Londesborough Court Limited

William Wilberforce

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 9 and 11 March 2016 and was unannounced. We previously visited the service on 3 April 2014 and found that the registered provider met all of the regulations we assessed.

The home is registered to provide accommodation for up to 64 people, some of whom may be living with dementia. On the day of the inspection there were 52 people living at the home, meaning that the top floor of the premises was unoccupied.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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. A new manager had been appointed who would be replacing the current registered manager (who was also a director of the company) when they had been registered as the manager.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following the home's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people were working at the home.

People told us that they felt safe whilst they were living at William Wilberforce. People were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. Staff also told us that they would not hesitate to use the home's whistle blowing procedure if needed.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. Staff had received training on the administration of medication and people told us they were happy with how they received their medicines.

People told us that staff were caring and that their privacy and dignity was respected. They said that they received the support they required from staff and that their care plans were reviewed and updated as needed. People's nutritional needs had been assessed and people told us they were very happy with the food provided.

People told us they would not hesitate to express concerns or make a complaint, and they were confident their concerns would be listened to and acted on. There was a process in place to manage complaints that were received by the home. In addition to this, there were systems in place to seek feedback from people who lived at the home, relatives and staff.

Care staff, people who lived at the home and relatives told us that the home was well managed. Quality audits undertaken by the registered manager were designed to identify any areas of improvement to staff practice that would promote safety and optimum care to people who lived at the home.

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 was safe.

People were protected against the risks associated with the use and management of medicines, as there were robust policies and procedures in place that were followed by staff.

Staff had been recruited safely and there were sufficient numbers of staff employed to ensure people received a safe and effective service.

Staff had received training on safeguarding adults from abuse and this meant they were able to identify concerns and refer them to the safeguarding authority.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act [MCA] and Deprivation of Liberty Safeguards [DoLS].

People's nutritional needs were assessed. People told us they liked the meals at the home and that there was a choice at each mealtime.

People told us they had access to health care professionals when required.

Is the service caring?

Good

The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

People told us that their privacy and dignity was respected by staff and we saw evidence of this on the day of the inspection.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests and the people who were important to them, and their preferences and wishes for care were included.

People had ample opportunities to take part in their chosen activities.

There was a complaints procedure in place and people told us they would be happy to speak to the manager if they had any concerns.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission.

There were sufficient opportunities for people who lived at the home and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe and effective care and support.

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.

The inspection took place on 9 and 11 March 2016 and was unannounced. The inspection team consisted of three adult social care (ASC) inspectors on day one, and one ASC inspector on day two.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider, information we had received from the local authorities who commissioned a service from the registered provider and information from health and social care professionals. The registered provider was not asked to submit a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

On the day of the inspection we spoke with eight people who lived at the home, five members of staff, the manager and two relatives. Following the day of the inspection we spoke with a further three relatives.

We looked around communal areas of the home and bedrooms, with people's permission. We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment and training records for three members of staff and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People told us that they felt safe living at William Wilberforce. One person said, "Yes, very safe" and another told us, "Yes, I feel safe – its ok here." We asked staff how they kept people safe and their comments included, "Our training in moving and handling", "Security of the premises", "We are trained to use equipment safely" and "We have bed and chair sensors if people are at high risk of falls, and we work in pairs when we use the hoist." One relative told us that they were satisfied their family member was safe as "There is always someone to help him move around."

We checked that the premises were being maintained in a safe condition. We saw up to date maintenance certificates for the fire alarm system, fire extinguishers, emergency lighting, portable appliances, mobility and bath hoists, the passenger lift and the emergency call system. Current electrical installation and gas safety certificates could not be found on the day of the inspection, but these were later forwarded to the Commission. We noted that the gas safety certificate expired on 26 February 2016 and an updated certificate was forwarded to the Commission to evidence that there was a current certificate in place.

The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. Staff were able to describe different types of abuse, and they told us that they would report any incidents or concerns they became aware of to the manager or any senior member of staff. One member of staff told us, "Safeguarding involves everything we do – we are closely observed by the deputy and senior staff and we are all aware of whistle blowing." Other staff we spoke with said they would not hesistate to use the whistle blowing procedure, and that they were confident their confidentiality would be maintained.

