

Ringdane Limited

# South Park Care Home

## Inspection report

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Date of inspection visit:  
13 January 2016  
14 January 2016

Date of publication:  
07 March 2016

## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Requires Improvement** ●

Is the service caring?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

This inspection was unannounced and took place on the 13 and 14 January 2016.

The last inspection took place on 13 and 14 August 2015. At that inspection we asked the registered provider to take action to make improvements to Regulation 18: Staffing; Regulation 12: Safe care and treatment; Regulation 14: Meeting nutritional and hydration needs; Regulation 9: Person centred care; Regulation 15: Premises and Equipment; Regulation 17: Good Governance. These actions have now been completed. After the comprehensive inspection on 13 and 14 August 2015 the registered provider wrote to us to say what they would do to meet the legal requirement in relation to the breaches of regulation.

South Park Care Home is a purpose built home registered to provide nursing care for older people. There are two separate units. Ebor unit accommodates up to 44 people with mental health and/or dementia care needs on two floors. Jorvik unit accommodates up to 36 people with general nursing needs. Jorvik unit has three floors, with most of the communal areas on the ground floor. The unit does have an additional communal lounge on the third floor.

The two units have their own staff teams and each has a 'Head of Unit', responsible for the day to day running of the unit. There are lifts on each unit. People living downstairs on Ebor unit have access to a safe garden area. People living upstairs on Ebor unit typically require more personal care and support than those living downstairs. The service is situated in a residential area to the west of York city centre and on a bus route to the city. There are parking facilities on site and local shops and other amenities close by.

At the time of this inspection there were a total of 48 people using the service. On Ebor unit there were 31 people with mental health conditions and/or dementia care needs and Jorvik unit supported 17 people with general nursing needs. At the time of this inspection there was refurbishment work on-going on Jorvik unit so the top floor had been closed and people had moved down into accommodation on the first floor of the unit.

There has not been a registered manager at this service since December 2013. A new manager was appointed in November 2015 and they submitted an application to register with the Care Quality Commission in December 2015. 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.

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and staff had been employed following robust recruitment and selection processes.

Improvements had been made to the number of staff employed in the service. Recruitment was on-going to

ensure enough staff were employed to meet the needs of people who used the service. Sufficient permanent staff had been recruited since our last inspection to ensure the use of agency staff had been reduced to a minimum. Staff did not appear rushed on the two days of our inspection and there was a good atmosphere in the service.

Improvements had been made to the medicine practices in the service. Medicines were administered safely by staff and the arrangements for ordering, storage, administration and recording were robust. However, we did note that the nursing staff continued to be interrupted by other staff and visiting professionals during the medicine rounds.

Improvements were made to the control and prevention of infections systems within the service and we found the service to be clean and hygienic. The registered provider had introduced mattress audits, steam cleaning of furniture, plastic tubing on light cords, purchased new quilts and pillows and new bed linen as some of the activities to address the infection prevention and control concerns from the last inspection.

Improvements had been made to staff training and supervision. The registered provider had an induction and training programme in place and staff were receiving regular supervision. Staff told us they still had problems accessing the on line training courses, but people using the service felt more confident in the staff skills and knowledge and said the reduction in agency staff meant they were receiving better care and support.

Improvements had been made to the dining experience of people living in the service. We saw that appropriate support with eating and drinking was provided to people who used the service and we saw that people received good quality meals and plentiful drinks throughout the day.

Improvements had been made to the way staff communicated with each other and with people and relatives. People felt more included in decisions about their care and we saw that appropriate care and support was being offered to people who used the service. We observed a number of positive interactions between the staff and people they were caring for. We were told by people and relatives that oral hygiene care, pressure care and contact with external health care professionals was much better.

Improvements had been made to the safety of the premises and the overall look and style of the environment. The registered provider had made significant investment in refurbishing and redecorating bathrooms, shower rooms, bedrooms and communal areas throughout the home. The updating of the environment continued at the time of our inspection and people were living in a pleasant and comfortable home.

Improvements had been made to the way that care and treatment of people who used the service was provided. We saw that staff were more attentive and people received appropriate care and support in accordance with their wishes. Calls for assistance were answered in a timely manner and staff were visible on the units and seen attending to people's needs.

Improvements to staff practice had been made to ensure that people were treated with respect and dignity by the staff. There was a formal complaints system in place to manage complaints if or when they were received. There was one complaint being investigated by the registered provider at the time of our inspection.

Improvements to the recording and documentation of care had been made. The registered provider had introduced a new format for the care plans and this was in place at the time of our inspection; although

some of the documentation was still being transferred over. The new paperwork was well organised, detailed and person centred and systems were in place for monthly reviews of the care files. However, some of the staff were uncertain where to find some of the information we asked for although they were eventually able to locate it and show it to us. We noted that staff were able to tell us about people's care needs and demonstrated an improved knowledge of their health care conditions.

