Millcroft & York Lodge Care Homes Limited

York Lodge

Inspection report

3 Myrtle Road
Crowborough
East Sussex
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Tel: 01892661457

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected York Lodge on the 21 April 2017 and the inspection was unannounced. York Lodge is located in Crowborough and provides accommodation and personal care for up to 22 older people. The home provides respite care for people, at the time of our inspection one person was receiving respite care with the plan to move to York Lodge on a full time basis. The home is set out over three floors and a basement. There is lift access between the ground floor and upper levels. At the time of our inspection there were 20 people living at the home. Everybody living at York Lodge was living with dementia and people had mobility and sensory challenges.

There was a registered manager in post. 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.

At the last inspection in March 2016, we identified area of improvement in relation to care plan audits, fire safety, infection control and end of life care plans. Recommendations had been made and at this inspection, we found improvements had been made.

People, staff and relatives spoke highly of the registered manager and their leadership style. However, despite people's praise, we found areas of care which were not consistently well-led. The provider's quality assurance framework had not consistently identified shortfalls and the audit of incidents and accidents was not consistently robust. We have identified this as an area of practice that requires improvement. We have a made a recommendation for improvement in the body of the report.

There were sufficient numbers of skilled, competent and experienced staff to ensure people's safety. People were cared for by staff that had a good understanding of adult safeguarding and who knew what to do if there were concerns over people's safety. People told us that they felt safe. One person told us, "I feel very safe here."

Staff were knowledgeable about people's behaviours which might challenge and areas of care which might pose a risk to people. A range of risk assessments were in place and people's ability to use the call bell was considered. Positive behaviour support plans were in place and staff were knowledgeable about people's behaviour and any potential triggers that may upset them or cause distress.

Positive relationships between people and staff had been developed. There was a friendly, caring and relaxed atmosphere within the home and people were encouraged to maintain relationships with family and friends. People were complimentary about the caring nature of staff. One relative told us, "Everyone is lovely. I am very happy."

People's privacy and dignity was respected and their right to confidentiality was maintained. People were

involved in their care and decisions that related to this. Care plan reviews, as well as residents meetings, enabled people to make their thoughts and suggestions known. People's right to make a complaint was also acknowledged, however, people told us they were happy and had no complaints. One person told us, "I love it here."

People received personalised and individualised care that was tailored to their needs and preferences. Person-centred care plans informed staff of people's preferences, needs and abilities and ensured that each person was treated as an individual. Staff had a good understanding of people's needs and preferences and supported people in accordance with these. People spoke highly of the activities available.

Staff understood their responsibilities with regard to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and acted appropriately to seek consent from people.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. One person told us, "The food is very good, no complaints." Special dietary requirements were met, and people's weight was monitored, with action taken when required. Health care was accessible for people and appointments were made for regular check-ups as needed.

There was a positive, welcoming and friendly atmosphere within the home. People's right to privacy and dignity was respected and staff had built positive relationships with people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

York Lodge was safe.

Staff had a clear understanding about how to protect people from abuse. People received the medicines safely when they needed them.

There were robust recruitment procedures in place and there were sufficient staff to keep people safe and meet their needs.

Risks associated with the environment were mitigated and risks associated with people's care were assessed, monitored and reviewed.

Is the service effective?

Good

York Lodge was effective.

Staff received training and supervision to support them in providing effective care to people.

Staff had a clear understanding of the Mental Capacity Act (MCA) 2005 and there were robust procedures in place to ensure that the service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

People were supported to have enough to eat and drink and to access health care services to maintain their health and wellbeing.

Is the service caring?

Good

York Lodge was caring.

People were supported by staff that were kind, caring and compassionate. Positive relationships had been developed.

People were involved in decisions that affected their lives and care and support needs.

People were supported in a stable and caring environment. The staff promoted an atmosphere which was kind and friendly.

Is the service responsive?

Good

York Lodge was responsive.

Care was personalised and tailored to people's individual needs and preferences.

People had access to a wide range of activities to meet their individual needs and interests.

People and their relatives were made aware of their right to complain. The registered manager encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Requires Improvement

York Lodge was not consistently well-led.

