HICA

Wilton Lodge - Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

At the last inspection of Wilton Lodge – Care Home in October 2016 the service did not meet all of the regulations we assessed under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that inspection the service was rated 'Requires Improvement'. This was because the provider was in breach of regulation 12: Safe care and treatment, on three occasions. This was with regard to safe management of medicines, health care and collaborative working with healthcare professionals. We also found that audits were not as effective as they could be and so we made a recommendation about identifying all shortfalls.

At that inspection we asked the provider to take action to make improvements to the management of medicines, meeting health care needs and working in collaboration with other health and social care professionals. They sent us an action plan saying when the improvements would be made.

This comprehensive inspection of Wilton Lodge – Care Home took place on 13 and 14 November 2017 and was unannounced. We found the overall rating for this service to be 'Good'. The rating is based on an aggregation of the ratings awarded for all 5 key questions. Action had been taken and there were significant improvements in the meeting of regulations since we visited in 2016.

Wilton Lodge is registered to provide personal care and accommodation for up to 48 older people, including those who may be living with dementia related conditions. Communal accommodation is provided in a variety of lounge and dining areas and bedroom accommodation is provided in single rooms, some with en-suite facilities. The home is situated in a residential area on a main road and close to local amenities and bus routes into the centre of the City of Kingston-Upon-Hull. At the time of this inspection the service was being provided to 47 people.

The registered provider was required to have a registered manager in post. On the day of the inspection we found that the registered manager had been in post for the last one and a half years. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 this inspection we found the provider now met the regulation on safe care and treatment with regard to safe management of medicines. Procedures had been tightened up and practice was now much safer. We found that the management of medication was safely carried out. Other risks were also assessed and managed for people individually and on a group basis so that people avoided injury wherever possible.

People were protected from the risk of harm because systems were in place to detect, monitor and report potential or actual safeguarding concerns. Staff were appropriately trained in safeguarding adults from abuse and understood their responsibilities in respect of managing potential and actual safeguarding

concerns.

The premises were safely maintained and there was evidence in the form of maintenance certificates, contracts and records to show this. Accidents and incidents were appropriately managed, risk assessed and mitigated. Equipment was safely used in the service.

Recruitment policies, procedures and practices were carefully followed to ensure staff were 'suitable' to care for and support vulnerable people. Staffing numbers were sufficient to meet people's needs.

People were protected from the risks of infection and disease because good infection control management systems and practices were in place.

At this inspection we found the provider now met the regulation on safe care and treatment with regard to supporting people's health care and working collaboratively with other health and social care professionals. People's medical conditions and health care needs were appropriately met.

Staff encouraged people to make choices and decisions wherever possible in order to exercise control over their lives.

People were cared for and supported by qualified and competent staff who were themselves regularly supervised and received annual appraisals of their personal performance. Staff respected the diversity that people presented and met their individual needs.

People's nutrition and hydration needs were met to support their health and wellbeing.

The premises were suitable for providing care to older people and measures had been taken when developing the service to include features which ensured the environment was 'friendly towards' those people living with dementia.

People's mental capacity was appropriately assessed and their rights were protected. Everyone that worked in the service had knowledge and understanding of their roles and responsibilities in respect of the Mental Capacity Act (MCA) 2005 and they understood the importance of people being supported to make decisions for themselves. The registered manager followed the 'best interests' route where people lacked capacity to make their own decisions.

Consent for all things to take place was respected so that staff always sought people's cooperation and agreement before completing any support tasks.

People received compassionate care from kind staff that knew about people's needs and preferences. People were involved in all aspects of their care and their rights were respected. The management team set good examples to the staff team with regard to attitude and approach, which meant staff had good role models to follow.

People's wellbeing, privacy, dignity and independence were monitored and respected. This ensured people were respected, that they felt satisfied and were enabled to make choices regarding their lives.

We saw that people were supported according to their person-centred care plans, which reflected their needs well and which were regularly reviewed. There were opportunities to engage in some pastimes and activities if people wished. People maintained family connections and support networks and their

communication needs were assessed and met.

We found that there was an effective complaint procedure in place and people's complaints were investigated without bias.

The service sensitively managed people's needs with regard to end of life preferences, wishes and care.

The provider now met the recommendation we had made at the last inspection to ensure quality assurance systems were effective. Audits, satisfaction surveys, meetings, handovers and the provider's own internal quality monitoring tools ensured there was effective monitoring of service delivery.

The registered manager understood their responsibilities with regard to good governance and practiced a management style that was open, inclusive and approachable.

The registered manager strove for continuous learning around best practice, updated their learning and practice at every opportunity and searched for innovative ways to deliver the service. The service fostered good partnerships with other agencies and organisations.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's medication was safely managed. They were protected from the risk of harm because the provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Risks were also managed and reduced so that people avoided injury or harm.

The premises were safely maintained, staffing numbers were sufficient to meet people's need and recruitment practices were safely followed.

Is the service effective?

Good

The service was effective.

People's health care was effectively monitored and supported. Staff worked collaboratively with other health and social care organisations. People were encouraged to make choices.

Qualified and competent staff were employed. They were regularly supervised and received appraisal of their performance.

Diversity among the people was respected and individual needs were met.

People received adequate nutrition and hydration to maintain their levels of health and wellbeing.

The premises were suitable for providing care to older people and the environment was suitable for those living with dementia.

People's mental capacity was appropriately assessed and their rights were protected.

Is the service caring?

Good

The service was caring.

People received compassionate care from kind staff. People's rights were respected and they were involved in all aspects of their care.

The attitude and approach of the management team and staff was friendly, supportive and encouraging.

People's wellbeing, privacy, dignity and independence were monitored and respected.

Is the service responsive?

Good

The service was responsive.

People were supported according to their person-centred care plans, which were regularly reviewed. They had the opportunity to engage in some pastimes and activities to stimulate their minds and provide entertainment.

Communication needs were assessed and met where possible.

People had their complaints investigated without bias.

Staff sensitively managed end of life preferences, requests and care needs.

Is the service well-led?

Good

The service was well led.

There was an effective quality assurance system in place, which led to improvements in service delivery.

People had the benefit of a well-led service, where the culture and the management style of the registered manager were both positive. Governance was understood and was good.

Continuous learning took place in the service and good relationships with other organisations and bodies were fostered to ensure people received the best possible care.

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

The inspection of Wilton Lodge – Care Home took place on 13 and 14 November 2017 and was unannounced. One adult social care inspector carried out the inspection. Information had been gathered before the inspection from notifications sent to the Care Quality Commission (CQC). Notifications are when providers send us information about certain changes, events or incidents that occur. We also received feedback from local authorities that contracted services with Wilton Lodge – Care Home and reviewed information from people who had contacted CQC to make their views known about the service. We had not requested a 'provider information return' (PIR) from the provider since before the last inspection, so there was no recent information to consider. This is a form that asks them to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with two people that used the service and carried out a Short Observation for Inspection (SOFI) on four people. A SOFI is a means of gathering information about people's experiences of care; people who we are unable to verbally communicate with.

We spoke with three relatives and two visiting healthcare professionals, as well as the deputy manager, the registered manager and four other staff that worked at Wilton Lodge – Care Home. We looked at care files for three people that used the service and at recruitment files and training records for five staff. We viewed records and documentation relating to the running of the service, including the quality assurance and monitoring, medication management and premises safety systems. We also looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We looked around the premises and saw communal areas and people's bedrooms, after asking their permission to do so.

Good

Is the service safe?

Our findings

People at Wilton Lodge – Care Home told us they felt safe living there, risks to their safety were reduced, sufficient numbers of staff were on duty to meet their needs, they preferred staff to manage medicines and they thought the premises were clean and comfortable.

People said, "I am treated very well" and "I feel safe, as I have lived here some time now." Relatives we spoke with also confirmed that people were safe. They said, "My relative receives good care from staff who are always smiling. Staff approach is always welcoming and they deal with issues safely. I have no worries about my relative being safe" and "The staff make sure my relative is safe and well looked after. They have had a couple of falls but staff have encouraged them to be more confident and they walk much better now."

At the last inspection in October 2016 we found that the provider was in breach of regulation 12: Safe care and treatment. This was with regard to safe management of medicines and particularly the failure to ensure appropriate time elapsed between medicine doses, medicines to be given 'as and when required' being given when they were not necessary and people missed some medicines due to poor stock controls and incorrect stock records.

At this inspection we found there had been improvements made in the management of medicines. New and previously identified medicine errors that had taken place were analysed and action taken to ensure only trained and competent staff managed medicines. All seniors responsible for medicines had been specially appraised regarding their performance in handling medicines, received extra training and competence assessments and only those achieving the service's standards for handling medicines safely were allowed to continue to administer them.

Medicines were safely managed within the service and a selection of medication administration record (MAR) charts we looked at were accurately completed. Medicines were obtained in a timely way so that people did not run out of them. They were securely stored, administered on time, recorded correctly and disposed of appropriately. One continuing issue was the synchronisation of start dates when a new medicine was prescribed in the middle of the administration cycle. The registered manager continued to work on this. Staff also completed a stock control audit three times a day at each shift handover and a full audit was completed weekly .

The store cupboard where medicines were held also housed an air conditioning unit but this was broken at the time we inspected and a new one had been ordered. The air temperature thermometer in the cupboard was reading at 24 degree centigrade, which is close to the maximum safe recommended storage temperature level of 25 degrees. When we asked the registered manager about this they assured us they would expedite the replacement of the air conditioning unit and ensure staff maintained close monitoring of the air temperature.

Five people received controlled drugs (CDs) in the service (those required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001). These were safely

handled, stored, recorded and accounted for, in line with current guidance on safe management of medicines. Stock checks tallied with the drug numbers that were held and records were accurate. We observed a senior staff member administering several people's medicines and saw they did so safely and respectfully.

Since our inspection the registered manager has sent us details of a pharmacy audit completed on 30 November 2017, shortly after the inspection. The report of this visit showed that the service's medicines policy, ordering, storage, disposal of medicines and management of controlled drugs were safe. Minor recommendations were made by the pharmacy audit, general ones, which we had identified during our inspection. We are confident that the registered manager will address all of these recommendations. The provider was no longer in breach of regulation 12 with regard to medicines management.

The service had systems in place to manage safeguarding incidents and staff were trained in safeguarding people from abuse. Workshops were held for staff on dealing with safeguarding incidents. Staff demonstrated knowledge of their safeguarding responsibilities and knew how to refer suspected or actual incidents to the local authority safeguarding team. Staff training records evidenced that staff were trained in this area. Safeguarding records were held in respect of handling incidents and the referrals that had been made to the local authority.

We discussed with staff the use of any means of restraint in their daily work. They told us categorically that the policy of the organisation stated there was zero tolerance of physical restraint of any sort. Discussions revealed that staff were aware of the people that used the service who may behave in a particular way that challenged them. For example, people living with dementia that may have refused personal care or put themselves in situations where they or others were at risk of harm or injury. We were told about examples of one person's recent behaviour and we found that staff had learned to recognise and respond appropriately when the person was likely to act out their anxieties that put them and others at risk of harm.

Formal notifications were sent to us regarding all incidents, which meant the registered provider was meeting the requirements of their registration. Risk assessments were in place to reduce people's risk of harm, for example, from falls, poor positioning, moving around the premises, inadequate nutritional intake and the use of bed safety rails. People had personal safety documentation for evacuating them individually from the building in an emergency or in case of fire. Maintenance safety certificates were in place for utilities and equipment used in the service, and these were all up-to-date. Contracts of maintenance were in place for ensuring the premises and equipment were regularly maintained. Audits were carried out to ensure fire safety and equipment safety measures were followed. All of this ensured people, staff and visitors' safety.

Staff used various equipment to assist people to move or transfer and we saw that this was now used effectively, as there had been some concerns raised in the past. People were assessed for the use of equipment and there were risk assessments in place to ensure no one used it incorrectly. Safety bed rails were in place and these had also been risk assessed for safe use. Where it was considered appropriate people were asked if they would like the use of adaptive cutlery and crockery aids so that they could maintain their independence.

There was a thorough recruitment procedure in use which ensured staff were suitable for the job. Staff files we looked at contained consistent documentation for the vetting and screening of candidates. The procedure was supported by consistent recruitment practices around requesting job applications, references and Disclosure and Barring Service (DBS) checks. A DBS check is a legal requirement for anyone applying to work with children or vulnerable adults. It checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions. We

evidenced that all safety checks had been carried out for the staff whose files we reviewed.

We also evidenced that staff provided proof of their identities, attended interviews, filled out health questionnaires and received correspondence about job offers. We saw that staff had not begun to work in the service until all of their recruitment checks had been completed, which meant people they cared for were protected from the risk of receiving support from staff that were unsuitable.

Staffing rosters that we reviewed corresponded with the numbers of staff on duty during our inspection. People and their relatives told us they thought there were enough staff to support people with their needs. Staff told us they covered shifts when necessary and found they had sufficient time to carry out their responsibilities to meet people's needs. Shifts consisted of between nine and twelve hours at night and seven, eight or twelve hours during the day. There was also a twilight shift in the evenings of four to six hours. Staff told us they worked flexibly in that they always continued with care to an individual long after their shift had ended, because it was important not to upset people or cause them anxiety with a change in staff members.

Systems in place ensured that prevention and control of infection was appropriately managed. The premises were clean and appropriately maintained. Staff had completed infection control training, followed guidelines for good practice and had personal protective equipment that they required to carry out their roles. Cleaning staff were employed and did a very good job of keeping the premises clean and free from unpleasant odours. The service's handyperson also assisted with high-level cleaning.

The staff understood that people had their own hoist slings to avoid cross infection and these were stored separately wherever possible. These were not individually named for people but staff knew which sling belonged to people and had sufficient numbers of them to ensure regular laundering.

A visiting healthcare professional stated that the service was clean and hygienic and one of the best services that they regularly visited. Waste management was appropriate and followed guidelines and contractual arrangements.

The registered provider had accident and incident policies and records in place. Records showed that these were recorded thoroughly and action taken to treat injured persons and prevent accidents reoccurring, was clear and in sufficient detail.

Good

Is the service effective?

Our findings

People told us they received a full assessment of their needs before receiving the service. Staff understood people well and had the knowledge to care for them. Their health was promoted by good nutrition and hydration, health care professionals were called upon for support and their consent to care was sought by staff before being delivered. People said, "In my view the food could be a little better, but staff are very attentive and treat me well. I have plenty of choice in my daily life, like when I get up and so on. Staff keep an eye on my health and I can see such as the chiropodist when I need to, who is here today" One relative told us, "The food here is really good. The chef asks my [family member] how they like their breakfast and I believe they have never made any bad comments about the food they are given."

At the last inspection in October 2016 we found that the provider was in breach of regulation 12: Safe care and treatment. We found people's health care needs were inappropriately met. For example, people received poor support with skin pressure care and associated positional changes. People with diabetes were not well supported with meal times and staff failed to act on instructions from nurses. Collaborative working with healthcare professionals was poor and other record keeping was found to be inconsistent.

At this inspection we found that people's health care needs were appropriately met. This was because improvements had been made in communication systems to ensure advice was taken and the support provided by other professionals was carefully followed. All staff now received up-to-date information in handovers, monitoring charts were completed more consistently and medicines for those people with diabetes were administered in line with more evenly spaced mealtimes.

A visiting health care professional corroborated our findings and said that much had improved with communication, sharing of information and acting on health advice. They said, "We've had to do some work with the staff over the last few months and now have 'case load holder meetings' with the manager, which has improved things greatly. Team meetings held more regularly has improved communication. The introduction of specific management plans for certain issues has helped staff improve how they manage problems with people's care needs. Staff now listen more carefully to our instructions and advice and act on it."

Staff told us they consulted people and their relatives about medical conditions and confirmed they liaised more closely with healthcare professionals. Information was collated and reviewed with changes in people's conditions and passed over in handovers or staff meetings. They said they held more meetings in which sometimes quizzes were held on people's general care needs, to ensure they knew what these were. Staff told us that people saw their doctor on request and the services of the district nurse, chiropodist, dentist and optician were accessed whenever necessary. Health care records held in people's files confirmed when they had seen a professional and the reason why. They contained guidance on how to manage people's health care and recorded the outcome of consultations. Diary notes recorded when people were assisted with the health care that was suggested for them.

People that used the service exercised the maximum amount of choice and control possible with regard to

care planning, individual care and treatment, their relationships with others such as family and friends and as citizens beyond the health and social care services that they were using. Sometimes their choice with regard to service development was limited because they were living with dementia and were unable to make direct choices regarding how the service was delivered and how changes were made to ensure continuous development. However, staff were astute in observing when changes in needs required changes in service delivery.

The provider had systems in place to ensure staff received the training and learned the skills they required to carry out their roles. A staff training record (matrix) was used to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed. The training record evidenced that staff training was continuously being brought up-to-date.

HICA had a training team for certain skill areas and also used on-line courses and workbooks to deliver training to its workforce. We saw courses planned for staff in safeguarding, moving and handling, fire safety, mental capacity act, health and safety and first aid.

Staff completed the organisation's induction programme, received regular one-to-one supervision and took part in a staff appraisal scheme. Induction, supervision and appraisal were all evidenced from documentation in staff files and via discussion with staff. Induction followed the guidelines and format of the Care Certificate, which is a set of standards that social care and health workers follow in their daily working life as recommended by Skills for Care, a national provider of accreditation in training.

Staff confirmed with us that they had completed mandatory training, which is minimum training they are required to do by the provider to ensure their competence. They had the opportunity to study for qualifications in health and social care.

Discussion with staff revealed the service provided people with meals that respected their religion, culture and dietary preferences, as meals were supplied via an outside catering company and delivered to Wilton Lodge – Care Home as part of a regular contract. Therefore while no one requested Kosher or Halal meals these could be supplied upon request. Vegetarian and gluten free options were provided to some people that required them. We were told that one person sometimes supplemented their meals themselves for extra variety, as they ate a vegetarian diet. A full cooked English breakfast was supplied to anyone requesting it. People made their choices known regarding nutritional needs in 'residents' meetings

Nutritional needs were met through consultation with people about their dietary likes and dislikes, allergies and medical conditions. Staff sought the advice of a Speech and Language Therapist (SALT) when needed. The kitchen staff ensured three nutritional meals a day were provided, plus snacks and drinks for anyone that requested them, including at supper time. Nutritional risk assessments were in place where people had difficulty swallowing or where they needed support to eat and drink. People were asked about their menus choices each day and these were recorded and provided to people, who told us they were satisfied with the meals on offer.

Staff worked well with other care and healthcare professionals and we received testimony of this from healthcare professionals that visited the service at the time of our inspection. This included positive information from a visiting district nurse and a chiropodist. We saw evidence that information sharing took place between the provider and other care providers.

Those people that used the service and living with dementia had signage and colour schemes that aided their orientation. Carpets, furniture fabrics and wallpapers were plain in the main, which helped to ensure

people's confusion was kept to a minimum. Environment incorporates design and building layout, colour schemes, textures, experience, light, sound and smell. The provider was making every effort to ensure the environment was suitable for its use. Changes had resulted in a café/bistro area, a new linen room and a planned wet-room shower facility. Environment audits had been carried out in July and October 2017 when specific work was identified.

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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. Where people were assessed as having no capacity to make their own decisions, the registered manager arranged for best interests decisions to be discussed and agreed. When we spoke with staff they confirmed the use of the best interest route for decisions made with people. The registered manager also ensured DoLS applications were made and reviews carried out. We saw that one person had an Independent Mental Capacity Advisor allocated to them so that their interests were independently represented. The person also went out with their occupational therapist and all documentation regarding their deprivation of liberty was reviewed monthly. All of this was managed within the requirements of the MCA legislation.

People consented to care and support from staff either by verbally agreeing to it when offered or cooperating through their body language and accepting support when staff offered their assistance. Some people signed documents that gave permission for their care plan to be implemented, photographs to be taken or medication to be handled.

Good

Is the service caring?

Our findings

People and relatives we spoke with told us that people had good relationships with staff and each other, that their individual needs were respected and any information they required was supplied so they understood it. They confirmed that advocacy services were available, confidentiality was upheld and privacy, dignity and independence were encouraged and respected. People said, "Staff are very kind. We get on well and they help with anything I need" and "I am always cared for discreetly, but encouraged to do what I can for myself." They also said, "The staff show lots of respect and are very attentive to people's needs" and "Staff are always discreet."

Relatives told us, "I've heard people asking for support with personal care and this has always been provided in a caring way. My family member is much happier here than any previous place they have lived", "My relative gets on well with the staff", "Both me and my sister visited here independently to look around and we both felt it was homely" and "The staff approach is very welcoming and they always deal with any issues and let me know what's going on."

Staff had a pleasant but professional manner when they approached people. Staff knew about people's needs and preferences and were kind when they offered support. Even when people's wishes were unknown staff treated them in a humanitarian way with compassion. Staff were quick to volunteer for extra activities such as supporting people on outings to the coast or on events held at seasonal times of the year.

The management team led by example and was polite, attentive and informative in their daily approach to people that used the service. The management team was happy to stand in when required to help support people.

At the time of our inspection we were told that people with diverse needs were adequately provided for. We saw that everyone had the same opportunities in the service to receive the support they required, were spoken with by staff in the same polite, but friendly way and were treated as individuals with particular needs that were to be met according to people's individual wishes and choices. Care plans, for example, recorded people's individual daily routines, how they wanted to be addressed, preferences for outings or meeting up with family members and any nutritional choices. Staff knew these details and responded to them accordingly.

We saw that people were treated and supported according to their specific needs, which incorporated consideration of their age, disability, gender, race, religion and belief. Those that followed a religion were enabled to join others for services in the community or in-house. We understood that religious ministers of various faiths could visit people on request. The Catholic priest visited and one person joined their brothers and sisters at a local Kingdom Hall. Those who used wheelchairs to mobilise were included in all of the activities that ambulant people undertook and every effort was made to ensure they had equal opportunity to join in, as in trips to Paull and Bridlington that people made in the summer. Everyone's views were taken into consideration especially with regard to their personal preferences for daily living, by listening to what they had to say and enabling them to make choices.

People's general well-being was considered and monitored by the staff who knew what might upset their mental or physical health. People were supported to engage in old and new pastimes, which meant they were able to 'keep a hold on' some aspects of the lifestyle they used to lead or learn a new skill. Activity and occupation helped people to feel their lives were worthwhile and purposeful, which aided their overall wellbeing. We found that most people were quite positive about their lives.

While almost everyone living at Wilton Lodge – Care Home had relatives or friends to represent them, we were told that advocacy services were available if required. Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them. Information was provided to people about who to contact and support was offered to ensure anyone needing an advocate was put in touch with one.

People had been consulted about their wishes following illness and when faced with the end of life decisions. Some had 'do not attempt cardiopulmonary resuscitation' documents in place to be protected from any unnecessary and unpleasant treatment, while those that did not were assured their right to life was protected and respected by the health and social care services they used.

People's privacy, dignity and independence were respected. Staff only provided personal care in privacy, knocked on doors before entering bedrooms and bathrooms and ensured all doors were closed quickly when entering and exiting, so that people were never seen in an undignified situation. We saw evidence in people's files of the ways in which personal care was provided and instructions included how best and most appropriately support was to be given to ensure people's dignity and privacy.

Good

Is the service responsive?

Our findings

People we spoke with felt their needs were being appropriately met. People and their relatives talked about the care they received, the activities they engaged in, whether or not they were listened to and if their complaints were appropriately addressed and resolved. People said, "I like singing or chatting to people" and "I just like to be kept entertained with anything really." People said, "If I had a complaint I'd know who to pass it to" and "I can complain if need be." They also said, "We sometimes have things to do and activities to join in with to keep us busy" and "Staff often play bingo with us or hold a quiz for us."

One relative told us, "My family member joins in with activities of their choice, though they much prefer just helping people do things, like making a drink for some of the ladies. They have been out to the pub once or twice and sometimes just sits and watches others. I would speak to staff if I had any complaints about their care, but there has been no need so far." Another said, "My relative tells me they have no complaints about the food or anything, though I think they forget what is given to them. They join in with activities when they can, but any outings they undertake are usually with me, to the garden centre or to see the horses in a village out in Holderness." One relative also said that the staff were very responsive to people's personal care and health needs and ensured their comfort at all times.

People were assessed regarding their individual needs, using a HICA assessment process, which covered nine areas of care. Anyone on a respite visit to the service was given a short-term care plan after having their needs assessed. Those people with permanent placements were provided with a full and detailed care plan within one month of admission. People's care files reflected the needs that people appeared to present.

Care plans were person-centred and contained information under all assessed areas of need. They provided information for staff on how to meet people's needs. They contained personal risk assessment forms to show how risk to people was reduced, for example, with pressure relief, falls, moving and handling, nutrition and bathing. We saw that care plans and risk assessments were reviewed monthly or as people's needs changed.

Activities were held in-house with staff and an activities coordinator. We were told by staff that people sometimes joined in with craft sessions, quizzes and themed events and also occupied themselves with the hairdresser or chiropodist. Staff told us that people used one of the lounges as a 'lookout post' for watching people going by on the main street outside the service. We saw items in place for simple pastimes, including board games, floor games (such as hoopla and skittles), magazines, newspapers and puzzle or reference books. We were told about an over 55's club that one person regularly attended and that occasionally another person went to the local pub for a drink. Some photographs around the service evidenced where people had been and what they had joined in with over the past months.

Staff understood the importance of providing people with choice wherever possible, so that people continued to make decisions for themselves and stayed in control of their lives. People had a choice of main menu each day and if they changed their mind the cook usually catered for them. They chose where they sat, who with, when they got out of or went to bed, what they wore each day and whether or not they went

out or joined in with entertainment and activities.

People's individual communication needs were assessed as part of their initial assessment of needs and any particular communication aids/methods were used, where possible to enable them to make their views known. Because many people at Wilton Lodge were living with various stages of dementia their communication needs were diverse. Most people verbalised their daily needs with which staff had become familiar, but some resorted to physical demonstrations or were less able to make choices and decisions. Where people were not living with dementia staff ensured their communication needs were also understood. The registered manager was aware of the Accessible Information Standard but had yet to formalise the standard's assessment process. This was an area they were to develop. People had already received information in large print, via loop systems and other languages where necessary, but only as the need presented itself.

The registered provider had a complaint policy and procedure in place. Records held on complaints showed that they were handled within timescales. We were told by staff that most complaints were made about lost laundry and small possessions, which usually turned up. Compliments were also recorded in the form of letters and cards.

Staff were aware of the complaint procedure and understood that complaints helped them to improve the care they provided. We saw that the service had addressed several complaints appropriately throughout the year and complainants had been given written details of explanations and solutions following investigation. Complaints ranged from issues with food to possessions or clothing going missing and people not always being assisted early enough in the day to noise from other people at night. A complaint log showed how issues had been analysed to avoid repetition and there were strategies put in place to ensure problems were resolved.

We assessed how people were cared for at the end of their life and found that staff sought appropriate healthcare support to enable people to have a comfortable, pain-free and dignified death. All care and end of life arrangements were recorded within people's care plans. For example, one person had information that stated the palliative care team were now involved in their care.

Staff were sensitive to people's needs and those of their relatives when end of life beckoned. Records showed that people received regular monitoring and support checks, which were recorded on monitoring charts for nutritional intake and output, pressure relief and application of topical creams and lotions. People and their relatives were treated respectfully, with compassion and dignity. Information was provided when necessary and communication was good.

Good

Is the service well-led?

Our findings

People and relatives we spoke with felt the service had a pleasant, family orientated atmosphere, where lots happened and people had the benefit of a well-run service, under the management of the current registered manager. Staff we spoke with said the culture of the service was, "Inclusive," "Approachable", "Productive" and "Efficient."

At the last inspection in October 2017 we found that audits were not as effective as they could be and so we made a recommendation about identifying all shortfalls, particularly with regard to identifying problems with the management of medicines and maintaining accurate records.

At this inspection we found there were improvements in the effectiveness of the quality assurance systems. We looked at documents relating to monitoring and quality assuring the delivery of the service. We saw that there were quality audits completed on a regular basis, which included those on care plans, medicines, accidents/incidents, safeguarding concerns, use of bed safety rails, bedroom safety and suitability, safety of wheelchairs, records, general health and safety, infection control and staff training.

For example, the audit and analysis of falls and accidents showed that appropriate action had been taken to ensure people were referred to the 'Falls Team' and were supplied with any equipment to aid their safe independence. Also the medicine administration audits contained details of any identified issues and recorded how these were to be addressed and when action had been taken to resolve them. Staff administering medicines were regularly competence assessed. Records were also audited more thoroughly so that issues were identified quickly and improvements made in maintaining them. These were in line with the requirements of regulation and we saw that they were appropriately maintained, up-to-date and securely held. Data protection requirements were followed and the organisation was registered with the Information Commissioner's Office to ensure safe management of information.

We found that the registered manager fully understood their governance responsibilities and ensured quality performance, risk and regulatory requirements were monitored and mitigated. Other aspects of the quality assurance system included sending out satisfaction surveys to people that used the service, relatives and health care professionals. However, the relatives we spoke with could not recall completing a survey. The early 2017 satisfaction survey issued to people that used the service identified a need for variation in meals provided and an improvement in how people were respected. The registered manager had taken these on board, as they had already made changes to menus and was nurturing the development of a culture where respect underpinned all care and support.

Aspects also included holding meetings for staff, people that used the service and relatives, where agenda items including food, activities, complaints and outings were discussed. Relatives confirmed they had attended relatives' meetings and found these to be useful. Staff and other meetings were held to obtain people's views of service delivery. A health care professional we spoke with told us that improvements had been made with communication with their department and this had resulted in benefits for certain people. For example, with falls, referrals to the falls team and measures being put in place to reduce these.

There was also a shift handover system, which ensured people's needs were discussed and monitored. There was evidence that Trade Unions had been in to speak with staff when changes to their working conditions were proposed. The organisation also continued to carry out its own internal quality auditing using the 'Early Warning Assessment Tool' to identify any non-compliance with regulations. This assessment tool showed that improvements had been made between June and October 2017 with an overall compliance achievement score of 89.5%.

The provider was required to have a registered manager in post and on the day of the inspection the manager had been registered for approximately one and a half years. The registered manager and provider were fully aware of the need to maintain their 'duty of candour'. This is the responsibility to be honest and to apologise for any mistake made under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Notifications were sent to the Care Quality Commission (CQC) and so the service fulfilled its registration responsibilities.

The management style of the registered manager and deputy manager was open, inclusive and approachable. Staff told us that "The registered manager is very supportive and encouraging. They instil confidence in us" and "The manager is easy to speak with and receptive to our moods." Staff told us they were friendly with each other at work and outside of work, which they considered to be a good thing. The staff knew about the visions and values of HICA, stating these were written into their contracts of employment and understood and implemented them whenever possible.

Staff encouraged people to have strong links with the local community, where possible, through religious affiliation, schools and by visiting local services and businesses: shops, stores and cafes. Visiting community members were welcomed. Relatives played an important role in helping people to keep in touch with the community by supporting them out to shops and cafes, the cinema/theatre or walks.

The registered manager strove for continuous learning around best practice and met with other care home managers in the organisation, updated their learning and practice at any opportunity and worked towards improving the service by searching for innovative ways of service delivery and the means of sustaining them.

The service fostered partnerships with other agencies and organisations by keeping in contact with them, sharing information and listening to and acting on advice when it was offered. This was confirmed by the district nursing staff we spoke with and evidence in care plans of the care, support and treatment provided to people. People were seen as individuals with differing needs and preferences.