Improvements had been made to the quality assurance system including the safety of the service, the risks relating to the health, safety and welfare of people who used the service and the way feedback from people who used the service and staff was obtained. The manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We received positive feedback from people who used the service, visitors, relatives and staff about the changes taking place in the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

Improvements were made to the number of staff employed in the service. Staff had been employed following robust recruitment and selection processes. Recruitment was on-going to ensure enough staff were employed to meet the needs of people who used the service.

Improvements had been made to the medicine practices in the service. Medicines were administered safely by staff and the arrangements for ordering, storage, administration and recording were robust.

Improvements were made to the control and prevention of infections systems within the service and we found the service to be clean and hygienic.

While improvements had been made we have not revised the rating for this key question; to 'Good' as this requires a longer term track record of consistent good practice.

**Requires Improvement** ●

### Is the service effective?

The service is effective.

Improvements had been made to staff training, supervision and in the way staff communicated with each other and with people and relatives. People felt more included in decisions about their care and we saw that appropriate care and support was being offered to people who used the service.

Improvements had been made to the dining experience of people living in the service. We saw that appropriate support with eating and drinking was provided to people who used the service and we saw that people received good quality meals and plentiful drinks throughout the day.

Improvements had been made to the safety of the premises and the overall look and style of the environment. The registered provider had made significant investment in refurbishing and redecorating bathrooms, shower rooms, bedrooms and

**Requires Improvement** ●

communal areas throughout the home.

While improvements had been made we have not revised the rating for this key question; to 'Good' as this requires a longer term track record of consistent good practice.

### **Is the service caring?**

The service is caring.

Improvements had been made to the way that care and treatment for people who used the service was provided. We saw that staff were more attentive and people received appropriate care and support in accordance with their wishes.

Improvements to staff practice had been made to ensure that people were treated with respect and dignity by the staff.

While improvements had been made we have not revised the rating for this key question; to 'Good' as this requires a longer term track record of consistent good practice.

**Requires Improvement** ●

### **Is the service responsive?**

The service was responsive.

Improvements to the recording and documentation of care had been made. The registered provider had introduced a new format for the care plans and the new paperwork was well organised, detailed and person centred and systems were in place for monthly reviews of the care files.

Staff were able to tell us about people's care needs and demonstrated an improved knowledge of their health care conditions.

There was a formal complaints system in place to manage complaints if or when they were received. There was one complaint being investigated by the registered provider at the time of our inspection.

While improvements had been made we have not revised the rating for this key question; to 'Good' as this requires a longer term track record of consistent good practice.

**Requires Improvement** ●

### **Is the service well-led?**

The service is well-led.

**Requires Improvement** ●

Improvements had been made to the quality assurance system including the safety of the service, the risks relating to the health, safety and welfare of people who used the service and the way feedback was obtained.

The manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We received positive feedback from people who used the service, visitors, relatives and staff about the changes taking place in the service.

While improvements had been made we have not revised the rating for this key question; to 'Good' as this requires a longer term track record of consistent good practice.

# South Park Care Home

## Detailed findings

### Background to this inspection

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

This inspection took place on 13 and 14 January 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, three specialist advisors and two experts-by-experience. A specialist advisor is someone who can provide expert advice to ensure that our judgements are informed by up to date and credible professional knowledge and experience. The specialist advisors had knowledge and experience relating to older people, mental health, dementia care and general nursing. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to older people and those living with dementia.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the City of York (CYC) Contracts and Monitoring Department and CYC Safeguarding Team. We asked the registered provider to submit a provider information return (PIR) prior to the inspection and this was returned within the given timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the regional managing director, the regional manager, the manager who has applied to become the registered manager (known as 'the manager' in this report), two unit managers and two quality managers. We also spoke with 19 members of staff and spoke in private with 12 visitors and 10 people who used the service. We spent time in the office looking at records, which included the care records for 10 people who used the service, the recruitment, induction, training and supervision records for six members of staff and records relating to the management of the service. We spent time observing the interaction between people, relatives and staff in the communal areas and during mealtimes. We used the Short Observational Framework for Inspection (SOFI) on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.



# Is the service safe?

## Our findings

At our last inspection in August 2015 we found that there were insufficient staff employed to meet the care and treatment needs of people who used the service. We also found that there were inadequate standards of cleanliness and hygiene, so people were not protected from the risk of acquired infections and there was unsafe medicine management. This was a breach of Regulations 12 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Part 3).

At this inspection on 13 and 14 January 2016 we found that the registered provider had followed the action plan they had written following the August 2015 inspection and sufficient improvement had taken place to demonstrate that the breaches had been met.

We asked people who used the service and their visitors if they felt there were enough staff on duty; the majority of people who spoke with us said "Yes." One person told us, "There is always enough staff to meet my needs, even during the evening and weekends," but another person said "They take their time when answering the call bells." Visitors to the service said, "No, I feel staff are rushing about, occasionally the staff are not visible, but I know they are here but with people" and "No, there are times in the day room when there are no staff around - after lunch mainly."