We checked the safeguarding folder and saw it included copies of the home's policy and procedure, contact details for the safeguarding team and information about the safeguarding threshold tool introduced by the local authority. We saw that alerts had been submitted to the local authority appropriately and that the monthly monitoring log used by the home recorded details of the incident and the action that had been taken by staff. Body maps were included in the folder so that any injuries could be recorded, if needed. In addition to this, there was a copy of the notification that had been submitted to CQC in respect of some of these incidents.

There was a generic risk assessment in place for people who lived at the home, plus more specific risk assessments for the risk of falls, nutrion and mobility. Risk assessments reorded significant hazards, who might be exposed to hazards, existing control measures and whether the risks where adequately controlled. However, we saw that the risk assessment for one person who was at risk of falls recorded they had fallen recently but there was no advice for staff on prevention apart from making sure the environment was free of clutter. The falls assessment used was scored but there was no indication of what constituted a low or high score. This was acknowledged by the manager who told us that this would be addressed in the new care planning system.

On the day of the inspecltion we observed staff transferring people using the mobility hoist, and saw that

this task was carried out safely. We also saw that people had been provided with pressure care equipment when they were assessed as being at risk of developing pressure sores. One person's care plan recorded, "Skin integrity – intact. Airflow mattress in place."

We saw that accidents and incidents had been recorded appropriately. Accidents had been audited each month; there had been ten accidents in December 2015, twelve accidents in January / February 2016 and six accidents in March 2016. These had mostly been unwitnessed and had resulted in skin tears, but on occasions more serious injuries had been sustained. Medical attention had been obtained for two people following accidents and they were both admitted to hospital; one because they could not 'weight bear' and another because their fall had resulted in a lump to the back of their head. We noted that, although care staff provided first aid and recorded accidents thoroughly, medical intervention was not always sought. Although there was no indication that people had not received appropriate care, we discussed this with the manager and they told us the would ensure staff were aware of the correct procedures to follow in respect of obtaining medical advice or intervention.

People's care plans included details of their current prescribed medication. People told us they understood why they were taking their medication and that they received their medication at the right time. One person said, "It's extremely good. I don't know how they do it, but I've been amazed how exactly right the medical side of things has flowed from [previous residence] to here, right down to being asked what time I want my medication. I've chosen to have it at the end of the day because I've always had it at that time."

Staff who were responsible for the administration of medication had completed appropriate training, and the manager and deputy manager were completing a NHS course that would lead to a Diploma in medication administration. A member of staff told us they had recently commenced medication training as they were preparing to become a senior care worker.

We saw that mediction was stored securely; there was a medication room on the ground floor and on the first floor. Medication was supplied in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. Blister packs were colour coded to denote the time of day the medication needed to be administered, and were stored in locked medication trolleys in the medication rooms. We saw that the temperatures of medication rooms and medication fridges were taken on a regular basis to ensure medication was been stored at the correct temperature.

Some people who lived at the home had been prescribed controlled drugs (CDs); these are medicines that have strict legal controls to govern how they are prescribed, stored and administered. There was a suitable storage cabinet and staff were recording the administration in a CD record book. We checked a sample of CDs held against the records in the CD book and found that these balanced.

We checked the folder where medication administration record (MAR) charts were stored. There was a list of sample signatures for staff so that records of administration could be checked. We saw that most people had a laminated 'front' sheet that included their photograph plus their date of birth, their preferred name, the name of their GP, any allergies, details of their medical conditions and how they preferred their medication to be administered. We saw that handwritten entries on MAR charts had been signed by two members of staff, which reduced the risk of errors occurring when information was transferred from the original packaging to the MAR chart. There were no gaps in recording on the MAR charts. Creams were recorded on a Topical MAR chart that included body maps to record where on the body the cream should be applied; those we saw were up to date. When people required their medication to be administered outside of the 'usual' times, this was clearly recorded on MAR charts. There were entries on MAR charts to evidence that medication records and the stock held had been audited to ensure that people had received their

prescribed medication. This was confirmed by a member of staff, who told us that night staff checked medication every night and two senior staff checked the CDs once a week.

