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?	**Requires improvement**

Overall summary

Ebor Court is a purpose built care home which provides residential and dementia care for up to 64 older people. 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 residential care, whilst the Guy Fawkes and Dame Judy Unit specialised in providing dementia care.

The service was last inspected in December 2014 at which time it was rated 'good' in each of the five key questions and 'good' overall.

We inspected this service on 18 November and 2 December 2015. This inspection was unannounced. One of our visits was carried out between 6am and 1pm so we could speak with night staff. At the time of our inspection there were 51 people using the service.

Prior to our visit, concerns were raised about a number of issues including staffing levels within the home and infection prevention and control practices. We have recorded our findings in relation to these concerns in the body of this report.

Summary of findings

During this inspection we found that the service was not always safe as 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.

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 received generally positive feedback telling us that the home was well-led. We observed that the manager was knowledgeable about relevant legislation and guidance on best practice. However, we noted that quality assurance processes were at times tokenistic and not robust enough in identifying concerns with the quality of care 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.

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 in post and on the day of the inspection there was a manager 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.

Although the service sought consent to provide care and support, it was not always clear, when relatives or carers signed on people's behalf, whether this was with the person's agreement or in their best interests. We have made a recommendation about recording consent in line with relevant guidance and legislation in the body of this report.

People's needs were assessed and care plans put in place detailing how these needs would be met. People told us they were not always involved in reviews of their care plans, however, we could see that there were systems to review and update care plans as people needs changed. We identified that care and support was not always person centred and have recommended that the registered manager reviews practices in-line with relevant guidance.

We received inconsistent feedback regarding staffing levels within the home and have recommended that the registered manager reviews staffing levels and staff deployment across a 24 hour period to ensure they continue to meet the needs of people using the service.

We found that staff understood the types of abuse they might see and how to respond appropriately to safeguarding concerns to keep people using the service safe.

We observed that the service had effective infection prevention and control policies and practices in place and the home was observed to be clean and tidy during our inspection.

There was a safe recruitment process and an effective induction to equip new staff with the skills and knowledge needed to carry out their roles. The registered provider ensured staff received on-going training and supervision to support them in their roles.

People we spoke with were generally positive about the kind and caring nature of staff. Staff supported people using the service to have choice and control and to maintain their privacy and dignity.

We received mixed feedback about the level activities within the home and support provided to enable people to pursue their own interests.

There was a system in place to manage and respond to complaints and feedback about the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

There were systems in place to identify and respond to signs of abuse to keep people using the service safe.

Risk management was not always effective. This placed people who used the service at increased risk of harm.

We received mixed feedback about staffing levels and noted that the registered manager needed to more proactively monitor staffing levels across a 24 hour period to ensure there were sufficient staff to meet the needs of people using the service.

Medication was managed safely and there were safe infection prevention and control procedures in place.

Is the service effective?

Requires improvement

The service was not always effective.

Staff received induction training and on-going refresher training to equip them with the skills needed to carry out their roles effectively.

People's food and fluid intake was not effectively monitored increasing the risk of malnutrition and dehydration.

Staff sought consent to care and treatment, but it was not always clear that this was done in line with relevant legislation and guidance.

People using the service were supported to access healthcare services.

Is the service caring?

Good

The service was caring.

People we spoke with were generally positive about the kind and caring nature of staff.

People were supported to make decisions and have choice and control over their daily routines.

People's privacy and dignity were maintained.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's needs were assessed and systems put in place to support staff to provide responsive care and support.

We observed that care and support provided was not always person centred.

Summary of findings

There was a system in place to manage and respond to complaints and to seek people's views and opinions.

Is the service well-led?

Requires improvement

The service was not always well-led.

We received positive feedback about the management of the service.

We noted that quality assurance processes were not always effective in identifying areas of concern and driving improvements.

The registered manager had a good up-to-date understanding of relevant legislation and guidance on best-practice.

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 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 18 November and 2 December 2015 and was unannounced. The inspection team was made up of two Adult Social Care Inspectors and a Specialist Advisor (SPA). A SPA is someone who can provide specialist advice to ensure that our judgements are informed by up to date clinical and professional knowledge. The SPA who supported with this inspection was a nurse specialist with expertise in community nursing, falls management and medication.