Quality monitoring systems and procedures did not always establish best practice or identify all areas for improvement.

Staff, people and relatives spoke positively of the registered manager's management approach and availability. People were able to comment on the service provided to influence service delivery.

Links with the local community had been established.

York Lodge

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 home, and to provide a rating for the home under the Care Act 2014.

The inspection took place on the 21 April 2017 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we checked the information that we held about the home and the provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR), this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make.

During our inspection we spoke with seven people, two relatives, registered manager, five care staff and the area manager. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at seven care plans and associated risk assessments, three staff files, medication administration record (MAR) sheets, incidents and accidents, policies and procedures other records relating to the management of the service. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's received and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We last inspected York Lodge on the 22 March 2016 where the service was rated as 'Requires Improvement.'

Good

Is the service safe?

Our findings

People told us they felt safe living at York Lodge. One person told us, "I like it here, it makes me feel safe and the staff are very nice." Another person told us, "Of-course I am safe here." Visiting relatives also confirmed they felt confident leaving their loved ones in the care of York Lodge. One relative told us, "I have no hesitations in leaving them here. I know they have previously had a bad report, but the care has always been good."

At the last inspection in March 2016 we identified areas of improvement in relation to fire safety and infection control. Recommendations were made and at this inspection, we found improvements had been made.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. All ground floor fire exit doors were now fitted with an alarm system that alerted staff in the event of a fire door being opened. This minimised the risk of people opening a fire door and staff not being alerted. Regular checks in relation to fire safety had been undertaken and people's ability to evacuate the building in the event of a fire had been considered as each person had an individual personal evacuation plan. Fire evacuation drills took place on a regular basis which considered how long it took for staff to fully evacuate the building, any problems and how improvements could be made.

Staff followed best practice guidelines with regards to infection control. Personal protective equipment (PPE) was readily available and the home presented as clean and tidy. The provider employed two full time housekeepers who followed a robust cleaning schedule. A dedicated laundry assistant was in post who spoke about the procedures for the management of laundry. They told us, "Laundry is washed at sixty degrees." This reduced the risk of laundry posing as an infection control risk. Soiled laundry was now transferred to the laundry room via an external exit instead of staff carrying soiled laundry through the kitchen.

York Lodge provided care for people who had memory loss or dementia. To keep people safe and minimise risk, risk assessments had been completed for environmental and individual risks. Risk assessments covered areas such as eating and drinking, toileting, leaving the premises unsupervised, sleep and rest and emotional wellbeing. Care and support was also provided to a number of people at risk of falls. Guidance produced by the National Institute for Health and Care Excellence (NICE) advises that falls and falls related injuries are a common and serious problem for older people. They can be a major cause of disability. The registered manager told us, "Following some falls, we have now introduced a new falls risk assessment and protocol. Any head injuries, staff are to call 999 and any minor injuries following a fall, staff are to contact 111 or the person's GP. We have also purchased a mangar airflow (inflatable device) to help support people get up following a fall." Falls risk assessments were in place which considered factors such as mental state, eye sight, hearing and continence. People's risk of falls was then assessed as either low, medium or high and a subsequent action plan was implemented. For example, one person was assessed as at low risk of falls and their action plan identified that if they were agitated that could increase their risk of falls and required staff to monitor them during times of agitation.

Staff were knowledgeable about the people they supported and specifically how to support people with behaviour which might challenge. One staff member told us, "People can experience agitation, distress and other behaviours, but we manage those through knowing people's triggers and using distraction techniques." Staff told us how some people living in the home could believe they were married or in a relationship and how that could cause distress and behaviours which challenged. During the inspection, we observed staff de-escalate a situation between a man and a woman by using humour and sensitively separating them by engaging them with other activities. People had individual positive support behaviour care plans in place which considered a description of the behaviour which could challenge, the triggers, early behaviour indicators and strategies to manage the behaviour. For example, one person's positive behaviour support plan identified they could become agitated, shout or lash out. Triggers for these behaviours were noted as confusion about the environment and wanting to get outside. Strategies to manage these behaviours included, 'distract (person) with activities they enjoy, cup of tea and a chat.'