There were specific instructions for people who had been prescribed Warfarin; people who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered. Some people had been prescribed 'as and when required' (PRN) medication and the MAR chart had only been signed when this medication had been administered. We saw that care plans included protocols that described when people would require this type of medication. Some people had chosen to administer their own medication and there were systems in place to monitor that people were taking their medication as prescribed.

There was a robust audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. The arrangements in place for returning unused medication to the pharmacy were satisfactory.

The notice board in the medication room held advice documents for staff, such as the Deprivation of Liberty Safeguards (DoLS) policy, the NHS Good Practice Guidance on the safe management of controlled drugs in care homes, care home guidance on referral to Urgent Care Practitioners, guidance on outbreaks of Influenza and a list of commonly used medicines with shortened expiry dates, with a reminder for staff to record the date opened and the expiry date on these products. This showed that staff had been provided with good practice guidance.

We checked the recruitment records for three members of staff and we noted that not all records clearly recorded the role for which the person had been employed. We saw that an application form had been completed, references obtained and checks made with the Disclosure and Barring Service (DBS), either by the home or the recruitment agency. The Disclosure and Barring Service 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 meant that only people considered to work with vulnerable people had been employed at William Wilberforce.

Staff told us they had had not been able to work at the home until all of their safety checks were in place. Some staff had been recruited via a recruitment agency and they had been responsible for carrying out the recruitment checks. We noted that copies of these checks were retained in some people's recruitment records but not in others. The manager told us they would ensure they had copies of these documents for staff recruited via the agency.

Standard staffing levels were seven staff during the day and three staff working from 7.00 pm until 7.00 am plus another member of night staff working from 11.00 pm until 9.00 am. We checked staff rotas and saw that staffing levels had been consistently maintained.

One first floor area of the home was occupied by eleven people who had more complex needs. The manager told us that one member of staff spent their day in this area of the home to support the people who lived there. We asked if they felt these staffing levels were sufficient and the manager told us that care staff were advised to request assistance from other staff on duty if the need arose.

Most people who lived at the home told us there were enough staff to support them with their day to day needs, although one person who lived at the home told us that there did not seem to be enough staff on duty as "They are very busy all of the time. They seem to be in a hurry so they don't have time to talk,

although it doesn't affect me too much." Other people told us, "I think there are probably enough staff but you might have to wait a little while if it's busy, like at lunchtime" and "We've more staff now. Sometimes have to wait a bit, but not too bad. Could be quicker but its OK." Two relatives told us they felt there were enough staff and that they had noticed the call bells were answered quickly.

We noted that numerous ancillary staff were employed, such as chefs, kitchen assistants, laundry assistants, domestic assistants and a handyperson. This meant that care staff could concentrate on providing personal care and support to the people who lived at the home.

The manager told us that she was in the process of reviewing people's dependency levels. She told us that current fees were based on dependency levels and she wanted to make sure that the fee people paid reflected the support they received. The number of staff hours provided was felt to be sufficient to meet the needs of the people who currently lived at the home

In house checks of the water temperatures, emergency lighting, fire extinguishers, fire doors and window opening restrictors were being carried out by the home's handyperson. A 'job progress' sheet was used by the home to record minor repairs that needed to be carried out, and when these had been completed by the handyperson. There was a fire risk assessment in place that was reviewed each year. Staff fire training was provided by an external contractor, and fire drills were carried out ensure that people who lived at the home and staff were aware of the action to take in the event of a fire.

We saw the registered provider's business contingency plan; this advised staff on the action to take in the event of a fire, power failures, flood, a pandemic and other emergency situations, and included the telephone numbers for people who staff may need to contact in an emergency. We also saw that people had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to evacuate the premises in an emergency, including any impairment they had, the support they would need from staff and any equipment they would need to use.

We noted that the premises were clean throughout and that there were no unpleasant odours in either communal or private areas of the home.

Good

Is the service effective?

Our findings

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. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that care plans recorded the decisions people were able to make and the types of areas that might require a best interest decision. A relative told us, "[My relative] has never been a decision maker. We would have a discussion and decide on what's in their best interest."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order. We saw that most people had appropriate documentation in place, and that the manager and staff displayed a good understanding of their role and responsibility regarding MCA and DoLS. However, we noted that one person had bed rails in place but there was no DoLS authorisation to record that this person needed to be deprived of their liberty in this way. We discussed this with the manager, who told us they would ensure action was taken to correct this.