Before the inspection we looked at information we held about the service, which included notifications sent to us since the last inspection. 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.

We did not ask this service to send us a provider information return (PIR) before the inspection. The PIR is a document that the registered provider can use to record key information about the service, what they do well and what improvements they plan to make.

As part of this inspection we spoke with 11 people using the service, two visitors who were relatives or friends of people living at Ebor Court and two visiting healthcare professionals. We spoke with the registered manager, the deputy manager, nine care workers, the cook and the maintenance person for the home

We looked at nine care plans and four staff recruitment and training files as well as a selection of records used to monitor the quality of the service. We observed interactions throughout the day between staff and people using the service; this included observations of medication being administered and lunch being served on two of the units.

Requires improvement

Is the service safe?

Our findings

People who used the service told us they felt safe. Comments included "We are really safe", "I feel safe and I am kept informed" and "I feel safe, yes definitely." A relative of someone using the service told us "[Name] is safe and well looked after."

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. Safeguarding adults training was provided as part of the induction for all new staff and existing staff had to complete refresher training to update their skills and knowledge. Staff we spoke with could identify the types of abuse they might see and described what action they would take if they had concerns. This showed us that training had equipped staff with the skills needed to identify and respond to signs of abuse.

We saw that where safeguarding concerns had been identified, these had been appropriately acted upon by the registered manager and referred to the local authority's safeguarding team. The Care Quality Commission (CQC) had also been notified of these alerts. This showed us that there were systems in place to respond to safeguarding concerns to keep people using the service safe.

People's needs were assessed, risks identified and risk assessments put in place to document how these risks would be managed. We saw personalised risk assessments to manage risks associated with providing personal care, managing medication, swallowing difficulties (dysphagia), the risk of falling and the risks associated with the use of bed rails. Staff used risk assessment tools to determine the level of risk, including the Malnutrition Universal Screening Tool (MUST), to identify people's risk of malnutrition, and a Waterlow Risk Assessment to identify the level of risk of developing pressure sores.

Where people's needs had changed or additional risks had been identified, we saw examples where risk reduction measures had been implemented. For example, where there were concerns about a person's diet, we saw that a short-term care plan had been implemented to include weekly weights, instructions that food and fluid intake should be monitored and a referral made to the dietician for further advice and guidance. However, this approach to risk management was inconsistent; we found examples where staff had not identified or responded to risks, examples where risk assessments did not contain sufficient detail and instances where risk assessments were not followed increasing the risk of avoidable harm.

We observed that the rubber grips on the bottom of one person's wheeled walking frame had worn almost through to the metal frame. This could stop it gliding on carpets and potentially cause it to slip on lino/wooden flooring causing a significant falls risk. We advised the senior care worker to have these replaced and recommended that all frames and walking sticks were checked and repaired if necessary. We also noted that some beds could be split in half, in case they needed to be moved, however, we saw a number of examples where the clasps joining the two halves together had broken or were missing. This meant the bed base could split and create a significant fall and injury risk.

One person's risk assessment identified swallowing difficulties. To manage this risk the person required thickened fluids, which were easier to swallow. However, this was not always observed and we noted that they had an un-thickened cup of tea when we visited them. This could increase the risk of health complications and showed us that staff were not always following risk assessments. Another care plan recorded that there was a high risk regarding a person's nutritional intake and documented that "risk monitoring plan required". This had not been implemented in the 17 days between the risk being identified and our visit.

We observed safe moving and handling practices throughout our inspection and saw that people were supported to mobilise independently around the home. We saw that one care plan identified that a person was at high risk of falls, having had five falls in a three month period. Although documenting that this person was on 30 minute observations, their risk assessment contained basic information only about how this risk would be managed and limited information about what else had been considered or put in place to try and reduce the risk of falls.

Accidents, incidents and near misses were recorded and reports of these were sent to the deputy manager or registered manager to be reviewed and signed off. This was to ensure that appropriate action had been taken in response to the concerns and that necessary preventative measures were taken to reduce the risks of similar incidents in the future. For example, one accident incident form had been completed following an unobserved fall, the

accident and incident report collected information about contributing factors and recorded what measures had been put in place to prevent further falls. We also noted that frequent documented checks had been put in place following this fall to monitor for any signs of injuries or ill effects.