We spent time observing daily life on both units; we found that staff did not appear rushed on the two days of our inspection and there was a good atmosphere in the service. The past problems of over reliance on agency staff had been addressed by the manager. At the point of our inspection no agency care staff had been needed that week and only a small number of shifts needed to be covered by agency nurses. Where this was the case, the manager told us they were using regular agency nurses who knew the people well.

We spoke to staff during our inspection and they all said the staffing levels were much better. One member of staff said, "There are no agency care staff now and that is a good thing. The standards of care being given are higher and we are responding to people's needs much quicker. The whole atmosphere in the service has changed and staff morale has risen." Another member of staff told us, "It remains very busy, but we are working better as a team."

We looked at the rota sheets for the four weeks leading up to our inspection. These indicated which staff were on duty and in what capacity and the staff we met on the inspection matched those on the rota sheet. The rotas showed us there were sufficient staff on duty during the day and at night, with sufficient skill mix to meet people's assessed needs. The staff team consisted of unit managers, nurses, care staff, ancillary workers, administrator, activity co-ordinators, catering staff and maintenance personnel.

Our observations of the service showed that the cleanliness and hygiene standards had improved. All areas we looked at were tidy, had been vacuumed and dusted and there were no malodours. The toilets and bathrooms we looked at were in a very clean condition and there were adequate hand washing and drying facilities. We noted that a new bath was being fitted which would, according to the unit manager, make bathing safer and nicer for people using the service.

Discussion with the manager and staff indicated that since our last inspection in August 2015 the service had made a number of significant changes to its infection prevention and control practices. We saw that new bed linen and towels had been purchased, along with new washable duvets and pillows. Following a mattress audit carried out by the manager, staff were now cleaning mattresses regularly and recording these in the cleaning schedule folder. The manager had also carried out an infection control audit each month and had completed action plans from the results. We could see that staff were included in these actions through discussion in staff meetings and supervisions, as we were given the minutes to look at.

We looked at the new cleaning schedules introduced since our last inspection and these had been completed and signed by the domestic staff on a daily basis. New domestic staff had been recruited since August 2015 and there were now sufficient staff employed to enable four staff to be on each daily shift. Discussion with the housekeeper indicated that they had carried out face to face meetings with the new staff. Individual training had been given to ensure everyone knew what the expected standards of cleanliness were and what their role and responsibilities entailed.

We found written evidence that staff had dealt with infection prevention and control in a positive way. We saw the case notes of one person who used the service who had developed a contagious infection. This was managed very well within the policies and protocols of the service. The infection was cleared within three days with no subsequent cross infection within the home.

Improvements had been made to the management of medicines in the service. We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. People we spoke with said their medicines were administered on time and were always available when needed.

We spoke with a care quality facilitator employed by the registered provider. They were a qualified pharmacy technician and told us that their role was to offer staff support and training around medicine management. We saw that they had completed training with the staff, carried out an audit of stock management and ordering and followed up any medicine errors with reflective practice for the staff concerned.

We observed the nurses giving out medicines at the lunch time meal. We saw that the nurse took the trolley to people's rooms, secured the trolley outside the rooms and administered the medication in an appropriate manner. The nurse communicated effectively with people, even those who could not say if they were in pain or were in need of support. The nurse told us, "We know the people who use the service. We look at their posture, their facial expressions and the majority of people can use gestures to let us know how they are feeling." Two people said the nurse gave them their medicines and that they were very happy with this arrangement.

During the period when medication was being administered to individual residents who stayed in their room, the nurse wore a tabard stating 'Do not disturb administering medicines'. However, we noted that on two occasions care workers asked the nurse questions and on one occasion the maintenance person interrupted, the nurse informed the care worker and maintenance staff that they would sort the issues out when they had completed the medication round. On another unit the nurse again was wearing their tabard but was interrupted by a visiting GP. These interruptions could potentially cause the nurse to make a medication error, which could put people at risk of harm.

We saw that one person was receiving covert medicine (this is where medicine is put in food or drinks to

disguise the medicine). We looked at this person's care file and found that a best interest meeting had been held to discuss the use of covert medicine and that the meeting had included the GP, family and social worker of the person who used the service. Advice had been sought from the GP and pharmacist about the benefits of crushing tablets or using a liquid form. The care plan clearly documented that the decision to crush the tablets and mix them in yoghurt had been taken because the liquid medicine coloured the yoghurt and the person who used the service then refused to take it.

We asked people if they felt safe, if the staff assisting them had the right skills and if they felt the premises were safe and secure. All the responses we received were positive about the service. Comments included, "All the staff are lovely" and, "I feel safe here." Visitors who spoke with us said, "I come at different times and days and I am really impressed with the staff – I think [Name] is well cared for" and "Yes, [Name] loves it here." Another visitor commented, "I am happy to go home in afternoon and leave [Name] here, knowing they will be safe and well cared for. Staff will always check up if [Name] is feeling fine and will contact me if there is incident."

The registered provider had policies and procedures in place to guide staff in safeguarding of vulnerable adults from abuse (SOVA). We spoke with staff about their understanding of SOVA. Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse. The staff told us that they had completed SOVA training in the last year and this was confirmed by their training records. The training records we saw showed that the majority of the staff were up-to-date with safeguarding training.

