procedures for managing, recording and disposal of medications. We observed staff supporting people appropriately with their medication and recording on Medication Administration Record (MAR) charts that they had given people their medication. Medication was stored in locked trolleys and there were two medication rooms within the home. Some prescription drugs are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled drugs and there are strict legal controls to govern how they are prescribed, stored and administered. We found that controlled drugs were stored correctly within suitable cabinets in the medication rooms, and that controlled drugs records were accurately completed.

Care files contained a medication care plan, with information in relation to the person's medication needs.

We looked at the MAR charts for three people who used the service, and found that these were appropriately completed. We checked the stock balance for a selection of medications, including controlled drugs. The

stock held by the service corresponded to the MARs. We noted that there was a significant amount of stock held for some people; in excess of a month's supply. Excessive stock can lead to wastage if prescriptions subsequently change. We found that the opening date had not been written on some eye ointment that had a limited shelf life once opened. This meant that we could not be certain that the medication was still effective. The acting manager said they would issue a reminder to staff about this. Creams for three residents were also out of stock when we completed our inspection. The acting manager was unable to tell us why it was not identified earlier that these creams were out of stock; they told us that there was a clear process for the ordering and booking in of medication and that it should have been identified during this process, at the start of the medication cycle 14 days earlier, that these creams had not arrived. They told us that they would order these immediately. We also noted on the last day of our inspection that the Topical Medication Administration Records (for prescribed creams) had not been completed for three people on the previous day so we could not be certain that staff had administered this medication as prescribed.

This showed that the systems in place to ensure people received their medication were not always effective in promptly identifying when medication was out of stock and the application of prescribed creams had not always been recorded consistently. The registered provider's policy was to audit medication monthly, but this had not been completed in March and April 2016.

This was a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. Safeguarding adults training was provided to all staff. Staff we spoke with could identify the types of abuse that could occur and were able to describe what action they would take if they had any concerns. Staff told us "I would speak to a manager."

There was a safeguarding file to record details of safeguarding referrals and investigations. In the five month period since our last inspection the registered provider had notified us of a high number of safeguarding incidents at the service. Most of these were incidents between residents where no, or minor, injuries had occurred. Where people had displayed aggressive behaviour towards others, care staff had completed ABC charts (Antecedent, Behaviour, Consequence) to understand the causes of distressed behaviours. Guidance had also been sought from community psychiatric nurses for a number of residents, where this was appropriate.

Overall we found there were systems in place to identify and respond to safeguarding concerns.

We looked around the premises during our inspection, including the communal areas, the hairdressing room, medication rooms and some bedrooms, with people's permission. We found that the home was clean and free from malodours. A visiting healthcare professional told us they had noticed some improvements in cleanliness within the home.

Is the service effective?

Our findings

At our inspection in December 2015 we found concerns in relation to the monitoring of nutrition and weight loss. This was a breach of Regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we checked to see that improvements had been made. We found that throughout our inspection there were drinks and snacks available. During the evening people were also offered toast and refreshments. The service had a 'protected mealtimes' policy to ensure that people could eat their meals without distractions such as visitors or support with other care tasks or activities.

People who used the service told us, "The food is quite good. If you ask for anything in particular they will do what they can. For example, salmon; now we always have it. [Food] varies every day and is served hot. It's warm when it comes to you." Other people told us, "The food is nice," "The food is fine" and "I get enough to eat and drink." We observed a mealtime and heard people using the service commenting that the food was "Very nice indeed."

We looked at care records in relation to nutrition and hydration. We found that people's care files contained a care plan regarding nutrition, and these included some information about people's preferences. We found that the registered provider completed food and fluid charts for people who were assessed as being at high risk in relation to their nutrition or hydration needs. However, these did not always contain clear information about how much food people had eaten. For example, we found records which stated 'All bran cereal' and 'mince and veg', but it was not clear how much of these foods had been eaten. Records were also not always clear in relation to people's fluid intake each day.

For three people whose care files we reviewed, it had been identified that they needed to be weighed weekly to more closely monitor weight loss or weight gain. We found that these people had not always been weighed weekly as required in their care plan, and the reason for this was not always clear from people's files.