There were sufficient numbers of staff to ensure that people were safe and well cared for. Staffing levels were based on people's assessed needs. The area manager and registered manager told us how they had used dependency tools previously, but found they did not work for them. The registered manager told us, "We base staffing levels on people's needs and are continually reviewing staffing levels. Staff levels consist of one senior care worker, three care workers, one kitchen assistant, three housekeepers and one maintenance worker." During the night shift, the provider employed two waking night staff members. A risk assessment was in place to demonstrate that two staff members at night was sufficient and would allow for a full evacuation at night if required. People, staff and visiting relatives confirmed staffing numbers were sufficient. One relative told us, "There are always staff buzzing around. I have no concerns about staffing levels." One person told us, "If I press my call bell, they always come and see me very quickly." Observations demonstrated that staffing levels were sufficient and staff were continually visible in the lounge area to provide interaction and stimulation for people.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. We identified in a couple of staff files, gaps in employment history and documentation failed to evidence whether these gaps were followed up. We brought these concerns to the attention of the registered manager who noted our concerns and agreed to take action. Despite these concerns, we found this had no impact on the care that people received. Staff's suitability had been checked with the Disclosure and Barring Service (DBS) and no concerns were identified. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with adults at risk.

Suitable arrangements were in place for safeguarding adults who used the service from the risk of potential abuse. Policies and procedures for safeguarding adults from harm were in place. These provided staff with guidance on identifying and responding to signs and allegations of abuse. Staff we spoke with told us they had received training in safeguarding. They were able to tell us the potential signs of abuse, what they would do if they suspected abuse and who they would report it to. Training records showed that staff had received training in safeguarding. Staff we spoke with told us they were confident they would be listened to and that the registered manager would deal with any issues they raised. One staff member told us, "If I noticed any unexplained bruising, that could be a sign of abuse, so I would report my concerns to the manager."

There were systems in place to ensure the safe administration of medicines with organisational medicine policies and procedures in place for staff to follow. We observed medicines being given to people and saw that staff followed correct procedures to ensure this was done safely. People were offered 'as required' or PRN medicines if prescribed. Information was then completed on Medicine Administration Records (MAR)

charts to identify why they had been given, the dosage and time. This meant that people received their medicines in a safe and consistent manner.

Medicines were administered by trained care staff. MAR charts were clear and accurate and reflected that medicines were administered in accordance with individual prescriptions. They contained individual information and photographs to support safe administration including PRN protocols and information about allergies. Staff who administered medicines were regularly observed by senior staff and competency checks completed to ensure correct procedures were followed and maintained.

Good

Is the service effective?

Our findings

People spoke positively about life in the home, the food served and the skills and abilities of the staff. One person told us, "The food is very good." Another person told us, "The staff are very good, they definitely know what they are doing." A visiting relative told us, "The staff really try their best here."

Staff worked in partnership with external health care professionals to promote good outcomes for people. Relatives also confirmed that they felt confident in staff's abilities to meet their loved one's care, support and health needs. One relative told us, "I have no concerns that staff cannot meet (person's) needs." People had regular input from their GP, district nursing team, chiropodist and other healthcare professionals. Staff told us how they worked in partnership with the mental health team and GP to reduce the amount of anti-psychotic medicines people were prescribed. The registered manager told us, "One person had become incredibly immobile, aggressive and incontinent. Through liaising with their GP and reviewing their medicines, they were no longer prescribed anti-psychotic medication and they are now mobile, continent and enjoying going on trips out."

Guidance produced by Alzheimer's society advised that 'eating and having a good meal is part of our everyday life and important to everybody, not least to people living with dementia.' People had individual nutritional care plans in place and people's risk of malnutrition had been assessed and guidance in place to mitigate those risks. For example, one person's nutritional care plan identified that their dementia could impact on their ability to recognise food and drink and they may mix their main meal with their juice. Actions for staff to follow included providing assistance at meal times whilst encouraging independence. Where people had lost weight, staff worked in partnership with the dietician and speech and language therapists. A fortified diet was provided to promote nutritional intake and where required staff monitored and recorded people's fluid and nutritional intake. The provider employed a local company to deliver the main meal at lunchtime, but people were still provided with a wide range of options. A four week rolling menu was in place and people were actively involved in the design of the menu and choosing the options which could be delivered. The daily menu was on display and a pictorial menu was also available to enable people to make their own choices of what they wished to eat. With permission, we joined people at lunchtime. Tables were neatly laid and decorated and people were asked where they would like to sit. Music was softly playing in the background and people were given options of what they would like to drink. Adapted cutlery and plate guards were provided to promote people's independence and where required, staff provided assistance. People and their relatives were complimentary about the food provided. One person told us, "I really like the food. Sausage and mash is my favourite."

Promotion of hydration in older people can assist in the management of diabetes and help prevent pressure ulcers, constipation, incontinence, falls, poor oral health, skin conditions and many other illnesses. Throughout the inspection, we observed that people had drinks to hand and food and fluid charts were in place where required to monitor people's hydration and nutritional intake throughout the day. At the end of each day, people's actual fluid intake was recorded and this allowed staff and the registered manager to monitor for any signs of dehydration.

Staff told us they were well supported and had received the training their needed to be effective in their role. For new staff an induction programme was in place which was based on the Care Certificate to ensure new starters received the appropriate training, support and guidance to enable them to provide safe and effective care to meet people's needs. Staff spoke highly of the induction and one staff member told us, "I really enjoyed the induction as I got to shadow other care workers and observe how they did things." There was a full and intensive programme of training which included essential training for staff. Training included, moving and handling, first aid, infection control and safeguarding. A programme of training had recently been delivered by the Dementia In Reach Team and staff spoke highly of the training programme. The registered manager told us, "The training programme was really good. It was a 16 week training course and covered areas such as dementia awareness and communication. We definitely learnt a lot from it."

Mechanisms were in place to support staff to develop their skills and improve the way they cared for people. Staff received regular supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff told us they felt supported within their roles and felt able to approach the registered manager with any queries, concerns or questions.

Guidance produced by the Social Care Institute for Excellence advises that simple changes to create a more dementia friendly care home environment can have a positive impact on a person living with dementia's emotional well-being and independence. The environment at York Lodge had been designed to meet the needs of people living with dementia. Signage was available throughout the home to help orientate people. Toilets were clearly visible and people's bedroom doors had their individual names on them. Throughout the inspection, people were seen navigating the home, making their way to their bedrooms or the toilet independently.

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. Training records confirmed that most staff had received training and staff spoke confidently about how they worked within the principles of the MCA 2005. One staff member told us, "We assume capacity and provide the person with information. We then consider their recall, judgement and ability to make an informed decision." Staff were clear regarding the need to ensure people were involved in day to day decisions and that consent was sought before any care or support was provided. Decision specific mental capacity assessments had been completed regarding people's ability to consent to living at York Lodge and where people lacked capacity appropriate applications had been made to the local authority to deprive people of their liberty.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The registered manager also kept hard copies of any lasting power of attorney held by relatives to demonstrate that relatives had the appropriate authority to act on behalf of their loved one if they lacked capacity for a specific decision.

Good

Is the service caring?

Our findings

The service had a relaxed atmosphere and people responded well to staff because they approached them in a kind and dignified way. People were consistently well cared for, supported and listened to and this had a positive effect on people's individual wellbeing. People and relatives spoke highly of the caring nature of staff. One person told us, "The staff are ever so caring." Another person told us, "The staff are always nice to me."

At the last inspection in March 2016 we identified areas of improvement in relation to end of life care plans. Recommendations were made and at this inspection, we found improvements had been made.

Guidance produced by the Department of Health advises that for many, 'a good death would involve being treated as an individual, with dignity and respect, without pain and other symptoms, in familiar surroundings and in the company of close family and friends. Too often, however, people with dementia receive undignified treatment and are ending their lives in pain.' End of life care plans were now in place which considered and explored people's wishes. The registered manager acknowledged that some were more detailed than others and this was due to families often finding the subject hard to discuss, but this was an area of practice they were focusing on.

Staff had a good understanding of people's needs. It was clear that staff always endeavoured to ensure people felt happy and were comfortable. For example, a number of people who were seated in the lounge had cushions under them to ensure that their pressure areas were supported. When people decided to move to another area, staff ensured that the cushions were repositioned and checked they were comfortable and had everything they needed. People and staff had developed positive relationships and it was apparent that staff knew people's needs and preferences well. Staff told us that they took time to get to know each person by talking with them and their families and that this enabled them to get to know each person and form relationships with them. Observations confirmed this. One staff member told us, "One person used to work in care homes, so we try and engage them with tasks such as folding laundry or light cleaning which they enjoy."

Friendships between people had blossomed while living at York Lodge. People were seen sitting interacting together and laughter was heard throughout the inspection. Two people were seen sitting together holding hands and staff told us how they had formed a strong friendship since both moving into the home. Throughout the inspection, we observed people chatting and laughing together. Visiting relatives knew the names of other residents and when spending time with their loved one in the lounge, also spent time engaging with other residents.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. During the inspection, we observed that when visitors arrived, they were welcomed by staff and immediately offered a hot drink. One relative told us, "They always make me feel welcome and always keep me updated on how (person) is doing."

People told us staff treated them with respect and dignity and this was the practice we observed throughout the inspection. York Lodge was homely and very welcoming. People were free to walk about as they wished and when they wished. One relative told us, "We love it here, she's very well looked after and it feels like home." The home was furnished with pictures, ornaments and soft furnishings which people told us gave it a homely feel. People were actively involved in decisions about their care and were offered choices in all aspects of their daily life. Staff recognised the importance of empowering people to make day to day decisions and we observed this in practice. For example, staff offered people choices on what they wanted to do, where they wanted to sit, what they wanted to drink, what they wanted to watch or what music they would like to listen to.

Guidance produced by the Social Care Institute for Excellence (SCIE) advises on the importance of choice and control for older people within care homes and empowering people to retain their identity. Staff recognised the importance of supporting people to dress in accordance with their lifestyle preference and promote their identity. One staff member commented to a person, 'I like your earrings.' Another staff member commented, 'I like your hair today.' People's differences were acknowledged and respected. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them.

People confirmed that they felt that staff respected their privacy and dignity. One person told us, "They are very good, they always knock before coming into my bedroom." Staff members understood the importance of upholding people's privacy and dignity. One staff member told us, "We protect people's dignity by ensuring they are covered up when providing personal care and always knocking on people's doors and gaining consent to enter." Support with continence care was provided in a discreet and dignified manner. Staff members offered assistance discreetly yet regularly to prevent any accidents. One staff member told us, "We get to know people's toileting habits, so that can really work in helping to reduce the risk of accidents."

People's equality and diversity needs were respected and staff were aware of what was important to people. Systems were in place to meet people's religious needs. The registered manager told us that church services took place on a regular basis at the home alongside Holy Communion. On the day of the inspection, no one attended Church on a Sunday, but the registered manager confirmed this could be arranged if people so wished.

Good

Is the service responsive?

Our findings

People received the care and support they needed and chose. We saw care was personalised to people's individual preferences. People were able to choose how to spend their day; some spent time in their room, others in the lounge or took part in activities. People who were able moved freely around the home and others were supported by staff to do so. There were a range of activities taking place at the home and people were able to join in if they wished. Visitors told us they were regularly updated about their relative's health and care needs. One person told us, "I am unbelievably happy." A visiting relative told us, "Any concerns they inform me immediately."

Pre-assessments took place before people moved into the home to ensure their needs and choices could be met. People, and where appropriate their representatives, were involved in developing their care plans and these were regularly reviewed. One relative told us, "Oh yes, I was involved in the care plan from the beginning." Care plans covered a range of areas including; health, medication, dietary needs, oral hygiene and personal care. Care plans considered what the person was able to do themselves and where they required support from staff. For example, one person's personal care plan noted, 'I am able to wash myself, however, I need supervision as well as I may miss some parts. I prefer to have a shower once a week as I need assistance to wash my back.'

Care records showed that people's needs were assessed and regularly reviewed and care plans were amended when people's needs changed. For example, staff noticed that one person was having problems swallowing their medicines. Carefully monitoring was introduced and the individual's GP was contacted. It was identified that due to the person's advancing dementia, they were struggling to swallow. Subsequently their medication was changed to dispersible and solution form. This demonstrated that staff adopted a flexible and responsive approach to ensure that people received person centred care.

Personalised care planning is at the heart of health and social care. It refers to an approach aimed at enabling people to plan and formulate their own care plans and to get the services that they need. Personalised care plans consider the person's past, their life story, their wishes, goals, aspirations and what's important for them when receiving care. People's individual life histories were recorded in care plans and care plans contained information on the person's family and friends, how they preferred to be called and also included a section titled, 'This is me.' Information was also available on what makes them feel better when they get anxious or upset. For example, one person's care plan noted, 'I need a lot of reassurance as where I am and what I am doing as I can forget why I am at York Lodge.'

The Alzheimer's Society state that spending time participating in meaningful activities can continue to be enjoyable and stimulating for people and taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. A wide range of activities were available for people to participate in and considerable thought and energy created an environment that provided stimulation and interaction. People, relatives and staff spoke highly about the activities provided and opportunities for social engagement. One relative told us, "There is always something going on and they are very good at keeping (person) stimulated.' Activities included arts and crafts, bingo, target games, skittles

and many others. The registered manager told us, "We are recruiting for an activity coordinator to strengthen activities, but currently staff lead on daily activities and do one to one activities with people." On the day of the inspection, we observed staff engage people in a game of target games and skittles. Staff supported people to individually participate and throw the ball to hit the target. Where people didn't wish to participate, staff enabled them to engage with other activities. For example, one person was playing the piano with a staff member, whilst someone else was sitting with their hot drink doing a jigsaw puzzle.

The provider recognised the importance of supporting people to access the local community and had a dedicated mini bus in situ, with trips out twice a week. The registered manager told us, "We are very lucky to have a mini bus and regular trips out." Staff also felt the opportunity of trips out promoted people's well-being. On the day of the inspection, people went out to Bodiam Castle for afternoon tea. Visiting relatives spoke highly of the trips out. One relative told us, "I don't know many care homes that offer trips out twice a week. I think it's a really good idea."

There were activities to ensure that people who were unable or chose not to go to the communal lounge, were not isolated in their rooms. Activities were adapted to meet their needs and activities such as listening to music, knitting, picture books and nail painting took place. Staff told us how they regularly spent one to one time with people doing activities of their choice or just sitting having a chat to reduce the risk of social isolation.

Staff interacted with people as they walked past, they used humour and, where it was appropriate, touch to engage with people. People responded to staff with smiles and chat and staff recognised the importance of supporting people to feel that they mattered. One person proudly showed of their painted nails which staff had supported them to paint. During the afternoon of the inspection, where people had chosen not to go on the trip out, staff supported people to engage with activities of their choice. Two people were painting with the support of staff. One person was supported to watch a television programme of their choice and staff engaged with other people asking what they would like to do.

There was a complaints procedure in place and people and their representatives told us they knew how to access and use this. People also told us they could bring up any concerns and issues at the 'residents meeting'. People and relatives felt they would be listened to and would usually approach the registered manager directly as she was available and approachable.

Requires Improvement

Is the service well-led?

Our findings

People told us they were happy living at York Lodge and felt the home was well managed. People, relatives and staff spoke highly of the registered manager and their leadership style. One person told us, "I know who she is, she is very nice. I like her." A visiting relative spoke highly of the registered manager and commented that they were approachable and friendly. Staff also felt the registered manager operated an open door policy and was supportive.

At the last inspection in March 2016 we identified areas of improvement in relation to care plan audits. Recommendations were made and at this inspection, we found improvements had been made in relation to care plan audits.

Whilst all feedback about the management was very positive, we found the leadership of the service was not effective in all areas. A governance framework was in place and the registered manager had access to range of tools to help them monitor, review and assess the quality of the service. These included; satisfaction surveys, medication audits, care plan audits and health and safety checks. However, the supporting governance framework and audit system was not robust and did not identify that some decision specific mental capacity assessments had not been completed. For example, a form of restrictive practice was used for one person which meant their bedroom door was locked when they were not in their bedroom. The registered manager talked us through the rationale for this and advised that the relatives were agreement and they held lasting power of attorney for health and welfare. However, a mental capacity assessment had not been completed to demonstrate that that individual lacked capacity and this was implemented in their best interest. We found this had no impact on the individual and the provider was open and responsive to our concerns.

A medication audit was completed monthly which considered the oversight of medicines. However, this had failed to identify that stock checks on controlled drugs (CDs) were not taking place on a regular basis and on occasions, CDs had been signed in by only one member of staff. Guidance produced by the National Institute for Health and Care Excellence advises that it is good practice for CDs to be signed in by two members of staff to ensure that the quantity of the CD that is being signed in is correct. We found this had no impact on people's care, as people received their medicines as prescribed and a stock check found that the quantity of CDs recorded matched what was in stock.

Documentation was in place for the recording of incidents and accidents. This included the date, time, person and staff involved and details of the incident/accident. Incidents and accidents were then reviewed by the registered manager to consider the root cause and the actions required to reduce any further incidents and accidents. Incidents and accidents were subject to a formal audit which considered the details of the incident and the action taken. However, the audit failed to consider if people were falling at the same time of day or during a specific time of day or in a specific area. We brought these concerns to the attention of the registered manager who agreed the audit could be improved.

The above examples, demonstrate that the provider's quality assurance framework was not consistently

robust. We have not judged these examples to be a breach of regulation, as these shortfalls had no direct impact on the level of care that people received. However, we have identified this as an area of practice that needs improvement.

We recommend that the provider seeks guidance from a reputable source on a robust quality assurance framework.

People, staff and relatives were actively involved in developing the service. Satisfaction surveys had recently been sent out to staff, healthcare professionals, people and their relatives. The registered manager was awaiting surveys to be returned to then analyse the results and help drive improvement. Staff and resident meetings were held on a regular basis. These provided people and staff with a forum to express ideas, concerns and discuss practice. Minutes from the last staff meeting in March 2017 reflected that training, medication and supervision were discussed. Minutes from the latest resident and relative meeting in February 2017 reflected that activities, care plans and complaints were discussed.

The culture and values of the provider and the home were embedded into every day care practice. One staff member told us, "It's a friendly home with a homely atmosphere." Another staff member told us, "The manager is fantastic; she really cares about staff and residents." A visiting relative told us, "We really like it here. It has a lovely atmosphere and staff are ever so kind."

With pride, staff and the registered manager told us of the improvements they had made since the last inspection. They commented, "We have implemented new care plans and documentation alongside new falls risk assessments and positive behaviour support plans. We have been working on the maintenance and décor of the service and have refurbished the sensory room and implemented a hair dressing area. We have been focusing on making the environment more homely and dementia friendly. There are still areas we wish to improve on, such as more activities and continuing to make the environment dementia friendly." The provider had employed an external care consultant to undertake an audit of the service which contributed to their overarching improvement plan. The audit was undertaken in April 2017 and inspected the service against CQC's five key questions. Actions from the audit identified for care plans to be reviewed to ensure they were up to date. On the day of the inspection, we found the registered manager was working towards this action.

Policies and procedures were in place which provided guidance to staff members on all aspects of the service, such as infection control, data protection and confidentiality. Staff were aware of the procedures and used them for reference. People's records were kept securely. All computerised data was password protected to ensure only authorised staff could access these records.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the York Lodge had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The provider was aware of their legal requirement to display their performance rating. We saw this was on display within the entrance hall of the service. During the inspection, we raised concerns with the area manager and registered manager that their rating was not displayed on their website. They explained that they had no control over the website and were liaising with the provider to take down the website as they were in the process of implementing a new website.

The manager was also aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and

treatment.

The service maintained good links with the local community. Local volunteers visited the service to spend time with people. One volunteer visited the home along with their dog which people enjoyed. Another volunteer visited the home weekly to support with activities.