Since our last inspection in August 2015, the number of safeguarding alerts sent in by the service had dropped from 26 (April to August 2015) to five (August 2015 to January 2016). The CYC commissioning team had carried out a number of monitoring visits to the service since our last inspection. We received information from them prior to this inspection that indicated they were pleased with the progress being made within the service and that improvements to the safety of people and the premises had been recognised.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond and minimise the risks. This helped to keep people safe, but also ensured they were able to make choices about aspects of their lives.

The manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. For example, we saw one person with a dressing on their head. The staff informed us this was from a recent fall; on reviewing the person's case file, we found that appropriate action had been taken, relevant paperwork had been completed and their family had been informed. It was noted in the case file that the wound was healing well. We were given access to the computerised records for accidents and incidents which showed what action had been taken and any investigations completed by the manager.

We saw that security to the building was maintained by the use of coded locks between the units and to exterior doors. People visiting the service had to ring for admission at the entrance and staff in reception or on the units would let them in once their business was verified. Staff used an electronic clocking in system and visitors signed the fire book, so an accurate record of who was in the building was available in the event of an emergency.

We spoke with the maintenance person and looked at documents relating to the service of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment included alarm systems such as fire safety and nurse call, moving and handling equipment such as hoists and slings, portable electrical items, water and gas systems and the passenger lifts.

Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person for wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights, window restrictors and bed rails. These environmental checks helped to ensure the safety of people who used the service.

One minor area of concern that we had was in relation to the lifts in the building. We saw that these were small in size and awkward to assist people in getting in and out. We saw staff struggling with people in wheelchairs, at the same time as carrying walking frames over their shoulder. We noted that staff were telling people to be careful of their arms as they entered and exited the lifts.

We looked at the recruitment files of six members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

## Is the service effective?

### Our findings

At our last inspection in August 2015 we found that the staff did not receive appropriate support, training, supervision and appraisals to enable them to carry out their duties. We also found that people did not have their nutrition and hydration needs met and were not given appropriate support by staff with eating and drinking. We saw that the people's care and support needs were not met and they had not been consulted or involved in the planning and decision making around their care. We found the premises were unclean, were not secure and were not maintained appropriately. This was a breach of Regulations 9, 14, 15 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Part 3).

At this inspection on 13 and 14 January 2016 we found that the registered provider had followed the action plan they had written following the August 2015 inspection and sufficient improvement had taken place to demonstrate that the breaches had been met.

Improvements had been made to staff training and supervision. The registered provider had an induction and training programme in place and staff were receiving regular supervision. Staff told us they still had problems accessing the online training courses, but people who used the service felt more confident in the staff skills and knowledge and said the reduction in agency staff meant they were receiving better care and support.

We found that much of the staff training and development was delivered online, with occasional courses also being delivered by external trainers on a face to face basis. We were told that the registered provider offered staff support and development through a visiting medication expert and dementia experts who worked with staff to improve skills and knowledge. We were able to meet and talk with some of these experts. We spent time with one of the trainers who told us about the care home assistant practitioner implementation programme (CHAP) which had been developed by the registered provider. It was aimed at senior care staff who wished to take on an extended role; during their training they were mentored and their work programme was checked and signed off by an impartial person. We were told that the training programme was verified by the Royal College of Nursing, but did not see evidence of that during our inspection.

Some of the qualified staff who spoke with us displayed a good knowledge of dementia care, which they said came from previous experience of caring for people with this type of condition. The nurses and care staff said they had received training to meet the needs of the people using the service as they had completed training in dementia care, Mental Capacity Act 2005 (MCA), challenging behaviour and moving/handling.

We were told by the manager that staff had paid time to undertake online training. However, some staff who spoke with us said "There is not time to do this at work and we have not been paid or given time back for doing it at home," whilst others confirmed that they were able to be paid for their training time. Two care staff told us they had applied for training which was appropriate to their role and were being supported to do this by the manager; this included dementia championship training. Another two care staff spoken with

were completing their National Vocational Qualifications (NVQ's) in Care at level two and three.

Nurses were given the opportunity to complete role specific training such as catheterisation and syringe driver courses. We discussed the revalidation course for nurses wishing to retain their registration through on-going training and reflection on their practice. The manager told us that the registered provider was setting up a forum within its services so that the nurses could have the opportunity to speak with their peers and complete the training, development and paperwork necessary to renew their registrations with the Nursing and Midwifery Council.

Evidence in the six staff files we looked at indicated that since our last inspection, all the staff had received at least one supervision session. We were given a copy of the manager's supervision plan which showed they had provided between one and three supervisions to the majority of staff by the end of 2015. Discussion with the staff indicated that they had a supervision session of around 30 minutes every two months with their unit manager and that they would have an annual appraisal. For some staff the appraisal had not yet taken place, but they were confident that with the recent change in management this would be done.