Accidents and incident reports were collated onto a monthly accident and incident report for the registered manager to audit, review and analyse for patterns and trends. However, this system was not always effective at minimising future risk of harm; in one example we noted that a person using the service had fallen out of bed as their bed rail had not been clicked back into place properly. Although this person did not sustain any injuries, this was a near miss. The records of this incident did not show what preventative action had been taken and whether this was an issue with the bed rails or human error. We subsequently checked bed rails in use and found that these were in good working order.

These examples showed us that risk management was inconsistent. Some risks had not been identified; other risks had been identified, however, appropriate action had not always been taken to respond to and mitigate these risks to prevent future incidents occurring. This placed people using the service at increased risk of harm.

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

The registered manager showed us the registered provider's business continuity plan. This 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 that there was a system in place to keep people safe, warm and meet their care and support needs in the event of an emergency. Personal emergency evacuation plans (PEEP's) were in place for people who would require assistance leaving the premises in the event of an emergency.

We looked at documents relating to the servicing and maintenance of equipment. The equipment serviced included the passenger lift, moving and handling equipment including hoists and slings, the nurse call bell system, the electrical wiring, the fire alarm systems and portable fire equipment. Although documents were not available on the day of our inspection we were subsequently sent a copy of the homes Gas Safety Certificate. We were told that the handyperson was in the process of completing portable appliance tests at the time of our inspection.

People using the service told us "There are enough staff" and "There are plenty of staff, they are lovely. Always there if you need them." Other people we spoke with said "We have been short staffed with illness, but they do their best to make us comfortable, but it's not perfect."

A relative told us "There seems to be staff around, I think there are enough; they don't seem to be rushing." However, one member of staff told us "There's not enough staff", whilst visiting healthcare professionals said "There are insufficient staff numbers and skill mix to provide the level of care required for the residents" and "There are not enough staff on duty; it can take us a long time to find someone to help. We have issues with trying to find staff."

At the time of our inspection there were 51 people using the service. The registered manager told us that the minimum safe staffing levels were eight staff on duty each morning, seven in the afternoon and a minimum of four staff on duty at night. We reviewed staff rotas and saw that staffing levels did not drop below this level. The registered manager completed a dependency tool; however, they told us that this did not provide a figure for the number of staff or hours needed to meet people's needs. We also saw that this was completed retrospectively so could not be used to identify the levels of staffing needed to meet the needs of people using the service for the coming month. The registered manager told us that they worked on a ratio during the day of one member of staff to six people using the service and spoke with people and staff during supervision to identify any issues with this ratio.

We visited the service during the night shift and saw that there was four staff on duty, one of which was an agency worker. The shift was organised with one member of staff on each floor and the night manager as a second member of staff on the ground floor. Whilst staff were unrushed, we noted that there was only one member of staff who could administer medications and a number of people on each floor who required support from two members of staff with repositioning or personal care. This meant that during the medication round there were no free staff available if people required assistance from more than one member of staff. We asked staff how staffing levels affected people using the service; they told us "Staffing levels can affect

Is the service safe?

choice. If there are not enough staff we have to say wait a minute and prioritise…we could get six people asking to go to bed and we have to make a decision, somebody has to wait."

We recommend that the registered manager review their staffing levels and staff deployment to ensure that there are suitable numbers of staff to meet people's needs across a 24 hour period.

Staff told us that they were asked to work additional shifts to cover gaps in the rota and, if this was not possible, agency staff would be used. Agency staff were predominantly used to cover night shifts. Staff we spoke with told us there were usually one or two members of agency staff working on the night shift. Whilst this could be problematic for new agency staff, as they did not know the home or the people they were supporting, staff told us that they used agency staff regularly, so they often felt part of the team. The registered manager told us that there were eight agency workers who they used on a regular basis to try and maintain continuity of care and they were also recruiting new staff to reduce the use of agency workers.

We looked at the recruitment files for four staff employed at the service. We saw that application forms were completed, interviews held and that two employment references and Disclosure and Barring Service (DBS) checks had been obtained before people started work. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. This information helped to ensure that only people considered suitable to work with vulnerable people had been employed.

There was an up-to-date medication policy and procedure in place at the time of our inspection. Staff responsible for administering medication had been appropriately trained and competency checks were completed to ensure they had the necessary skills and were working in line with guidance on best practice. Where people required support to take their medication, we saw that clear direction was recorded in their medication care plan with instructions, for example, 'Likes them in a pot with a glass of water.'

We observed two medication rounds and looked at the process used to manage medication within the service. We concluded that medication was safely ordered, received, stored, recorded, administered and returned when not used. People using the service told us "I have medicines; staff look after them for me."

Medication Administration Records (MAR) were used to record medication given to people who used the service. We saw that MARs were accurately completed and regularly audited to ensure that they contained the correct information. Where people were prescribed topical creams, there were records including a body map to show when and where creams needed to be applied.

Staff who completed medication rounds were knowledgeable about the policies and procedures for managing medications including refusals of medication. One person using the service received their medication covertly. Covert medication is the administration of medication in a disguised form in situations where people might refuse to take necessary medication. Covert medication is usually administered in a person's food or drink, but can only be done where a person lacks capacity and it is in their best interests. We saw that this had been authorised by the person's medical practitioner and that appropriate documentation was in place to support this, including guidance on how to administer covert medication.

We observed that medications were appropriately stored in a secure air conditioned room, which was clean and tidy. We saw that, where necessary, medication was stored in a fridge and that fridge temperatures were regularly checked and within safe limits.

Some prescription medicines are controlled under the Misuse of Drugs legislation. 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. We observed that the controlled drugs book was accurately completed without any omissions or discrepancies and two staff did a weekly audit to ensure stock levels were accurate.

People using the service told us "The home is always clean" and a relative said "It always seems clean and tidy." We observed that the home was clean, hygienic and there were no unpleasant smells at the time of our inspection. Staff were observed regularly washing their hands and using personal protective equipment (PPE) such as gloves and

aprons where necessary. We saw that spare cleaning products and PPE were available and, when asked, staff did not raise concerns about the supply or availability of these items.

We saw that soap dispensers were available and hand towels in bathrooms. A visiting healthcare professional told us that soap dispensers were sometimes empty when they visited and they had recently noticed that a bin in the bathroom had not been emptied over the weekend. Staff we spoke with told us that they had recently run out of toilet roll and had had to use paper tissues instead. We were told that more toilet rolls had been ordered and were due to be delivered that day.

There was an up-to-date infection control policy in place at the time of our inspection and a nominated infection control champion. They told us that they monitored hand hygiene and carried out checks. We saw that staff were required to complete annual training on infection control. An infection control audit had been completed in September 2015 and a housekeeping audit in October 2015.

Staff we spoke with told us that there were sufficient domestic hours. We saw that there were cleaning schedules to instruct staff as to what required cleaning and when. We were told that bed linen was changed daily or weekly as required and that mattress audits were completed each month to check that these were clean. We spoke with a member of the domestic staff, they said “We clean all areas of the home; we have plenty of cleaning products.” They gave examples of the chemicals and different cloths used for different tasks then disposed of. This practice helped to eliminate the risks from the spread of infection.

We asked about deep cleaning of rooms. We were told that these were done if someone was sick or had a spillage; however we were told that curtains were not on a deep cleaning schedule. We discussed how this may be beneficial with staff.

Requires improvement

Is the service effective?

Our findings

People using the service told us "The staff know what they are doing" and a visiting healthcare professional said "Staff here are fab, they are usually quite well informed."

New staff completed two weeks of induction training to equip them with the skills and knowledge to carry out their roles effectively. We saw that this included training on moving and handling, health and safety, first aid, food hygiene, dementia awareness, safeguarding vulnerable adults and infection control. We spoke with a new member of staff who told us "The training is very in depth" and explained that it included practical lessons on safe moving and handling techniques. Following induction training, new staff had to complete a minimum of three shadow shifts with more experienced members of staff and fill in an induction booklet during their first six months detailing how they would manage certain situations. For example, one worker said they had to write down how they would defuse a difficult situation. This section would then be signed off when they had been observed putting this into practice.

In addition to the induction training, staff we spoke with told us they had to complete refresher training to update their knowledge and skills. We reviewed the training matrix used to record the training completed by each member of staff and when this needed to be updated. We saw that staff completed regular training throughout the year and the registered manager monitored this to identify when further training was needed. This ensured that new staff were supported to gain the skills, experience and confidence to carry out their roles effectively and maintain and update their knowledge when needed.

The registered provider had a supervision policy in place. The registered manager told us that staff had supervision meetings every three months and annual appraisals with their line manager. We looked at supervision and appraisal records and saw that staff were receiving regular supervision and also received an annual appraisal. Staff we spoke with told us they felt supported in their role and that advice and guidance was available where needed. One person said "I've never felt alone and always felt supported."

We observed the morning handover meeting between the manager of the night shift and staff starting the day shift. We saw that each person using the service was discussed, an update given of any recent changes and important information handed over. Where someone had been unwell during the night, this was handed over to the day shift to monitor and respond to. We saw that staff completed a handover record which documented this information for staff to reference during their shift.

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.

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 any conditions on authorisations to deprive a person of their liberty were being met. We found that DoLS were applied for and that appropriate authorisations were in place.

Staff had received training on the MCA and understood the steps to take if they felt someone was unable to make decisions for themselves. We saw evidence of a best interest decision that had been made to administer medication covertly; records from this showed that the decision was made in consultation with the person's G.P and family.

Care plans contained information about whether a person had a power of attorney (POA) in place. A POA 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. It is important for carers to be aware when a POA is in place, so that decisions are made by the right person. Where a POA was in place, care plans contained information about this person and the scope of their authority. 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 POA.

Requires improvement

Is the service effective?

We could see that the service sought to obtain consent to provide care and support, consent to have photographs taken, consent for relatives to access people's care file and consent for staff to administer medication. However, we noted that people's carers or representative had sometimes signed the care plans and it was not always 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 recommend that the service seeks advice and guidance from a reputable source about consent to care and treatment.

People using the service spoke positively about the food served at Ebor Court. Comments included "I enjoy the food. I get double helpings", "The food is quite good" and "The food is very nice, excellent in fact."

The registered provider employed two cooks and two kitchen assistants. Meals were prepared in a kitchen on the ground floor and delivered in a 'hot trolley' to each unit at mealtimes.

We spoke with one of the cooks who told us people could have a cooked breakfast, cereals or toast for breakfast, they prepared a choice of two hot main meals at lunchtime and a variety of cold options and one hot option at tea time. The cook explained that they had a four week seasonal menu which changed four times a year. We saw that meal options were discussed at residents meetings to help plan future menus. The cook we spoke with was knowledgeable about people's special dietary requirements and allergies and described in detail how they pureed food for certain people using the service and fortified other meals to boost people's calorific intake.

The cook told us that staff asked the day before what people would like to eat, although alternative options were available if people changed their mind. We saw that an electronic menu was displayed on a screen in the main entrance of the home; however, there were no menu's available on each floor and no accessible menus, including large print or pictorial menus, for people with communication difficulties. One person using the service told us "I can't say that we know what we're going to get, we find out on the day." We observed lunch on two of the floors and saw that options were available and people were generally given choice and control over what they ate. People told us "We get a choice. I would send it back if I didn't like it."

We found that monitoring to ensure people ate and drank enough was not effective. We saw that the service had introduced food and fluid charts to monitor people's nutritional intake, however, these did not record in sufficient detail what people ate or how much, with a typical record documenting "1" main meal or "3/4" pudding. This made it difficult to effectively monitor how much that person had eaten that day. We observed that snacks were available on each floor. These included biscuits, crisps and fruit. People could help themselves to these. However, we noted that food charts often did not evidence that people whose nutritional status was at risk, had been offered or encouraged to eat or have snacks outside of mealtimes.

We found that monitoring of people's fluid intake was also not effective. Records typically recorded that a person had "1" drink or "Juice". Fluid charts did not record how much fluid that person had drunk and there was no daily totals to monitor exactly how much that person had drunk over the course of the day. Without this in place there was a risk that people could become dehydrated as staff were not effectively monitoring fluid intake. We also found examples where food and fluid charts had not been completed that day meaning that staff had not monitored people's food and fluid intake as was recorded necessary in their care plan.

For two people using the service it had been identified that weights needed to be completed weekly to more closely monitor weight loss or weight gain. We noted that 18 days had passed since these people had last been weighed. This was a significant cause for concern given that one person using the service had a recent history of significant weight loss.

This was a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans contained information and contact details for healthcare professionals involved in their care and support. Records showed that people were visited by, or supported to visit, healthcare professionals including G.P's, district nurses, dieticians, opticians and dentists. We

Requires improvement

Is the service effective?

saw examples where people had been seen by healthcare professionals and a summary of the visit was recorded in their care plan, including information about the outcome and any follow-up actions required.

We saw that people were able to see their GP when unwell as a weekly GP surgery was held at the home. We observed that people who may benefit from a GP consultation were discussed at morning handover and names added to a list for the GP to see. A visiting healthcare professional told us “The staff are generally good at identifying patients whom they feel should be seen."

Good

Is the service caring?

Our findings

We asked people using the service if they thought staff were caring. Comments we received included "The staff are really caring and assist me when I need help", "Everyone is very kind" and "I would recommend it here, we are well looked after." Other people told us "Some of the staff are very good" and "I like this home, I feel comfortable here. The care is good, not excellent. Some shortcomings." However, feedback was not consistently positive and three people we spoke raised concerns about some members of staff or regarding specific incidents, commenting "Staff can be a bit sharp…some staff can be rude and a bit abrupt."

During our inspection, we observed a number of positive and caring interactions between staff and people using the service. We saw examples of staff speaking to people in a thoughtful, kind and respectful manner and staff appeared calm, unrushed and relaxed when providing care and support to people using the service. We observed that staff engaged with people using the service whilst providing support and that support provided was not restrictive and took into account people's wishes and preferences.

We asked staff if the people they worked with cared for people using the service, one person told us "Other staff care, you can see the emotion in staff when we lose a resident, everyone shows empathy and concern." A relative of someone using the service told us "All the staff are very nice and approachable. I feel they care; they hold their hands when walking and are attentive during meals. They are quite fun and jolly, friendly and approachable." A visiting healthcare professional we spoke with said "The staff are very supportive and caring." This largely positive feedback showed that the service was caring and that staff cared for the people they were supporting.

We saw that people using the service were supported to have choice and control over their daily routines. For example, we observed staff asking people's permission when providing assistance or offering options or choices about where to go and what to do. One person said "The care is good. I choose when to get up and go to bed. I can have a bath anytime." Another person told us "I can make choices about how I spend my time. When I get up, when I have a shower." Other comments included "I have lots of freedom here" and "You can ask for anything you want." We saw that people were free to move around the separate units, that people had personal space and privacy in their own room or could make use of numerous communal areas or alternative quiet areas to sit alone or to meet visitors in private.

We were told that people were treated with dignity and respect. A person using the service said "I am treated with dignity. All the staff are very polite and helpful." Staff we spoke with understood the importance of maintaining people's privacy and dignity. One member of staff told us "We make sure the doors are closed and the curtains closed when providing personal care. We put a towel across them to keep people covered up. We knock before going into a room and ask if it is ok to do things." We observed that care and support provided in communal areas was appropriate and maintained people's dignity. We saw that staff knocked before entering people's rooms if their door was shut. This showed us that staff supported people to maintain their privacy and dignity.

Requires improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved to Ebor Court and care plans put in place to guide staff on how best to meet those needs. We saw pre-admission assessments collected basic information about the care and support people required and this was updated once people moved in and as staff got to know them. Care plans contained information from the person, their family and other health and social care professionals. We saw evidence that care plans were reviewed, however, people using the service and relatives told us that they had not always been involved in these. One relative told us "The care plan has been discussed with the family…We have a tea gathering for relatives where we can raise any issues" another person told us "There's been no review meetings, we looked at the care plans when they moved in, but there's been nothing in between."

Care plans were written in a person centred way and contained information about what people could do for themselves and what support was needed from staff. Alongside this, care plans contained person centred information about people's likes, dislikes and personal preferences. We found that this information was basic in places and provided limited detail. For example, we saw that one person's care plan around nutrition documented that they "Prefer not to eat meat everyday", but provided no further information about favourite foods or foods they disliked.

We saw that care plans also contained a 'Life History' which gave a succinct summary of that person including information about their family history, details about their careers and other significant life events. One person we spoke with very quickly talked to us about their life history, which was clearly important to them. When we subsequently spoke with two members of staff they appeared surprised by the information we had learnt. A visiting health and social care professional told us that "Staff are usually quite well informed", but noted on a recent occasion they had spoken to two members of staff who did not know much about the person they were supporting. This showed us that whilst there were systems in place to gather and record information about people using the service, this was not always effective and staff did not always have relevant and up-to-date knowledge about the people they were supporting.

One member of staff we spoke with said they had been encouraged to look at the care plans during their shadow shifts as part of their induction. They commented "I read the care plans and try to get to know them better, it gives me something to talk to them about as well as the basic info there's a life story."

Where people had specific health needs, information had been added to care plans to help staff better understand these needs. For example, where one person had a history of dizziness, information had been printed from NHS choices explaining possible causes of dizziness, signs and symptoms and advice and guidance on how best to respond to someone with this condition. However, we noted that one care plan identified a person had hypothyroidism, but information about hyperthyroidism had been added to the care file. We addressed this with the registered manager who told us they would rectify this mistake.

We saw that each unit had a "Floor Management Record", this contained daily handover records as well as records of recent accidents and injuries. Staff maintained a daily record of the care and support provided to each person using the service and had put in place additional 'short-term care plans' where needs had changed or additional support was needed, for example, where somebody was temporarily unwell. These records were used to share information to ensure that staff were providing support based on up to date information about people's changing needs.

We observed that staff were generally attentive and responsive to people's needs during our inspection. However, a relative told us "Sometimes [Name] ends up wearing the same clothes for four or five days, staff do not always notice. They always put it right when I raise it though." This was not good person centred care. During lunchtime we observed staff serving a person using the service a plate of puréed meal. This food was given to the person using the service without an adequate explanation of what they had been served. We noted that this person was struggling to understand what was being said because of a hearing impairment and observed that staff failed to take this this person's communication needs into account when providing their support and this led to a degree of

Is the service responsive?

frustration for the person using the service. This was not person centred care. One person we spoke with said "You have to ask for everything here at least twice…If they don't want us here why don't they just say."

On the day or our inspection lunch was served early as the local GP surgery was holding a weekly clinic in the afternoon. We observed that people were still eating their breakfast at 11:20 and when lunch was served shortly afterwards at 12:00, some people did not eat this or had minimal amounts and the food was cleared away uneaten. This did not promote person centred care.

We recommend that the registered provider considers advice and guidance from a reputable source regarding the planning and delivery of person centred care.

The registered manager told us that they did not employ an activities coordinator, but instead paid for people to visit the service and run activities or group sessions. The registered manager told us they also encouraged staff to do activities. We observed that each unit had a notice board and this contained an activities rota of classes and events taking place that week. We saw that there was a weekly tai chi class, art therapy class, dance class, cake baking and decorating class, stretch and exercise class and a monthly reminiscence group. People using the service told us "There are activities if you want to go, there's plenty if you want to do things, we never get bored" and "Socially we can go to classes; I like them, something different." However, one person we spoke with commented "We could do with more activities to stimulate the mind. The classes here are aimed at people living with dementia." Another person said "I get left as I need limited attention. Sometimes I am left to cope on my own. I would love to have a chat with staff, but they are always busy with people who need more help than I do…I think they are short of staff."

We were told that the home had Wi-Fi so that people using the service could access the internet and speak to their family, friends or relatives over the internet.

The registered provider had a complaints policy and there was information about how to make a complaint on display in the entrance hall of the service. People using the service told us they felt able to raise complaints or concerns if needed, with comments including "I could talk to someone if I had any concerns." Another person we spoke with said that they had "No worries or concerns, but I could tell staff."

We reviewed the registered provider's complaints log, which indicated that there had been 13 complaints made about the service in the last 6 months. We saw that in each instance a record of the complaint was recorded, this was investigated and a written response provided to resolve the issue.

We saw that there was a suggestion box in the main entrance for people using the service, staff or visitors to make comments or suggestions and leaflets were left on each floor asking people to review the care home for an external independent website that collated reviews of care homes. We also saw that there was a "suggestion tree" in the main entrance which people could post ideas or comments to.

The service held regular residents meetings and that these were attended by between five and eight people who used the service. We reviewed minutes from residents meetings held in August, September, October and November 2015. We saw that people using the service were asked for feedback and suggestions on the food available and ideas for future menus. We saw that people using the service discussed activities on offer and suggestions for trips out and activities to be held within the home.

Requires improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of registration. There was a registered manager in post on the day of our inspection and, as such, the registered provider was meeting the conditions of registration. The registered manager was supported by two deputy managers, two night care managers and a number of senior care assistants.

People using the service told us "It seems very well run, it's a nice place. If you ask for anything they'd get it if they could" and "I Like it here…it's very nice, they do look after you." We asked staff if they thought the service was well-led, comments included "[The Registered Manager] is brilliant they see us, they come onto the floors to say hello", "It is well run" and "Yes and no, in terms of care to residents yes, in terms of support for staff, I feel sometimes concerns aren't listened to."

We noted that there was a relaxed atmosphere within the service and care and support was provided throughout the day in a calm and unrushed manner. Staff were organised and appeared to know what was expected of them and what needed doing at particular times throughout the day.

The registered manager completed monthly surveys to gain feedback from people using the service and to monitor the quality of the care and support provided. These covered a range of topics including social activities, cleanliness, laundry, privacy and dignity, cleanliness and care. In addition, a staff survey had been sent out with regards to training provided and a visitor's survey. This showed us that the registered manager was committed to gaining feedback about the care and support provided. We saw that results were collated and that suggestions or areas for improvement had been acted upon.

The registered manager also completed a comprehensive and wide ranging list of audits to monitor the quality of care and support provided across all areas of the service. We saw that monthly audits included checks of care plans, accidents and incidents, floor management records, bed rails, finance and of medication administration records. These showed that issues and concerns were identified and remedial action and improvements made. We saw that where concerns had been identified, subsequent checks were completed to ensure that the issue had been resolved. However, this was not consistent and we saw audits that provided little evidence of actions taken or details about how concerns identified would be addressed. For example, we noted that there had been a number of falls within the service. We reviewed the monthly falls audit and saw that whilst this collated details of individual incidents, it did not contain any information about what action had been taken in response.

We concluded that although the registered manager completed numerous quality assurance audits for all areas of the service, this system was at times tokenistic and not always robust enough in identifying concerns and driving improvements in the quality of care and support provided. This meant that issues and concerns we identified during our inspection, including concerns around risk management, the monitoring to ensure that people ate and drank enough and concerns around person centred care had not been identified and addressed.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the registered manager was knowledgeable about changes and developments in legislation and guidance on best practice and that this information was shared with staff through regular staff and senior staff meetings. We saw that staff meetings were held in June, August and November 2015 and minutes from these showed that discussions had taken place about pay incentives, care plan audits, infection control issues as well as discussions about complaints and whistleblowing concerns. We saw minutes for senior staff meetings held in August, September and October 2015. These meetings were used to discuss the importance of daily audits, completing supervisions and medication competency checks as well as addressing other issues with recording. This showed us that the registered manager was using staff and senior staff meetings to share information, address areas of concerns and to drive improvements within the service.

We saw that a monthly newsletter was sent out to relatives and friends of people using the service, providing news and information about upcoming events and activities planned that month.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered manager had not fully assessed the risks to the health and safety of people using the service and had not done all that is reasonably practicable to mitigate any such risks. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The registered manager had not taken sufficient steps to ensure that the nutritional and hydration needs of people using the service had been met. Regulation 14 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered manager did not operate effective systems to monitor the quality of care and support provided. Regulation 17 (2) (a).