Care plans recorded when a relative had power of attorney (POA) for their family member. A Power of Attorney is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. Most of the care plans we saw recorded details of whether the person's responsibility was in respect of care and welfare and / or finances, but one did not include this information.

We saw that people had behaviour management plans in place to guide staff on how to manage situations if people became agitated or showed signs of distress. This meant that staff did not need to use restraint.

People were asked to sign a consent form at the time of their initial assessment. This included consent to physical examination (if required), consultation with other professionals, having a photograph taken and permission for care plans to be read by staff. People had signed this form when they were able to do so, but we noted that staff had sometimes signed these forms. We discussed with the manager how these forms should record that the person did not have capacity to consent rather than the form being signed on their behalf. On the day of the inspection we observed that staff checked that people had consented, either directly or by implied consent, to being assisted by them before they offered support. One person who lived at the home told us, "Yes, they ask for consent, and they are not pushy."

People who lived at the home told us that staff had the right skills to do the job. One person said, "Most of them. One or two come and don't seem to be trained but not often. When they are new they put them with another staff member. They are nice girls." Relatives were very positive about the skills of the staff employed at the home. One relative commented, "They seem to – they treat him with respect and are very patient with

him. They ask him questions to help him express his views" and another said, "I cannot fault the staff."

Records evidenced that new staff who had been recruited via an agency had completed some training with the agency before they started work at the home; this included moving and handling theory and practical, safeguarding adults from abuse, infection control and health and safety in a care home. We saw that staff also had 'orientation' to the home including the culture of the organisation, the philosophy and principles of care, the use of hoists and slings, medication, complaints, recording, abuse and confidentiality. The staff rotas we saw recorded the names of new staff who were shadowing experienced staff as part of their induction training; these staff were on duty in addition to the usual staff complement. We saw that some staff had started the Care Certificate that had been introduced by Skills for Care, a nationally recognised training resource.

Staff told us they had attended a variety of training courses during the last year, including moving and handling, safeguarding adults from abuse and "Lots of e-learning." Staff had an individual 'experience and training assessment' in their records. We checked some of these records and noted that staff had completed a variety of training during the previous year. One person had completed first aid, Infection control, dementia, health and safety, fire safety, the control of substances hazardous to health (COSHH), diabetes, stroke awareness and nutrition. We noted that some people had completed numerous e-learning sessions in one day and asked the manager if they considered this training to be in sufficient depth. The manager told us that they had recognised that the current training provided by the home did not suit all staff and they were planning to move to a different training provider; this would not be on-line training. They had a staff meeting planned for the evening of 9 March to discuss their plans.

There were a small number of gaps in training that was considered to be essential by the home. We saw that staff training was monitored each month by the manager and that staff were sent a letter to remind them of any outstanding training that they needed to complete. The manager assured us that this was being followed up.

Staff told us that they felt well supported and had supervision meetings with the manager on a regular basis, usually every three months. The deputy manager told us that these meetings were held more often for new staff. These are meetings where staff can discuss their performance and any concerns they might have with a manager.

People's care plans recorded their current health care needs, including details of their prescribed medication. We saw that any contact with health care professionals was thoroughly recorded; this included the reason for the contact and the outcome. People told us that they could see their GP or other health care professionals when they needed to. One person said, "The chiropodist comes every six weeks and the GP comes every week so I could see him if I needed to." A relative told us that staff were "Quick to call out the GP if they had any concerns, and that they wre always kept informed about any health issues." Records we saw evidenced that health care professionals such as speech and language therapy [SALT] services, community nurses and chiropodists were involved appropriately in people's care, and that any contact with care managers was also recorded.

We saw that people had been provided with equipment to help reduce the risk of pressure sores, such as pressure relieving mattresses and cushions. One person had an ulcerated toe and their care plan recorded the circumstances under which they should be taken to A & E for further treatment (as a matter of urgency).

People had hospital passports in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff. We saw that

hospital passports included details of any allergies the person had plus "Things that are important to me." However, we saw that the section to record whether or not a person was able to consent to treatment had not been completed, which meant that hospital staff would not have been fully informed about the person's ability to make decisions and give consent.