The staff monitored people's health and wellbeing. We were told by people and relatives that oral hygiene care, pressure care and contact with external health care professionals was much better. People were able to talk to health care professionals about their care and treatment. We saw evidence that individuals had input from their GP's, district nurses, chiropodist, opticians and dentists. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). The care files we looked at had photographs of people, with signed consent from either the person or their family/next of kin.

Discussion with the staff showed they had a good understanding about conditions linked to the care of people who used the service, including the risk of choking. We saw an improvement in staff practices from those seen at our last inspection. People were sat up appropriately whilst in bed and supported to eat and drink, pressure care was being delivered appropriately and staff were seen responding to people's requests for assistance in a timely manner.

Relatives told us they had seen recent changes in staff practice. One relative was very positive about some areas of concern that had been raised in our last inspection. They told us, "[Name] needs to stay in bed. Their skin care is very good – [Name] is better in bed and the special mattress helps. Their mouth care is good and the staff look after them well." Another relative was positive about the overall standards of care and said, "The caring aspect is definitely there."

Staff within the service were monitoring and reviewing risks relating to people's mental and physical wellbeing. This meant people were kept safe and they received appropriate interventions as needed from health and social care professionals. For example, behaviour management charts were kept on file where needed. Behaviour management plans and risk assessments had been reviewed and updated in the care files we looked at. We observed that staff demonstrated flexibility in a number of ways including not restricting people on the dementia unit from moving about the unit, but walking with them and chatting as they went along the corridors.

Improvements had been made to the dining experience of people living in the service. We saw that appropriate support with eating and drinking was provided to people who used the service and we saw that people received good quality meals and plentiful drinks throughout the day.

Entries in the care files we looked at indicated that people who were deemed to be at nutritional risk had

been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. We saw that the service was working with the dietetics team in the community to encourage people not to have supplements in their diet, but look at 'fortified' diets to increase their calorific intake. In response the service had introduced high calorie snacks such as milkshakes, smoothies, fresh fruit, full fat yoghurts, cheese and crackers in between meals.

Everyone we spoke with said the food was very good. People and visitors told us, "Seems to be a good variety – the food is mashed for [Name] as they have problems swallowing" and "I have only seen food served twice whilst I was here. [Name's] food is pureed, but they are eating well and the staff always make sure [Name] has a drink." Another person told us, "Very good, good choice."

People who used the service had their food and fluid intakes monitored and reviewed on a regular basis. Lunch was observed in a bright, airy, clean dining room with plenty of space for people who used mobility equipment to move around. People were able to choose their meals from an appropriate choice and the kitchen staff had a list of likes and dislikes of people who were unable to choose for themselves. Special diets were catered for including any related to the person's cultural/religious needs. People we spoke with said they enjoyed the food offered to them.

Staff interaction with people was good and there was regular checking to make sure people drank enough. We noted that people who required help with eating or drinking received support from the staff, both in the dining rooms and in the bedrooms. Progress with eating was at various speeds as might be expected and the service was unhurried. We saw that several people opted for extra food and alternative meals as offered by the staff. We observed several people being fed pureed diets by staff. This was done in a professional and effective manner without rushing the person.

The manager told us that since the last inspection, the views of people and relatives had been sought about the times of meals as it had been noted that some people were losing weight. We saw in meeting minutes that the discussions resulted in moving the main meal of the day from midday to evening time. We were told that this change had resulted in people's weights improving and we were shown the weight charts to prove this. Other introductions to the service were a number of cold drink dispensers located in the dining rooms and entrance hall. This made getting a cold drink much easier for visitors and people living in the service.

Improvements had been made to the safety of the premises and the overall look and style of the environment. The registered provider had made significant investment in refurbishing and redecorating bathrooms, shower rooms, bedrooms and communal areas throughout the home. The updating of the environment continued at the time of our inspection and people were living in a pleasant and comfortable home.

There had been an extensive programme of redecoration and refurbishment including the replacing of furniture, carpets and curtains in the communal areas and bedrooms. The top floor of Jorvik unit was empty at the time of this inspection so it could be totally refurbished. Two shower rooms on the Ebor unit had been turned into wet rooms and two new baths were being installed during our inspection. The bathrooms on Jorvik unit had also been refurbished. Work had taken place to create a large open plan area in the lounge on Ebor unit. This had been redecorated and the manager said they had plans to create a feature wall to capture the attention of people living with dementia.

The new decoration in the service was quite neutral in places, but more consideration of dementia design principles could have been considered such as coloured doors for bedrooms and coloured seats for toilets. The manager showed us the new signage that had been delivered that would help orientate people to



where toilets, bathrooms and bedrooms were located. The manager also spoke about their plans to decorate the corridors as themed areas to create more interest and mental stimulation for people living with dementia. We accept that these changes are relatively new and work is on-going to build on that already completed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 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.

Records showed that 26 people who used the service had a DoLS in place around restricting their freedom of movement. These were kept under review and new applications had been submitted where needed and were awaiting the outcome from the authorised supervisory body. Documentation was completed appropriately by the manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS.