When we spoke with the cook about people's special dietary requirements, they were knowledgeable about most people's needs. The cook advised us that of the two food choices available each day, at least one of these was suitable for people on a diabetic diet. We saw that the chef informed care staff which of these was the option that was suitable for diabetics when food was being served. The chef did not have access to an up to date list of people's dietary requirements, but the registered provider addressed this on the day of our inspection by producing a list of each person's requirements, and made a copy of this list available on each floor for all staff to refer to.

The acting manager completed the monthly weights audit tool on the second day of our inspection to monitor any changes in weight of people using the service, because the audit tool had not been completed in March and April 2016. They were also ensuring that the weights had been transferred into people's individual files. This audit was intended to be used to record any actions taken as a result of weight loss.

We spoke with a visiting healthcare professional who told us, "The food here looks good; I don't see it taken away from people uneaten. There are lots of people here with weight loss, but I have no concerns that this is because of the home or a lack of nutrition." They continued, "The food and calories are appropriate, but some people may be at risk of weight loss due to their swallowing difficulties or the impact of their dementia. Many people are underweight when they come here, so often we're checking to see they've put on some weight or maintained weight. They [staff] alert me to people's weight loss." They also told us, "Staff do eat with people, to encourage them to eat."

We saw examples where appropriate referrals were made to relevant health professionals where people were losing weight and examples where weight had then been regained. However, we found that records in relation to people's nutritional and fluid intake were poor and have reported on this further under Regulation 17 in the well-led domain.

People who lived at the home and most visitors told us they felt that staff had the skills they needed to carry out their roles. People who lived at the home told us, "You only have to ask them and they will do anything they can" and "I don't have any concerns about the staff's skills."

All new staff completed two weeks of induction training to equip them with the skills and knowledge to carry out their roles. We saw this included training on safeguarding vulnerable adults, dementia awareness, pressure care, health and nutrition, challenging behaviour with physical interventions, food hygiene, health and safety, first aid, Mental Capacity Act 2005, medication awareness, end of life care, communication, moving and handling, person centred planning and equality and diversity. Staff told us, "There is a two week induction. I can't fault the training; it is the most intensive I've ever done. The training is superb." Following the induction training, new staff completed a minimum of three shifts shadowing more experienced members of staff. The registered provider also required new starters to complete an induction booklet over the first six months detailing how they would manage certain situations. Each section would then be signed off when the staff member had been observed competently putting this into practice. We looked at the induction records for seven staff who had started this year and found that although new staff had completed the two week induction training, none of them had commenced the registered providers six month induction booklet. We discussed this with the regional director who told us these would be commenced straightaway.

We reviewed the training matrix used to record the training completed by each staff member and when this needed to be updated. We saw that staff received annual refresher training to update their knowledge and skills. Staff told us, "Training was good. It gave me skills and knowledge." Staff also commented very positively on a 'virtual dementia tour' they had taken part in recently. A mobile vehicle came to the home and recreated an environment where staff could experience and better understand some of the sensations experienced by people living with dementia. Staff wore specially adapted headphones, glasses and shoes and were instructed to complete tasks designed to help them understand the impact of sensory impairments and balance and coordination issues. Staff gave examples of how they had changed their approach as a result of this experience.

We spoke with the acting manager about staff communication. Staff handovers were conducted twice a day, when day staff came on shift in the morning, then again when night staff came on shift in the evening. This allowed them to exchange key information and updates. We saw daily handover reports that included information on who required 30 minute observations, any significant events, medication changes and general comments.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the registered provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. There were 13 people living at the home subject to a DoLS authorisation at the time of our inspection.

At our inspection in December 2015 we found that some people's carers or representative had signed the care plan and it was not clear whether they were signing on the person's behalf, and with their consent, or because the person lacked the mental capacity to consent to this care and support, in which case a best interest decision would be required. We made a recommendation that the registered provider seek advice and guidance about consent to care and treatment.

At this inspection we found that there was information on file regarding people's Lasting Power of Attorney (LPA), where they had one, and the scope of their LPA's authority. An LPA is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare and/or finances). We saw records that showed the registered manager had checked with the Office of the Public Guardian to confirm the details of one person's LPA. We also saw examples of family being involved in best interest decisions, in relation to bed rails for example. We did though see a mental capacity assessment where it was not clear what decision was being assessed. A person's capacity should be assessed in relation to a specific decision or action. The registered provider advised us that they were introducing new paperwork in relation to capacity assessments so the current documentation would be improving.

Staff demonstrated some understanding of the MCA and the importance of gaining consent before providing care to someone. People using the service also told us, "They ask me first if I want help with things." This showed us that staff sought consent to provide care in line with legislation and guidance.

Before the inspection we received information of concern that some people had not received timely access to healthcare services when they needed them. We saw evidence in care files of contact with other healthcare services where people required them, such as contact with the district nursing team, community psychiatric nurses and GPs. A GP routinely visited the service once a week, so people were able to see the GP for any non-urgent issues when they came for their weekly visit. We observed three different types of healthcare professionals visiting the service during our inspection. One visiting healthcare professional that we spoke with commented positively about the service and told us the home acted on advice they gave them. They told us, "They [staff] definitely follow guidance I give them" and "They are quite good now at picking up problems. They are good at proactively trying to prevent falls."

A person using the service told us "The doctor has been to see me today." A relative told us they had had concerns in the past that staff had not noticed when their relative was unwell, and that they had had to prompt the staff to ring the GP. They said things had improved significantly recently and that they now felt confident that staff were checking their relative and that the staff would keep them updated on their relative's well-being.

Another visiting healthcare professional told us they had no concerns about any delays from the home in seeking assistance. However, they did have concerns about communication at the home and told us that information they handed over to senior carers was not always passed on to other staff or recorded. They felt the home was not well organised, and gave examples such as staff advising them that prescription dressings had not arrived for people, and then subsequently finding the dressings elsewhere in the home.

In the 'multi-disciplinary visits' section of one person's care file we found detailed instructions from a healthcare professional about how to transfer the person. This information had not been used to update the person's mobility and falls care plan. We found another example where the home had failed to record the action they had taken in response to a district nurse's advice to order a new foam mattress for the person.

We found that people were supported to access healthcare services, but examples like this showed us that record keeping and communication in relation to how staff were supporting people to maintain good health and follow the advice of healthcare professionals was not always consistent. We have reported on this under Regulation 17 in the well-led domain.

Is the service caring?

Our findings

People using the service told us "[The staff] are all pretty good and nice," "The staff are alright" and "The staff are very nice; we like them." Others told us "The carers are very kind. They will help you in whatever way they can", "Staff are okay" and "The staff are kind and treat you with respect."

The interactions we observed between staff and people who used the service were positive and respectful. We observed staff chatting with people and people appeared comfortable with them. A visiting healthcare professional told us "They [staff] really seem to care" and "Staff are kind and respectful." Another visiting healthcare professional told us "Whilst I have concerns about the disorganisation and communication at the home, I've never had any concerns about the staff not being caring. We've noticed some of the new staff are also lovely." One staff member told us that they felt some of the younger members of the staff team did not always speak to people respectfully. However, other staff did not raise any concerns about this and told us that, "Staff are so caring." One staff member said, "Having worked at other places I do think it's a nice home. Staff are good with residents and care about them."

During our inspection we observed some positive interactions where staff responded sensitively to people using the service. We saw one staff member supporting a person who was very upset and confused about having lost people. The staff member acknowledged their loss and was very reassuring. They responded appropriately and re-directed the person's attention on to positive topics and alternative activities, which the person responded very well to.

People who used the service told us they had choice and control about their care and generally felt their views were acted on. One person said "They ask your opinion". Another told us, "Staff involve us in decisions. We can just choose when we want to go to bed for instance." We observed staff offering people choices, such as what they wanted to eat and whether they wanted to join in activities. Staff responded to requests made by people.

Conversation with staff showed us that the majority of people using the service had contact with relatives or friends, some of whom visited very regularly. Information about advocacy services was available to people in the reception of the home, and we were told that one person using the service had an advocate at the time of our inspection. The acting manager had supported this person to get an advocate. An advocate is a person who provides support to help someone express their views and wishes, and to help make sure their voice is heard.

People using the service told us that their privacy and dignity was respected. One person told us "They always knock; nobody ever walks straight in." Another person said that when staff supported them to shower "They respect my dignity; no problems with that." One person told us "I am very comfortable with the staff." When we spoke with staff they were able to explain how they respected people's privacy and dignity. They gave examples such as covering people up when they were getting showered. We observed that when staff passed on information to each other about people using the service, such as requesting assistance to support someone with personal care, they were generally discreet. A visiting healthcare

professional told us, "They [staff] are mindful of people's privacy. They ordered a screen for me, so that I can see people discreetly if they don't want to leave the lounge for me to check their legs or feet for instance."

Before this inspection we received information of concern that people's dignity was not always respected, because staff were not prompt in attending to people's personal care needs or changing incontinence pads in a timely manner. We spoke with people using the service, staff, relatives and the registered provider about this. One staff member told us that sometimes certain people's incontinence pads were wet in the evening. Another said that they could always tell when someone needed support to change a pad, but felt that some other staff were not as prompt at identifying this. A visiting healthcare professional said they had observed that one person's catheter bag was sometimes very full in the morning, raising concern about the timeliness of staff providing assistance with catheter care. Other staff we spoke with however did not raise concerns about people not receiving timely support with their continence needs, and we did not observe any concerns about people receiving support in a timely way with personal care during our inspection. The people using the service who we spoke with did not raise concerns about their continence needs not being met.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. Most people using the service could potentially be at risk of discrimination due to age or disability, but we saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. People who wished to practice their religious faith were supported to do this; staff organised taxis for people to go to church on Sundays and there was also a visiting service in the home approximately once a month.

Is the service responsive?

Our findings

We saw that the registered provider completed an assessment of people's needs before they moved to Ebor Court. This considered people's needs from the perspective of the person, their relatives and any professionals involved. Files included some information about people's life history and aspirations. The pre-admission assessment in one file we reviewed was only completed with limited information from the person, and no other information from other people, even though the person had family involved. This meant that opportunities to understand more about the person may have been missed.

All of the people using the service had a care plan. We saw evidence that some people had been involved in discussions about their care plan and reviews of their care. There were examples of care agreement and review forms where family members had been asked their views and feedback, in some cases via the telephone, about their relative's care.

We saw that care plans developed by the registered provider included information about people's needs and some preferences. Care plans were in place regarding people's needs in relation to; health and wellbeing, mobility and falls, medication, continence, memory and understanding, mental health and capacity, communication, skin and pressure care, nutrition and sleep. The care files also contained records of multi-disciplinary visits from other professionals.

Where people had specific health needs, information had been added to the care plans to help staff understand how to support them with these needs. For example, where a person had Parkinson's Disease, information had been printed from the NHS choices website about Parkinson's Disease and its symptoms. Information about diabetes was also included in the care files of people who were diabetic. Staff demonstrated a basic understanding of diabetes and were aware of the importance of regular meals and food monitoring for these people. They were also able to explain symptoms they may expect to see if someone's blood sugar level was too high or low. We did, however, have concerns that staff had not received any training about diabetes, yet there were eight people with diabetes living at the home at the time of our inspection, and one person in particular had been experiencing ill health and difficulty relating to their diabetes and blood sugar levels. As a residential care service, rather than a nursing care service, the home did have support from the district nursing team in relation to diabetes management and insulin injections for individuals, but additional training would have given staff more confidence and knowledge in how to respond to the needs of people currently supported by the home. Staff confirmed that they had not received training in diabetes care, but had read the information leaflets in people's care files about diabetes. The home did not have a diabetes care policy and a visiting healthcare professional also told us that they did not feel all staff had good knowledge about diabetes or catheter care.

We recommend that the registered provider seeks advice from a reputable source about best practice in diabetes care.

We found that care plans were difficult to follow because there was not always a clear chronology of events in relation to that person. For example, in one care file records referred to dressings coming off the person's

arm, then two days later there were references to dressings on a thigh. It was not clear what these dressings were for. The file did not contain a clear and structured wound care plan that enabled staff to follow the progress of each wound. In another person's file, the chronology of the person's weight loss was unclear; there was a query about whether there had been an error with the weight recordings, but it was not clear from records if this had subsequently been established. Another file contained inconsistent and unclear information in relation to the person's falls history.

We found examples where the care plan did not accurately reflect the person's current needs. For instance, one person's care plan stated they did not have any behavioural difficulties, yet daily records indicated there had been a number of incidents of aggression and inappropriate sexualised behaviours towards staff. Another person's care records contained contradictory information about their continence care needs and continence products used. This meant that there was not always up-to-date information available to guide care staff on how to best meet that person's needs.

The registered provider used a 'floor management folder', in which staff kept daily records, monitoring sheets and various communication records. We found that sometimes information relating to individuals was in this folder, rather than in the person's care file, which added to the difficulty in establishing a clear chronology of events in relation to a person, because information was not consistently kept in the same places. We were concerned that staff might miss important information about people's needs because of this.

The registered provider's policy was to review care plans monthly, but we found that on one floor of the home, care plans had not always been reviewed monthly over the last five months. We saw that in one care file most of the care plans and risk assessments had not been reviewed since February 2016, apart from higher risk areas, such as nutrition, pressure care and falls. These were reviewed in April or May 2016. The acting manager told us that they had already identified that care plans on this floor of the home needed to be reviewed. They told us that the change in management and staffing had impacted on these being kept up to date, and that they and the deputy manager had been tasked with reviewing all these care files as a priority.

We have reported further on this under Regulation 17, in the well-led domain.

The regional director told us that the registered provider had developed a new care plan format which was shortly being introduced into all the company's homes, including Ebor Court. They told us they would re-write every person's care plan on this new format, so that the care plans would be clearer, up to date and easier for staff to use.

The registered provider employed a regional activities executive, responsible for promoting activities within the registered provider's homes in the area. We spoke with them about the activities available at the service. They told us they would be holding social committee meetings with people using the service once a month discuss ideas and plans for activities and entertainment. We saw minutes of the most recent social committee meeting in May 2016 which showed that ideas for activities had been discussed. The home did not employ a dedicated activities person, because care staff were responsible for engaging people in activities as part of their role. The home also used external facilitators to run activities at the home, such as a weekly art group. The regional activities executive told us that a trip was planned to go and watch a play and visit York Minster. They had also arranged for a 'pop up' Italian restaurant to come to the home in July 2016. We were told that all staff were involved in supporting people to take part in purposeful activities on a day to day basis. For instance, the cooks and domestic staff were allocated time each day to engage people in household tasks where they had capacity to do so. These ancillary staff all undertook the same training as

care staff, including safeguarding, dementia awareness and health and safety, so they were able to work with people directly. Newspapers, crosswords and word-searches were also available in the home.

We received mixed feedback about the activities at the home. One relative told us that staff had "Gone the extra mile" for their relative, in terms of activities. They told us, "[My relative] likes tropical fish, so they've got them a fish tank for their room, which he has been looking at. They have also put his name down for a trip to Wyevale [garden centre]. They have been trying to stimulate them and give them as many opportunities and activities as possible." A visiting healthcare professional told us there often seemed to be things going on at the home. However, another relative told us that they felt their relative would benefit from more activities and stimulation. People using the service told us, "There's not been many things lately...we're quite lively so would like some more activities." Another told us "I'm never bored, because I like chatting to people and going out walking."

During our inspection we did see some activities taking place, such as the weekly art group, which a number of people appeared to be enjoying participating in, and staff completing a crossword with a group of people using the service. Care staff also took the opportunity to chat with residents when they had time. We did however, also see periods where people were unoccupied for large parts of the morning or afternoon. Staffing levels limited the amount of flexibility staff had to spend time engaging people in social or leisure opportunities, particularly during busy periods of the day. On the last day of our inspection residents gathered in one area of the home to wait for a pianist to come and do a music session, but when the pianist did not arrive, and it was established that they had been unable to come that day, no other alternative activities were arranged. People chose to remain seated where they had gathered for the rest of the morning.

People using the service told us they would be comfortable making a complaint if they were unhappy about something. People told us "If I made a complaint, yes I think they would listen" and "If there was anything that concerned me I'd be confident to let them know." Another person told us, "I would say something if I wasn't happy with anything and if I did they would put it right." One relative told us "In the past I've raised issues and things weren't getting addressed. [In review meetings] they made notes and things didn't get done. But things are so much better now, since the regional manager has become more involved in the service. Things have been put in place and I feel that [relative] is being cared for. They are actually taking note and keeping us informed. I can now go home and feel they are being well cared for." Another relative we spoke with did though still have some outstanding concerns about their relative's care and staffing levels.

There was a complaints policy and procedure in place, and this had been updated since our last inspection. We looked at the registered provider's complaints and compliments log. Records showed that in the last six months there were 17 complaints (including informal complaints and concerns) and four compliments received. Complaints had been investigated and a response given. There was a suggestion box in the main entrance and a 'suggestion tree', which people could put comments on. This showed us that people had opportunity to raise any concerns and there was a system in place to respond to complaints.

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of registration. There was no registered manager in post on the day of our inspection and, as such, the registered provider was not meeting their conditions of registration.

Since our last inspection the registered manager had left, following a period of absence. We were told that this had impacted on the registered provider's progress towards meeting the action plan they developed after the findings of our last inspection. A former deputy manager of the service had returned to work at the home two weeks before our inspection and they were in the role of acting manager of the home, until the registered provider had recruited a permanent manager. Nobody we spoke with told us that the change in management had had a negative impact on the care people using the service received. However, it was evident that the gap in having a manager of the service had had a significant impact on the quality assurance monitoring, record keeping, staff supervision meetings and overall leadership at the service.

In our last inspection we found that quality assurance processes were not robust enough in identifying concerns with the quality of the support provided and in driving improvements. This was a breach of Regulation 17 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We checked to see if improvements had been made in this area and found that the registered provider's quality assurance audits had not been consistently completed since our last inspection and that as a consequence, these quality assurance processes were even less robust than at our last visit.

The registered provider had a wide ranging set of audits to monitor the quality of care and support provided. These monthly audits covered topics including falls, care plans, accidents and incidents, pressure sores, finance, medication, infection control and activities. These had been completed in January and February 2016, and there were some examples of actions taken as a result of audits. For instance, some issues in relation to medication compliance handover records and medication administration checks were discussed with staff in a team meeting. We did note, however, that a medication compliance handover record was not completed on the first day of our inspection, so this reminder to staff had not been effective in ensuring that improvements to completion of this documentation had been sustained. We found that other actions identified in audits prior to March 2016 had not been completed, such as an action to make a referral to the GP to discuss falls prevention for one person. When we discussed this with the registered provider, the deputy manager told us that the person had seen the GP regarding falls, but this was not documented.

The majority of the audits had not been completed in March and April 2016. In May 2016 the acting manager had retrospectively completed some of the March audits, in areas considered to be highest risk. These were; the pressure sore audit, complaints monitoring audit, monthly weight loss action plan, bed rail audit and monthly accidents analysis.

Some of the April 2016 audits had also been completed by the acting manager in May. Again, these were the audits considered highest priority; complaints monitoring audit, pressure sore audit and bed rail audit.

The delay in completing these audits meant that action was not taken in a timely manner to address any issues that had arisen during the month. For instance, we found that accident and incident reports were not routinely signed by the registered manager to indicate they had reviewed the information, and because the analysis for March and April 2016 had both been completed retrospectively in May, opportunities to identify patterns and prevent reoccurrence in a timely way had been missed.

In addition, because the remainder of the audits had not been completed this meant that opportunities to identify problems and take corrective action had been missed. For instance, because medication audits had not been completed in March and April 2016, there had been less opportunity for the registered provider to identify and address the shortfalls we identified in our inspection.

None of the audits were countersigned by the regional director to verify that they had checked that audits were being completed and that the manager was ensuring that actions had been completed. The registered provider's quality assurance policy stated that Area Manager Reviews of Compliance and External Reviews of Compliance were undertaken. There was no evidence that these compliance reviews had been undertaken since our last inspection.

A number of the safeguarding alerts we had been notified of over the previous five months had been completed retrospectively, when the deputy manager had found out about incidents through ABC behaviour monitoring charts. It is a requirement that we receive notifications without delay. Safeguarding audits had also not been completed in April and May 2016, despite there being a high number of safeguarding referrals in April.

Where people had displayed aggressive behaviour towards others, the registered provider recorded some information about people's behaviours in their memory and understanding assessment and care plan. However, these care plans did not provide a clear behaviour management plan with the person's triggers for behaviours or specific instruction to staff on how to respond to people's behaviours. These are important to ensure staff understand ways they may be able to help prevent incidents occurring and to make sure staff know how to respond consistently and appropriately. A visiting healthcare professional did tell us that they felt staff generally followed the guidance that they gave them in this area, but they felt that some people using the service would benefit from more one to one support from staff.

Throughout our inspection we identified a number of concerns with the quality of record keeping in care files. This included concerns about monitoring of food and fluid intake for people identified at nutritional risk and a lack of documentation to demonstrate what action had been taken in response to incidents. Some care files were also overdue their monthly review. These shortfalls had not been identified in the quality assurance processes, which showed that these systems were not effective in identifying and addressing issues.

The regional director told us that they were aware of the gaps in audits and care file reviews and that they had updated their action plan for the home in response to our last inspection. They confirmed that they had prioritised completion of audits in areas considered highest risk, such as falls, pressure care and nutrition. They acknowledged that it had been an unsettled period for the home due to changes in staffing and management and said that they were committed to making the necessary improvements moving forward. They also advised us they were recruiting a permanent manager for the home, and were providing extra support to the acting manager and deputy manager in the interim, by visiting the home two or three times a week.

Staff we spoke with felt supported by the acting manager. They told us "[Acting manager] seems

approachable. They are good and it will be beneficial having them back." A relative told us, "I feel confident that [Acting manager] will ensure things are done." The acting manager was supported by a deputy manager, two night duty managers and senior care staff. A member of night care staff told us, "If I had any issues, I would go to the night managers as they are good and I know they would pass things on."

Monthly staff meetings had not taken place in March and April 2016, but there had been one in May when the acting manager started. The staff meeting minutes we reviewed covered the following topics; staffing updates, rotas, roles and responsibilities, expectations and standards required of staff, medication issues, accident recording and cleanliness. There were also opportunities for staff to raise their concerns.

We reviewed the registered provider's supervision policy when we inspected the service in December 2015 and this policy had not changed since our last inspection. The policy was for staff to have supervision meetings every three months and an annual appraisal. We looked at supervision and appraisal records and saw that approximately one third of the staff team had not received supervision this year. The acting manager advised us that this was due to the impact of not having a manager and one of the deputy managers for the period in April and that they would take action to address this. The staff we spoke with told us, "We get supervisions three monthly I think; my last one was a few months ago though. We have a chat, discuss what you need to work on and any issues."

There were mixed views about the morale of staff at the home. One staff member told us that they loved their job, but having to cover extra shifts due to staffing vacancies and sickness was making them and other staff tired, and they felt that it was a contributory factor in some staff leaving.

The registered provider's policy was to conduct monthly resident satisfaction surveys to get feedback on a variety of topics. These included; care, cleanliness, laundry, privacy and dignity, social activities and food. We found that a resident satisfaction surveys had not been conducted since March 2016.

A resident and visitor's survey had last been sent out in March 2016, but there was no evidence that any learning or action had been taken as a result of the most recent survey responses. Whilst there was generally positive feedback from the three relatives who had responded to the March survey, two of them had stated they were not invited to relatives meetings. When we checked meeting minutes we found that no relatives meetings had taken place since January 2016.

There was mixed feedback from relatives and visiting professionals about the overall quality of the service, but people who used the service told us "It's a nice place... I'm well looked after" and "It's good all round, no complaints whatsoever."

The registered provider had a quality assurance system, but this was not being used effectively and the concerns we identified throughout our inspection, including poor record keeping in relation to people's care and nutritional needs, gaps in audits and ineffective medication systems showed us that elements of the service were not being managed effectively and the systems used to monitor the quality of the service and drive improvements were not sufficiently robust. This was a breach of Regulation 17 (2)(a)(b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure there were adequate systems for the proper and safe management of medicines, which was a breach of Regulation 12(2)(g).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to assess, monitor and improve the quality and safety of the service; failed to assess, monitor and mitigate risks relating to the health safety and welfare of service users and failed to maintain accurate, complete and contemporaneous records in relation to people and their care and treatment.

The enforcement action we took:

Warning notice