Relatives told us they were happy with the level of communication between themselves and staff at the home. One relative told us, "I am always having discussions with the manager or assistant manager about medication. If I say I think she needs medication or to see her GP, they act. They always keep me in touch with everything that is happening." Another relative said, "[My relative] is prone to falls. Every time it happens they ring me straight away – after ringing for an ambulance."

Staff told us that people were asked about their special dietary requirements when they moved into the home, and this was shared with staff at handover meetings; these was a copy of this information in each person's care plan and a copy in the kitchen.

Assessments, care plans and risk assessments recorded a person's particular needs in respect of eating and drinking. Care plans also showed that staff took advice from dieticians and the speech and language therapy team (SALT) when they had concerns about a person's nutritional intake or the risk of coughing / choking. This information had been incorporated into a person's care plan. One person's plan recorded, "Unable to eat / drink independently, eats slowly. Soft diet. Fortisips prescribed. Keep upright when eating as at risk of choking" and another recorded, "Type 2 diabetes. Requires soft, enriched diet. Appetite has deteriorated. Offered food each meal time – fluids encouraged." People were also weighed as part of nutritional screening, and staff told us they monitored a person's dietary intake on food and fluid charts when this had been identified as an area of concern. However, we saw that recording was not as accurate or detailed as it could be, and that sometimes food and fluid intake was recorded elsewhere but not on the chart. We discussed this with the manager who assured us that they would speak to staff and monitor these recordings.

Care plans recorded people's dietary likes and dislikes, such as, "Likes a brandy with ginger ale in an evening" and "I always like my meals at night time." Most people who lived at the home told us that the food was good. Comments included, "The food is nice. I have a domestic science background myself. They have quite a good chef here – on the whole the food is good", "The food is excellent – its varied" and "The food is nice – I enjoy it." However, some people who lived at the home and relatives told us that the food was 'repetetive'. One person said, "The food is the biggest drawback. Its's the same things week in and week out. They are looking into it – there's a meeting this week." This showed that staff had listened to people's concerns and were meeting with them to discuss the improvements that were needed. We saw that there was a menu board with the choices for breakfast, lunch and the evening meal recorded. However, we noted that the meal provided at lunch time was not the same as the meal advertised on the notice board; this could have been confusing for some people.

There was a main dining room that was used by most people who lived at William Wilberforce. There was also a bistro that people could use, either on their own or with family and friends; this was run on a 'donation basis' for visitors. On the day of the inspection we observed the lunchtime experience in the main dining room. We saw that tables were set with table mats, napkins and condiments. Some people were offered clothes protectors. People were offered a choice of juice or water and offered a bread roll to have with their soup; they were served the main component of the meal and then asked if they would like potatoes and vegetables. Appropriate assistance was offered to people and one person was encouraged to eat more. We saw that people chatted to each other which made the mealtime a social experience, although we noted there was little intereaction between people who lived at the home and staff. Meals were taken on

trays by staff to some people who had chosen to eat in their room.

One relative told us that they felt the music played over meal times "Could be happier." They added, "If that is all we have to complain about, how good is that!" The manager told us she was aware of the concerns some people had about the type of music being played and they were considering what people might prefer.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Relatives and staff told us they thought the premises were suitable for the people who lived at the home. One person told us, "I have a nice room and bathroom. It's lovely here – very much like a hotel." Relatives told us, "I looked at several homes and none came up to the standard other than this one" and "[My relative] likes that it doesn't feel clinical – not a series of chairs around the room. He can sit with the family and not feel it's like an institution." Although bedrooms were numbered, we noted that none of the bedroom doors had people's names or signs on them to help people to identify their own room. The manager told us that name plates had been ordered for each person who lived at the home and would be fitted as soon as they arrived. This would make it easier for people who were living with dementia to locate their own room.

Good

Is the service caring?

Our findings

Everyone who we spoke with said they felt staff cared about them. Comments included, "If I ask them for help with anything they do it willingly and it's well done", "They are very kind. They do everything I need them to or that I ask" and "They are kind and caring." This was confirmed by the relatives who we spoke with. Comments included, "The staff are friendly and provide excellent care – nothing seems to be lacking", "I do think so. I don't know how they do it. They are very patient", "They [staff] get attached to service users – they care about them" and "Mum loves her main carer." A member of staff told us they believed that staff genuinely cared about people who lived at the home. They said, "You can tell it comes from the heart."

One person mentioned that staff language skills were a barrier but this was not raised as an issue by anyone else. Relatives told us that language was not a barrier to staff providing good care.

People told us that staff respected their privacy and dignity. They told us that staff knocked on their bedroom door before entering and we observed that this was the case. One person said, "Yes they do – they do it professionally." Staff told us that they knew how important it was to respect people's dignity and to maintain their confidentiality. They told us, "There is usually just one care worker with one person", "We ask what assistance they would like and we use towels to protect their modesty" and "We ask if they would like a bath or a shower. We ask what help they need and what they would like to wear."

Relatives told us that their family member's privacy and dignity was respected by staff at all times. Bedrooms were spacious and there were also various areas of the home where people could meet with relatives and friends in private, and where private meetings could be held.

We saw that care plans did not record whether people wished to be assisted with personal care by a male or female carer; this information would have enhanced a person's dignity and ensured that their individual wishes for care could be promoted.

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. We were told that some people had religious needs but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. However, we did note that care plans would have benefited from having more information about equality and diversity.

We saw that the people who lived at the home were clean, appropriately dressed, had tidy hair and were wearing appropriate footwear. Men were clean shaven (if this was their wish). One person told us that it was important for them to be dressed smartly and we saw this to be the case. A relative told us that their family member was "Well groomed – they have always had a shave and a shower."

One person told us that they tried hard to remain independent and that staff supported them to do so.

Relatives told us that staff supported their family member to be as independent as possible, although one relative said their family member was not able to do very much for themselves and another relative said that some staff were better at promoting this than others. Staff told us that they promoted independence. One member of staff said they supported people to remain independent "By encouraging them to walk" and another told us "We offer to help and ask what assistance they need."

One person's care plan recorded that they would like their relative to assist them with a shower. This had been discussed with the relative, who was happy to assist with this task. This showed that the home supported family involvement if this is what the person's wished.

We saw that one person's care plan recorded that their relative acted as their advocate and information about advocacy services was available at the home. 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.

Good

Is the service responsive?

Our findings

The care documentation we saw included care needs assessments, risk assessments and care plans. A pre-admission assessment had been completed prior to the person moving into the home, and this information had been developed into an individual plan of care. People who lived at the home had care plans in place for promoting personal needs, diet, medication, mobility, social / leisure, pressure care, mental health, communication, infection control and capacity / consent.

Care plans were developed from information gathered from the person themselves, their family and friends and from health and social care professionals involved in their care. Each area of the care plan recorded the assessed need and service user view, the aim of care and staff instruction, and had been signed by a member of staff and the person concerned (when they were able to do so). One relative told us they had some input into their family member's care plan when they were first admitted to the home, and another relative said they had been "Very involved."

The manager told us that they were in the process of introducing a computerised care planning system; some information was already on the new system but other information still needed to be uploaded. Some care plans had recently been updated and we saw that they included bullet points of 'urgent needs'. This meant that staff had easy access to important information about a person's care needs.

We saw that assessments, risk assessments and care plans had been updated as needed so that they included up to date information for staff to follow. However, we noted there were some omissions in care plans. One person's 'Do Not Attempt Resuscitation' (DNAR) form did not have a review date, one person's moving and handling risk assessment did not record details of the hoist or sling that needed to be used, one person's body map had not been dated and some falls risk assessments recorded a score but there was no indication of whether this meant they were at low, medium or high risk of having a fall. One person had been diagnosed with epilepsy. The care plan did not identify the type of epilepsy and there was no information to guide staff on how to support people who were living with epilepsy. We discussed this with the manager. She told us that she had recognised this and that she was due to attend training the following week; this included advice on the best way to complete seizure charts. She would then cascade this information to the rest of the staff group.

We saw that attempts had been made to ensure that the care provided was person centred. One relative told us that their family member had difficulty expressing that they would like more breakfast. They had discussed this with staff, and the decision was made that they would offer them more in a way that they only had to respond 'Yes' or 'No', and that this had been successful. One person's care plan advised staff how to wake someone to ensure they were not startled. It recorded, "Its important to stroke her arm to wake her and get at eye level. She is slow to respond so be patient. Explain what is happening."

People who we spoke with told us that their care was centred around them, and we saw that care plans recorded people's support needs when they got up, at mealtimes, during the day, when they went to bed and during the night, as well as the activities they enjoyed. It was clear that care workers knew people's

individual personalities, wishes and care needs. Staff told us they got to know people by reading their care plans and by talking with them and their family members.

We saw the 'handover' file that was used to record information that was passed from shift to shift. This included a list of people who were at high risk of falls (five people were considered to be at high risk) and lists of people who had a pressure mat or a floor sensor, plus the minutes of the most recent staff meeting. The manager told us that the daily handover sheet was completed at the end of each shift; it was sent to all senior staff, all managers and the directors of the company by email; we saw that senior staff signed to evidence that they had read the email. Information was recorded about people who lived at the home as well as more general information, such as "I wrote all notes from residents who had GP visit yesterday on their files." The manager told us that the information from the handover sheet was read out to staff at the beginning of each shift. The manager had produced a new handover sheet that she believed would be more effective; each person who lived at the home was listed and the form included space to record the person's name / room number, significant events and the action taken.

There was an activities coordinator working at the home over a seven day period. We saw the activity calendar for March 2016. This showed that a wide variety of activities were offered including exercises, reflexology, 'knit and natter', crafts, baking, manicures, hairdressing, massages, 'Ted the pat dog', Zen colouring and external entertainers. In addition to this, there were activities that acted as reminiscence such as "Icing buns for Good Friday" and Easter egg making. People told us there were activities they could take part in; they mentioned exercise classes and a singer. One person said, "I am going out now to something organised by the church. They come and collect us on the bus". Other people told us, "Yes, we have a lady who organises them. I like knitting, and we do have exercise if you want to do them" and "I think there are activities at certain times but I don't get involved. There is television so there is always entertainment. There are things to do."

Staff told us that they knew people's interests from reading their care plans and from talking to them. They said they reminded people what was on the activities calendar and they tried to involve people who were living with dementia in suitable activities. The activities coordinator told us that they spent one to one time with people as well as organising group activities; this included playing a game of cards, reading to people and helping them with their mail.

Relatives told us that their family members had activities to take part in. One relative said, "They have a programme – [Name of relative] likes drawing, crafts and singing", "I attended an exercise class with mum the other day" and "[Name] enjoys watching the gliders." Relatives also said they were able to visit the home at any time. One relative said, "Last Sunday I went in the evening. I sat in mum's room so we could watch Crufts."

On the day of the inspection we saw that staff went out of their way to make visitors welcome and offered them refreshments. One relative told us, "They always greet us with a smile – we are made to feel very welcome" and another said, "Staff are always cheery – they always greet me as [Name]." Staff told us that some people had their own telephone and that they also had a 'resident' mobile phone for people to use. One care worker told us, "We contact families on people's behalf" and "We have a coffee morning once a month for relatives, and we have a newsletter that is emailed to families and displayed on the notice board."

Staff told us how they encouraged people to make decisions and choices about their daily lives, such as "We use gentle encouragement. We would show things to people to help them make decisions" and "We need to be patient and our tone of voice is important. We may show them a choice of clothes. We remind them what

meals they have chosen from the menu."

We saw that the complaints procedure was displayed in the home. People who lived at the home told us that they could raise issues and they were confident they would be dealt with. One person said, "Yes, I would feel comfortable raising things. I'd approach it in the right manner though. I think that's important, don't you?" and "Oh yes, I would tell them! I don't know if they'd sort it or not because I haven't had to, but I'd certainly tell them!" Relatives told us, "I would speak to them – I wouldn't hesitate. I had discussions with them about something when my relative was first admitted and they put it right straight away" and "I would know who to complain to. I am confident I would get the right response."

We checked the complaints log and saw the folder was divided into months and any complaints or concerns that had been received had been stored accordingly and recorded on the complaints action plan. Complaints received had been reviewed in November 2015; there had been four complaints received between 30 January 2015 and 30 November 2015. A recent concern received had mentioned 'staff approach'. The manager told us that a meeting had been arranged for that evening (9 March) to discuss this. We also saw that a specific meeting had been held to discuss a previous complaint. This showed that people's concerns had been listened to and that action was being taken.

Staff told us they would listen to a person's complaint or concern and would deal with the complaint immediately if they were able to do so. Otherwise, they would report the issue to the manager. One member of staff said, "If people think I am doing something wrong, I would ask how I could put it right." Staff said they were confident that the manager would listen and investigate any concerns or complaints forwarded to them.

Meetings had been held for people who lived at the home, although these had not been held on a regular basis. A meeting for 'residents' and relatives had been arranged for the week after this inspection; we saw this advertised on the home's notice board.

The most recent 'resident' survey had been carried out in March 2015 and we saw the analysis of the returned surveys. The manager told us that they planned to carry out another survey for people who lived at the home and for relatives in April 2016. They told us that people would be handed the survey and given an envelope to return it to the home to protect their confidentiality. This meant that people who lived at the home and their relatives were being given opportunities to comment on the care provided.

Good

Is the service well-led?

Our findings

We asked for a variety of records and documents during our inspection. We found that the majority of these were well kept, easily accessible and stored securely. However, some safety certificates could not be found on the day of the inspection. The manager acknowledged that these were not well organised; they informed us after the inspection that they had reorganised maintenance information into one folder so it was possible to locate certificates and identify when they were due for renewal.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

We saw that there were clear lines of communication between the manager and staff. The manager knew about the specific needs of people living at William Wilberforce, as they had worked at the home in another capacity before being appointed as the manager. We asked staff if they felt able to discuss things with the manager and we received positive responses. One member of staff said, "She's brilliant. We have a really good team" and another said, "She knows what she is doing – I can learn a lot from her as she is knowledgeable."

A relative told us that they had attended meetings with the manager "From time to time" and that they had found the manager to be very helpful. They said that the manager had asked if they had identified any improvements that needed to be made to the home or their family members care, which they felt to be a positive way of managing the service.

Staff described the culture as, "Very caring, friendly, relaxing, outdoor space, calm and peaceful", "Warm, tender and loving", "It feels like home" and "A nice atmosphere – welcoming and caring. People feel safe." Comments from people who lived at the home included, "It's a nice atmosphere here and quite friendly", "It's a nice relaxed atmosphere but also professional. It's purpose built – a nice environment" and "I get frustrated that I can't do the things I used to do. It's not like home but it is a nice home. I've lived in other care homes and this is the best one locally." Relatives described the culture as "Approachable and pleasant", "Friendly, perfect" and "The home is peaceful, calm and respectful." Two relatives told us they would recommend the home to other people.

We saw the minutes of senior staff meetings and full staff meetings. Staff told us that they had the opportunity to ask questions, make suggestions and express concerns at staff meetings and that they felt they were listened to. One staff member said, "Everyone gets the chance to speak."

We asked staff if there had been any learning from incidents or complaints received by the home. They could not recall any specific incidents but told us they were confident that any issues would be talked about openly and would always be followed up. One member of staff said, "We all make mistakes. We would definitely discuss this and try to put things right."

Audits were carried out on various topics. A monthly audit form recorded that audits had been undertaken on pressure sores, nutrition, falls / accidents, medication, kitchen, administration, personnel, supervision and appraisals, maintenance, infection control, health and safety and risk. Each area had entries that recorded important information and any identified shortfalls. For example, the nutrition audit recorded that three people currently had input from the dietician and three people had pressure sores and that all had been referred to the district nursing team. However, some areas recorded shortfalls and there was no action plan to record how these had been addressed. For example, the kitchen audit recorded that the windows needed to be cleaned, the floors needed a deep clean and a COSHH cupboard was needed for the kitchen. There was no record of when this work had been completed. The audit on pressure sores showed that the numbers had increased from three in January 2016 to five in February 2016. We discussed this with the manager who told us that she had recognised this pattern; she had looked into this and seen that staff had been recording sore areas and grazes as well as pressure sores. The incidence of pressure sores had not actually increased.

The manager told us that, as part of the new audit system she had introduced, an action plan was produced each month. These were signed and dated when the actions had been completed.