Staff had completed training on MCA awareness during the last year. Staff we spoke with were aware of how the DoLS and MCA legislation applied to people who used the service and how they were used to keep people safe. We saw in care records that the staff had taken appropriate steps to ensure people's capacity was assessed and to record their ability to make complex decisions.

Staff followed the basic principle that people had capacity unless they had been assessed as not having it. In discussions, staff were clear about how they gained consent prior to delivering care and treatment. Staff told us, "People are supported to make their own choices about daily life. We can use picture boards to help people make their decisions", "People are able to do what they want to do here. Such as choose their own clothes, meals, where they wish to sit" and, "I have done MCA training. Most people here can make their own decisions."

Improvements had been made to the way staff communicated with each other and with people and relatives. People felt more included in decisions about their care and we saw that appropriate care and support was being offered to people who used the service. One person told us, "You can do what you want to within reason. Staff do not mind when you get up or go to bed and they are always around if you need help."

Where people had a person acting as their Power of Attorney (POA) this was clearly recorded in their care file. A POA is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare and/or finances).



# Is the service caring?

## Our findings

At our last inspection in August 2015 we found that people were not consistently treated the way they wanted to be treated and that care practices were not always appropriate. We also saw that staff did not treat people with respect and dignity. This was a breach of Regulations 9 and 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Part 3).

At this inspection on 13 and 14 January 2016 we found that the registered provider had followed the action plan they had written following the August 2015 inspection and sufficient improvement had taken place to demonstrate that the breaches had been met.

Improvements had been made to the way that care and treatment of people who used the service was provided. We saw that staff were more attentive and people received appropriate care and support in accordance with their wishes. Calls for assistance were answered in a timely manner and staff were visible on the units and seen attending to people's needs.

We noted that in contrast to the last inspection, the staff were now interacting with people and talking to them while engaging in care and support. We saw that one person on Ebor unit was subject to one to one 24 hour observation carried out by staff in close proximity for the person's safety and that of others. We observed that staff with this person were patient and calm, initiating conversation and engaging the person rather than simply following and observing.

The service had recently introduced a 'My Choices' booklet in people's care files to document people's preferences and likes/dislikes. We looked at a number of these as part of our review of the care files. We found that they were not always completed; although when we spoke with staff they were able to talk to us about people's wishes.

We saw that a number of people remained in their rooms throughout the day, but we witnessed staff checking on these people and assisting to their care needs. We saw that staff approached people in a friendly way and enjoyed a chat with a sense of humour with the people they were supporting at the time. We observed staff interactions in one lounge of Ebor unit and although the interactions we saw were good, we found that staff were focused on a small group of people and others who struggled to interact did not receive the same level of attention. For example, everyone was given a cup of tea and a piece of cake, but we saw that one person was holding up their empty cup and the staff remained oblivious to this; subsequently the person did not get a second cup of tea.

The registered provider had a policy and procedures for promoting equality and diversity within the service. Discussion with the staff indicated that they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in the care files. We saw that a number of people using the service had different faiths. Visitors and people living in the service confirmed that they were able to take part in different services in the home and attend meetings

and services in the community.

We saw that visitors came to the home throughout the day and that they were made welcome by staff. It was apparent that these were regular visitors who had a good relationship with the staff and the manager. They chatted to other people who lived at the home as well as their relative or friend. One visitor told us, "The staff here are approachable, friendly and caring. They know people well and the recent changes have been very good." One relative told us they still had some concerns about the staff at the service. Their concerns were discussed with the manager who went to see and talk to them. We were shown documentation by the manager on the second day of our inspection that indicated the relative's concerns had been looked at and staff practices had been checked and found to be appropriate.

We asked people about their personal care, such as oral hygiene and personal grooming. People who spoke with us said they were satisfied with their care and that they could have a bath or shower whenever they wanted one. Visitors were also positive about their relative's care. One visitor told us "I think they are looked after very well. I have asked the staff to trim [Name's] fingernails and this has been done." Another visitor said, "I have previously complained about oral hygiene, but in the last few weeks [Name's] teeth cleaning has been a lot better and so too is personal care."

Improvements to staff practice had been made to ensure that people were treated with respect and dignity by the staff. People said, "I've got no problem with dignity or privacy, the staff are very good" and "Everything is okay, dignity-wise, all done privately." One person told us, "The staff have a lovely way of not embarrassing you, especially when they are doing your pressure care or more personal care." We observed staff asking people on Ebor unit if it was okay to wash their hands and faces after meals and where clothing was seen to be stained from food or drink the care staff made sure these were changed or cleaned.

We observed how staff promoted people's privacy and dignity during the day by knocking on bedroom doors prior to entering, ensuring toilet and bathroom doors were closed when in use and holding discussions with people in private when required. We saw staff respond straight away when people asked for assistance with personal care or support to get up out of their chairs. Staff told us that treatment from visiting health care professionals took place in people's bedrooms so their privacy and dignity was maintained and any discussions about their care were conducted in private and kept confidential.

We did see that some staff addressed people in a very informal manner. For example, one member of staff called people, "Doll." However, we discussed this with the manager and they showed us examples of people's care files where it was clearly documented that the informal manner of speech and action was acceptable to some people, with one file recording "[Name] responds well to close contact and terms of endearment." We were told by the manager that staff knew who to use this approach to and those who would not like this.

## Is the service responsive?

### Our findings

At our last inspection on 13 and 14 August 2015 we found that care files were untidy, not in good order and information within them was patchy and inconsistent. Staff who spoke with us either could not find the information we asked for in the files or were unaware of people's care needs because they had not read the care files. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Part 3).

At this inspection on 13 and 14 January 2016 we found that the registered provider had followed the action plan they had written following the August 2015 inspection and sufficient improvement had taken place to demonstrate that the breach had been met.

Improvements to the recording and documentation of care had been made. The registered provider had introduced a new format for the care plans and this was in place at the time of our inspection, although some of the documentation was still being transferred over. The new paperwork was well organised, detailed and person centred and systems were in place for monthly reviews of the care files. However, some of the staff were uncertain where to find some of the information we asked for, although they were eventually able to locate it and show it to us. We noted that staff were able to tell us about people's care needs and demonstrated an improved knowledge of their health care conditions.

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. We looked at the care records for people on both units and found that all the notes we reviewed had been recently put into the new format. The unit manager on Jorvik had done a lot of these reviews and the notes we read were relevant, neat and up to date. Individual case files often referenced charts and records elsewhere. On each occasion when we asked for these, staff had to hunt to locate them, as there did not appear to be a clear or consistent system for what was kept where.

We found that daily 'continuity' notes were held separate from the individual case files and were not obviously linked to the care plans. There was a risk with such a system that busy staff would go to these first for an update or handover and may not be aware of the context from the care plan. We noted that the daily records appeared to be descriptive or reactive and did not tend to refer back to care plans. Managers need to ensure that individualised care plans drive daily care and that staff were familiar with them.

We saw that the new care notes included a 'My Choices' booklet. Using the person's voice, it set out the personal preferences of each individual and attempted to give a more personal pen picture. One of the activity coordinators, spoke with us about putting together a life story for each individual and they said would make sense for these two things to be brought together. Differentiating between people and ensuring that each was seen as a unique individual with a person-centred plan of care was crucial to achieving the best possible quality of life for each individual. At the time of our inspection the 'My Choices' booklets were partially completed and did not link directly to the care plans.

Not everyone who used the service was sure if they had seen their care plans or had input to them. However,

we saw that people and families were invited to yearly reviews of their care plans and those who spoke with us were unanimous in the view that things were okay in the service and staff did change their care practices to match circumstances such as deteriorating health or mobility. All the relatives we spoke with said they were involved in partnership with the staff in the care of their loved ones in the service. None were able to say that they were specifically involved in the development of a care plan, but told us that they were always kept informed by the staff and always consulted about what was happening.

There were two activities coordinators working within the service and there was a well-publicised programme of activities on each unit. We spoke with both activity coordinators and they said they worked full time from 09:30 to 17:00 Monday to Friday. We were told that some of their hours could be flexible to enable them to put on evening activities or weekend events as needed. On Jorvik unit we saw that people and relatives enjoyed an afternoon tea in the conservatory with fresh made cream cakes and pots of tea and coffee. This was a very sociable event with people chatting to each other and singing along to music. We were told that people also took part in a chocolate tasting session and trying different teas such as Mango and Strawberry and Ginger, Lemon and Honey, although we did not witness this at the time.

On Ebor unit the activity coordinator showed us the individual activity boxes they were developing for each person. These contained personal objects designed to trigger memories for the person and stimulate interaction. The activity coordinator understood about the different needs of people living with dementia. They told us, "To help me understand the likes and dislikes of people who have limited verbal communication, I look for other clues such as noticing the person's foot tapping to some music – so I know they like that." The activity coordinator said they had tried group activities, but these did not work very well on Ebor unit and said they did mainly one to one work such as nail care, looking at photographs and chats. Some people liked to go out for a walk to the shops and the activity person was hoping to start using the unit minibus to take people on trips out. We saw that a number of people liked to sit and use the touch and feel boxes on the unit. We were also shown the new large piece therapy jigsaws purchased for the unit, which were in use during our inspection.

People were encouraged to maintain their links within the community through their social activities such as meetings with the local church and schools, visitors / family and friends taking them out and about and trips with the staff into the local area. People had daily newspapers delivered to the service and some had on-line access to social media sites and the internet so they could keep up to date with news and views relating to their social and political outlooks.

We received mixed feedback from people and relatives as to their satisfaction with the level of activities in the service. One relative told us, "It needs someone who knows what they are doing. Activities now are nowhere near as good as they used to be. At one time relatives all joined in. For example recently they had an Elvis day and all they did was sit in front of the television watching one of his old movies." However, other relatives said, "There is always something going on" and "[Name] looks forward to seeing different people. They like joining in the activities." One person who spent a lot of time in bed told us, "I like it here, I can enjoy myself."

Both activity coordinators had past experience of caring for people. They had attended 'Personal Activity Leaders' or PALS training in-house and had also completed sessions on Approaching Dementia and Dementia Awareness. Both members of staff were enthusiastic and energetic individuals who were keen to improve the level of activities within the service. However, if person-centred activities were to become a central part of the service's ethos, it was essential that both activity coordinators worked closely with nursing staff, carers and managers to ensure that meaningful and pleasurable occupation was as important an aspect of care as safety and the management of good health.

We found that a copy of the registered provider's complaints policy and procedure was on display in the entrance hall, but this was in very small print which was difficult to read. The manager said the original one that was large clear print had been removed during the redecoration programme and that it would be reinstated as soon as possible. We saw that the registered provider had introduced new touch screen monitors in the entrance hall where staff, visitors and people who used the service could give feedback to the manager. This could be anonymous if wished. We were shown the print out of this information which was monitored as part of the quality assurance system. There was also a suggestion box on the wall in the entrance hall.

At our last inspection we found that the concerns of the people who used the service and the relatives were not always being listened to by the manager and acted on. At this inspection we found that some people felt that there were positive improvements around communication with the management team although not everyone agreed with this. Where we did receive negative comments, these were fed back to the managers at the end of the inspection on both days. We were shown evidence that these issues were being dealt with appropriately. There was one formal complaint being investigated by the registered provider at the time of our inspection.

# Is the service well-led?

## Our findings

At the last inspection on 13 and 14 August 2015 we found that people were not protected against the risks of inappropriate or unsafe care and treatment, because of the ineffective operation of quality assurance systems to identify, assess and manage risks relating to the health, safety and welfare of people who used the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Part 3).

At this inspection on 13 and 14 January 2016 we found that the registered provider had followed the action plan they had written following the August 2015 inspection and sufficient improvement had taken place to demonstrate that the breach had been met.

Improvements had been made to the quality assurance system including the safety of the service, the risks relating to the health, safety and welfare of people who used the service and the way feedback from people who used the service and staff was obtained. The manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We received positive feedback from people who used the service, visitors, relatives and staff about the changes taking place in the service.

At the time of our inspection the service had been without a registered manager since 2013, although there had been interim managers during this period. The manager in post at the time of this inspection had been there since November 2015. They had sent an application to the Care Quality Commission (CQC) to become the registered manager in December 2015. This had been accepted and was being processed at the time of our inspection

We sent the registered provider a provider information return (PIR) that required completion and return to CQC before the inspection. This was completed and returned within the given timescales. The information in the PIR enabled us to contact health and social care professionals prior to the inspection to gain their views about the service.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

There was a manager in post who was supported by two unit managers and an office administrator. Since our last inspection there had been some positive changes in the management of the service which had resulted in a much improved service. The manager monitored the quality of the service by regularly speaking with people to ensure they were happy with the service they received.

The culture and ethos of the service had improved with people feeling more cared for and involved in the service. People we spoke with knew the manager's name and said they had the opportunity to speak with

them each day. One visitor told us, "The last manager really helped to get the home on its feet and the current manager is building on that. It's amazing how it's turned around." Other visitors said, "My confidence in the service is starting to come back", "I have noticed a big change in management [Name's] door is genuinely always open. There is a much better atmosphere. They are a good bunch" and "They kept changing managers. I went to them and never got an answer. But in the last two months things have improved a lot. [Name's] door is always open and you know they will do something about things."

Staff described the manager as "Approachable" and "Straight talking." They said that they felt positive about recent changes, which had been quite significant, but beneficial for both people who used the service and staff. We were told the units were more organised and the staff team better informed. Staff said the changes started with the interim manager and the new permanent manager was maintaining the momentum. Staff said the manager ran regular staff meetings and that staff could talk to them about any issues and they were listened to and that information discussed with the manager was kept confidential whenever possible. Staff had regular supervision meetings and annual appraisals with the manager and these meetings were used to discuss staff's performance and training needs; they had also been used to give positive feedback to staff.

Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires, meetings and one to one sessions. We were given access to the documented meeting minutes and surveys. We could see from these that information was usually analysed by the registered provider and where necessary action was taken to make changes or improvements to the service. People told us they felt they could have a say in how the service was run and there was a positive atmosphere in the service. One person told us "I am really happy here" and another said "No qualms ever about leaving [Name], really pleased about how they are looking after them", adding that the service had improved recently, particularly the decor.

The service had two tablet computers and a new electronic quality assurance process (TRACA). We were given an explanation of how the system worked. Quality audits were undertaken to check that the systems in place at the home were being followed by staff. The manager carried out monthly audits of the systems and practices to assess the quality of the service, which were then used to make improvements. The last recorded audits were completed in December 2015 and January 2016 and covered areas such as reportable incidents, recruitment, complaints, staffing, safeguarding and health and safety. We saw that the audits highlighted any shortfalls in the service, which were then followed up at the next audit. We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed by the manager monthly and again annually. We also saw that internal audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified.