City of York Council

Windsor House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Windsor House is a residential care home run by City of York Council. It provides personal care and accommodation for up to 27 older people who may be living with dementia. The service also provides respite care, with nine of the rooms reserved to provide temporary accommodation. This could either be planned respite if, for example, a person's carer went on holiday or emergency respite during periods of crisis.

The service is purpose built and accommodation is provided across two floors with lift access. There is some parking on site. The home is situated in a residential area of York to the west of the city centre.

We inspected this service on 22 and 26 July 2016. The inspection was unannounced. On the first day of our inspection, there were 24 people using the service; 18 people living at the home and six people using the service's respite beds.

The service was last inspected in September 2014 at which time it was compliant with the regulations in force at the time.

The registered provider is required to have a registered manager as a condition of registration for this service. The service did have a manager registered with the Care Quality Commission (CQC); however, they were not at work at the time of our inspection. We were supported during our inspection by the head of service and two registered managers from other homes run by the registered provider. A registered manager is a person who has registered with the 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.

During our inspection, we found that medicines were not always kept securely or stored at the correct temperature. The registered provider had not effectively risk assessed the safe storage of medicines. More frequent fire drills were needed and records showed that weekly fire alarm tests had not been consistently completed.

We identified concerns regarding staffing levels within the home. Staffing levels impacted on the time available for staff to support people with meaningful activities and staff felt they were not always able to quickly respond to people's needs. Staff raised concerns about the lack of time they had to support people with meaningful activities.

We identified concerns around how the registered provider evidenced consent to care and treatment. Records did not consistently evidence that people's capacity to make informed decisions had been considered when seeking consent.

There had been a number of different managers since our last inspection of the service creating uncertainty

amongst staff. Staff morale was low as there was uncertainty about the future. Feedback about the new registered manager was positive although they were not at work at the time of our inspection.

Staff completed risk assessments to identify risks and plans were put in place to manage these risks to keep people who used the service safe. We found that staff understood their role and responsibilities with regards to safeguarding vulnerable adults.

Staff had regular training and supervisions and appraisals were completed to support staff development. However, there were some gaps in staff training.

We received positive feedback about the food and drinks provided at the home. We observed that people were supported and encouraged to eat and drink regularly. People were supported to access healthcare services where necessary.

There was a system in place to gather feedback and respond to complaints. We received positive feedback about the caring staff. People were encouraged to make decisions. Support was provided to maintain people's privacy and dignity. People who used the service provided generally positive feedback about the home.

Care plans were in the process of being updated using a new care plan format. The new care plans were more detailed and person centred to support staff in providing responsive care.

Quality assurance systems needed to be improved to ensure issues and concerns were identified and action consistently taken to address concerns.

We found breaches of regulation in relation to medicines, staffing levels and consent to care. You can see what action we told the registered provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were supported by staff who understood their role and responsibilities with regards to safeguarding vulnerable adults.

Risks were identified and assessed and risk assessments were used to guide staff on how to reduce risks to maintain people's safety.

People told us they were supported to take their prescribed medicines. However, the management and safe storage of medicines needed to be improved.

We identified concerns regarding staffing levels within the home. Staffing levels impacted on the time available for staff to support people with meaningful activities and staff felt they were not always able to quickly respond to people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

We received positive feedback about the skills and experience of staff working at Windsor House. Training and supervisions were provided, although some training needed to be updated.

Evidence that people had consented to the care and support provided was not always appropriately recorded. Clear and complete records were not in place in relation to people's capacity to make decisions.

People were supported to eat and drink enough. We received positive feedback about the food provided.

Staff supported people who used the service to access healthcare services where necessary.

Is the service caring?

Good

The service was caring.

We received positive feedback about the caring attitude of staff. We observed staff to be kind and caring towards people who used the service.

People who used the service were encouraged to express their wishes and views and support to make decisions about their care and support.

Staff provided support which maintained people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Activities were provided, however, staff raised concerns that staffing levels impacted on the support they were able to provide for people to engage in meaningful activities.

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

Is the service well-led?

Requires Improvement

The service was not always well-led.

We received positive feedback about the new manager and their management of the home, however, work was needed to improve staff morale.

We found that records were not always well-maintained and the quality assurance system needed to be improved.

Windsor House

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. The inspection was planned to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 22 and 26 July 2016. The inspection was unannounced. The inspection team was made up of one Adult Social Care (ASC) Inspector.

Before our inspection, we looked at information we held about the service, which included information shared with the Care Quality Commission via our public website and notifications sent to us since our last inspection of the service. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We used this information to plan our inspection. We did not ask the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and what improvements they plan to make.

During the inspection, we spoke with six people who used the service and one visiting health and social care professional. We spoke with the head of service, two registered managers from other services run by the registered provider, seven care staff and the cook.

We looked at five people's care files, recruitment records for three members of staff, training records, medication records and a selection of records used to monitor the quality of the service. We observed interactions between staff and people who used the service and observed lunch being served.

Requires Improvement

Is the service safe?

Our findings

Where necessary, staff supported people who used the service to take prescribed medicines. One person who used the service said, "My tablets are always given to me...they take care of them." We found that the registered provider had a medication policy and procedure. Staff had training and medicine competency checks were completed to ensure that staff had learnt how to administer medicine safely and in line with guidance on best practice.

Medicines were stored in a locked treatment room. However, we observed one occasion where the treatment room door was left ajar and there was no visible staff presence. We also observed that the medication trolley containing people's medicines was left open when the member of staff went into people's room to give them their tablets. People's doors were closed and the medication trolley was left unsupervised. On these occasions people who used the service or visitors had unrestricted access to prescribed medicines. This was unsafe given that the service supported people who may be living with dementia.

We also identified that effective systems were not in place to ensure that medicines were stored at the right temperature. There were gaps in records where daily temperature checks had not been recorded. Checks that had been completed recorded that the temperature within the treatment room had exceeded the recommended temperature at which medicines should be stored. The pharmacy had not been contacted to discuss whether it was safe to continue administering these medicines. On the second day of our inspection, the pharmacy had been contacted and an air conditioning unit had been moved into the treatment room to ensure medicines were stored within the recommended limits.

Whilst the registered provider was responsive to our concerns, these issues had not been identified and addressed prior to our visit and showed us that more effective systems were needed to monitor the safe storage of medicines.

The pharmacy supplied medicines in a monitored dosage system. This contained a 28 day supply of each person's medicine. The pharmacy also supplied printed Medication Administration Records (MARs) for staff to record medicine they had given to people who used the service. We checked completed MARs and found gaps on two records where staff had not recorded whether that person had been given their medicine as prescribed. We found a further MAR where staff had not consistently used codes to record where 'as required' medicine had been offered, but refused. This meant that MARs had not been accurately completed and kept up to date and there was a risk that medication errors could occur. We were told that new systems had been introduced to address issues with medicine management and saw that all staff had recently completed medication competency tests as part of this process.

Where people who used the service were staying for respite, staff told us people bought medicines from home and these were 'checked-in' by two staff. We were told medicine had to be in the original packaging so that staff could follow the pharmacy label for instruction. Staff transcribed instructions from the pharmacy label to complete handwritten MARs. However, we spoke with the registered provider about

ensuring that staff countersigned handwritten MARs to reduce the risk of transcribing errors.

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

We reviewed staffing levels within the service. The registered provider used a 'dependency tool' to determine how many staff were needed on each shift. This indicated that staffing levels at Windsor House were appropriate to meet the needs of people who used the service. On the first day of our inspection, there were 24 people using the service. Staffing levels during the day comprised of one senior care assistant and two care assistants on the ground floor and two care assistants on the first floor. The service also had a cook and general assistant in the kitchen and a general assistant responsible for laundry and cleaning. At night, there was one senior night care assistant and two care assistants on duty. Agency staff were used to maintain these staffing levels where necessary.

We asked people who used the service if there were enough staff on duty to meet their needs. Feedback included, "There is enough staff. I used the call bell once and they came quickly" and "Yes there is enough staff." However, one person who used the service told us staff sometimes said, "I am busy at the moment, can I come back later?"

Two staff we spoke with said they felt staffing levels were safe. However, four staff told us they felt staffing levels impacted on people's safety.

People at high risk of falls had pressure mats in place, which triggered an alert if they tried to get out of bed or walk unsafely. Staff told us "If you have got four or five people on bed buzzers how do you deal with that?" and "We cannot answer them all." Staff told us they felt that there would be less falls in the home if they were able to respond to people's call bells more quickly. During our inspection, we did not identify concerns about the length of time it took staff to respond to call bell or alerts. However, feedback from staff indicated that they sometimes struggled to respond promptly to alerts and that this increased the risk of harm occurring.

Staff we spoke with said they felt that staffing levels impacted on the support they were able to provide for people to engage in meaningful activities. Comments included, "I do feel there are not enough things going on....we are constantly doing main sort of tasks, for example, taking people to the toilet, not activities", "I just wish we had more time for activities...to take them out and do activities", "There's not enough carers, they do try to do activities, but sometimes they can't", and "We don't feel there are enough staff...it's taking away from doing things like activities. Its basic care needs only. We cannot give that time we used to be able to give as we are rushing around all the time." One member of staff told us, "There's a period in the afternoon when we can take people out, but I have heard staff say 'I don't have time'." We observed that staff spent long periods of the day providing support with practical caring tasks and that there was limited time for one to one interaction or meaningful stimulation outside of this. Some staff we spoke with felt there were an increased number of incidents involving people who used the service, because staff were not always able to support with activities and provide meaningful stimulation. Staff explained that they felt the lack of meaningful stimulation led to people being bored or restless, whilst staffing levels meant that they were not always able to intervene quickly enough to prevent incidents occurring when people did become anxious or upset. Other comments regarding staffing levels included, "It's hard as we have got breaks to cover. We seem to be rushing around all the time as there are too many jobs to do. It's not a relaxing environment for people with dementia."

The home had a number of lounges and communal areas where people could sit and spend their time.

Because of this and the layout of the home, there was not always a visible staff presence in communal areas and we observed that people were unsupervised for short periods during the day. We saw examples where people required assistance, but staff were not present to identify and respond to this. For example, one person had been sitting in a communal lounge and had got up and walked unsupervised down the corridor without using their walking frame. When staff observed this they were quick to remind the person that they needed to use their frame to reduce the risk of falling. We observed another example where they tried to get up unaided and again there was no visible staff presence or support available to them.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service said, "I've got nothing to worry about", "Yes I feel safe", "I do very much so feel safe. I am very happy here" and "If I didn't feel safe I wouldn't stay here. No there's nothing worrying me."

We found people who used the service were protected from abuse by staff who were trained to recognise and respond to safeguarding concerns. Staff we spoke with appropriately described their role in identifying safeguarding concerns and reporting these to a senior member of staff or the registered manager. The registered provider had a safeguarding vulnerable adults policy and procedure to provide further guidance to staff on how safeguarding concerns were managed within the service. Records showed that safeguarding concerns were investigated in consultation with the local authority's adult safeguarding team.

The service had a robust recruitment process. We reviewed records relating to three staff and found that references were obtained and Disclosure and Barring Service (DBS) checks completed before new staff started work. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer recruitment decisions and are designed to prevent unsuitable people from working with adults or children who may be vulnerable.

Each person who used the service had a care file containing copies of risk assessments and care plans. Risk assessments were used to identify and assess risks to people who used the service. These, alongside care plans, provided details about what support was needed and how this support should be provided to keep people safe. For example, where someone was at risk of developing problems with their skin, a Waterlow Assessment had been completed to identify the level of risk. The person's care plan and risks assessments contained details about the special mattress used to reduce this risk and the staff's role in monitoring skin problems to identify where further advice may be needed from healthcare professionals. This demonstrated that risks were being identified and action taken to reduce these risks to maintain people's safety.

If people who used the service were involved in an accident or incident, staff completed a form to record what had happened and any action taken. At the time of our inspection, we found 12 forms completed following an accident or incident in July 2016. These contained appropriate details about the incident and how staff had responded, for example, recording where first aid was given following a fall. However, we were concerned that the manager follow-up section for these reports had not been completed for 10 out of the 12 forms. This meant that accident and incidents forms had not been reviewed and signed off by a senior member of staff to check that appropriate action was taken, including any follow-up action needed to reduce future risk of harm. We were told that this was a breakdown in communication and would be addressed. We saw that accident and incident reports that had occurred in previous months had been reviewed and signed off in a timely manner. We saw that analysis had also been completed of accidents and incidents to identify any patterns that were occurring so that preventative actions could be taken to further reduce risks.

Checks of the building and equipment used were completed to minimise health and safety risks. We saw documentation and certificates which showed that relevant checks had been carried out on the electrical installation, gas services, portable electrical equipment and lifting equipment including hoists and the passenger lift.

Contingencies were in place to keep people safe in the event of an emergency. The registered provider had a business continuity plan providing information about how they planned to continue meeting people's needs in the event of an emergency such as a fire, flood or loss of power. However, we spoke with the registered provider about updating the service's 'on call' file and discussed moving this to the care leaders office so that it was more accessible if staff needed advice and guidance from management in the event of an out of hours emergency.

Personal Emergency Evacuation Plans (PEEPs) were in place providing information about the support people would need to leave the home in the event of a fire. The registered provider had an up-to-date fire risk assessment although this identified that more frequent fire drills were needed. We saw records of a fire drill completed in December 2014 and were told that a drill had been completed in 2015, however, there were no records available relating to this. This may have meant that staff would not know how to appropriately respond in the event of an emergency. We saw that an action plan was in place to address this issue, but noted that the person responsible and the date by which it would be completed had not been filled in. We also identified gaps in the records which showed that weekly fire alarm tests had not been consistently completed in June and July 2016.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and DoLS. We found that care files did not consistently evidence that people who used the service had consented to the care and support provided or to having their photograph taken. Where people had signed a consent to care and treatment record, there was not always evidence that staff had explored that person's capacity to make an informed decision before seeking consent.

Where people may be deprived of their liberty, requests for authorisation were submitted. However, there was not always evidence that capacity assessments had been completed as part of the process of identifying potential deprivations of liberty.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service said, "The staff are very good, I think they are employed because of that reason" and "If you've got any problems you go to them and they help you. If they don't know, they go to someone who does."

The registered provider required staff to complete a range of training to equip them with the skills needed to carry out their roles effectively. Training was provided by City of York Council's Workforce Development Unit, with additional online learning courses also used to update staff's knowledge and skills. Training provided included first aid, managing medication, infection control, safeguarding adults, the Mental Capacity Act 2005, moving and positioning people and fire awareness.

We were shown a training matrix which had been implemented to provide details of all training staff had completed. This showed us there were some gaps in staff's training or examples where training needed to be updated. For example, training records showed that 10 out of 37 staff had completed training on the Mental Capacity Act 2005. We were told that courses were not always immediately available from the Workforce Development Unit and this could lead to a delay in staff completing certain courses. The head of service told us that there was an on-going programme to audit training across the registered provider's homes and that, where there were gaps in staff's training, staff had been booked onto courses or nominated

for the waiting list for the next available course. We were told that online learning was being used where training courses were not available and that the Workforce Development Unit were commissioning extra training sessions to address gaps in staff's training. We also saw action plans were in place detailing how the registered provider intended to ensure all training was brought up-to-date.

We recommend that the registered provider continues to review staff training needs to ensure staff training is kept up-to-date.

The registered provider had also committed to improving staff's knowledge and understanding of supporting people who may be living with dementia. We saw that staff had completed person centred dementia awareness training and also a 'virtual dementia tour', a training experience designed to provide insight into what it might be like to live with dementia. Staff we spoke with told us this had been a positive learning experience which helped them understand how best to support people with dementia.

Staff we asked told us they had regular supervision. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. The registered manager completed supervisions with senior care assistants and senior care assistants held supervision meetings with care assistants. We spoke with a senior care assistant who showed us the supervisions they had completed. This demonstrated that staff had received regular supervision. They explained that the registered manager monitored their records to ensure they were up-to-date with completing regular supervisions. Records of supervisions completed showed that they were appropriately used to support staff's development, discuss wellbeing and any issues or concerns with staff's practice.

People who used the service said, "The food is all right, I find it quite good. We usually get a choice", "We get good food, it's very good" and "The food is very good, there's always two main courses and two sweets and you can always get more."

A member of staff said, "The meals are fantastic here and they do cater for people with different needs...They [people who used the service] are given a choice; there is always two main meals and if they don't want that [cook's name] will whip something else up."

We observed lunch being served on the first day of our inspection. We saw that there were two choices available, food served looked appetising and appropriate portion sizes were provided. We found there was a positive atmosphere during lunch. Staff were warm and attentive towards people who used the service, offering choices and encouraging people to eat and drink. We heard people who used the service say "That's lovely" and "It's very nice" regarding the food provided and "You look after us don't you" towards staff serving meals. Where people did not like what was offered or had not eaten much, we saw that staff offered alternatives.

The cook told us they had a four week menu with two options for lunch and dinnertime. The cook said that they asked people who used the service what they would like to go on the menu and also got feedback from staff about what people did and did not like. The cook told us that details about people's special dietary requirements or food allergies was gathered during assessments completed when people moved to the home and this information was passed to the kitchen. The cook showed a good understanding of their responsibilities to provide food to meet people's specific dietary requirements including providing pureed meals, fortified meals and diabetic options.

We asked staff how they supported people to ensure they ate and drink enough. Comments included, "We monitor so we know exactly what people have eaten" and "They [people who used the service] are weighed

monthly for their BMI or weekly if needed. If there are concerns they are on a food and fluid chart." Food and fluid charts were used to record what people ate and drank in order that staff could identify where people were not eating and drinking enough. At the time of our inspection, one person's fluid intake was being monitored due to concerns about dehydration. We found that this person's fluid chart for a three day period had either not been completed, been completed but contained insufficient detail or evidenced a low fluid intake. Although we found no evidence that this person had become dehydrated, we spoke with the registered provider about improving recording around monitoring people's fluid intake. Accurate recording on fluid charts help staff to identify when people are not drinking enough and to manage the risks associated with dehydration.

Each person's care file recorded details about any health needs they had and information about healthcare professionals involved in supporting them. Staff maintained a record of visits from and to healthcare professionals. These records showed us people were supported to see a range of healthcare professionals where necessary. Records of accidents and incidents showed staff sought appropriate medical attention or further advice and guidance if needed. One person who used the service told us, "I was unwell and was taken to hospital." A member of staff said, "If people have appointments we tend to take them or people's family will take them."

The heard of service showed us steps taken to ensure people who used the service had eye tests done. This showed us there were systems in place to support people to maintain good health and to access healthcare service where necessary.

Good

Is the service caring?

Our findings

People who used the service told us, "The staff are very nice", "They're very helpful...yes caring" and "I have nothing to grumble about. It's quite pleasant here really. They [staff] are all very nice people."

During our inspection, we spent time observing interactions between staff and people who used the service. We observed staff being kind, considerate and respectful towards people living at Windsor House. We observed lunch being served and staff supporting people who used the service in communal areas. We found that staff spoke with people in a caring way. People who used the service responded positively towards staff showing us that they valued their company and enjoyed speaking with them. We saw examples where staff initiated spontaneous conversation and laughed and joked with people who used the service. There was a friendly and relaxed atmosphere throughout the service and people who used the service acted in a way that showed us they were happy with the care and support by staff.

Each person who used the service had a care file which recorded important information about that person, their hobbies and interests. This information supported staff to get to know people who used the service and to develop meaningful caring relationships with them. A member of staff we spoke with explained how they used the care files to get to know people and find out about their likes, dislikes and routines.

The head of service told us they tried to use existing staff to cover shifts to reduce the use of agency staff and maintain continuity of care for people who used the service. Staff told us, "Staff do know the residents very well" and "We do have a lot of relief staff here; but they do come regularly though so a lot of them do know the residents." Although one member of staff said, "It would be nice if we had more time with the residents for interactions, games, reminiscence, getting to know them more."

Our observations showed us that staff did know the people they were supporting and how best to support them. We observed that staff knew people by name and knew how best to speak and interact with them.

People who used the service told us they were supported to make decisions. We asked staff how they supported people who used the service to express their views and to make decisions about their care and support. Comments included "We show them choices, for example at dinner" and "I try and talk to them 'would you like this or that'. It's all about choices."

We observed that staff did support and encourage people to make decisions and express their wishes and views. This was particularly evident during lunchtime, where staff were patient and attentive in explaining the options available, showing people the options where necessary and brining alternative choices if people did not like what was provided.

People who used the service told us staff treated them with dignity and respect. One person commented, "They [staff] definitely speak respectfully to you."

We asked staff how they supported people who used the service to maintain their privacy and dignity.

Comments included "We are discreet; we don't shout it out and take them to their rooms [to assist with personal care]" and "We take people into their bedrooms, make sure the doors are shut and then lock the doors, as other service users could walk in." This showed us that staff were mindful of maintaining people's privacy and dignity.

During our inspection, we saw that staff knocked before entering people's rooms. We observed people being taken to their rooms where support with personal care was required and that conversations held in communal area were appropriate and respectful of people's privacy.

Good

Is the service responsive?

Our findings

Assessments were completed before people moved into Windsor House or stayed there for a period of respite. Assessments gathered information about people's care and support needs and were used to develop care plans to guide staff on how best to meet those needs. A person who was staying at the service for a period of respite explained that the assessments completed before they arrived helped staff to know how to meet their needs. They told us, "They [staff] had a good idea what support was needed, if they didn't they asked me."

Each person who used the service had a care file containing copies of completed assessments, care plans and risk assessments. We saw that care files contained a 'This is me' document which was filled in by the person who used the service or, where they might be unable, their family or friends. This gathered person centred information about that individual to support staff to provide personalised care and support. Person centred care takes into account people's needs, preferences and strengths and recognises the importance of the individual as an equal partner in planning their own care and support.

At the time of our inspection, care files were in the process of being updated using a new format and the head of service told us this process would be completed by August 2016. The care files that had been updated using the new file format contained more detailed person centred information about people's needs as well as their personal preferences with regards to how those needs should be met. This information helped staff get to know people who used the service and enabled them to provide responsive care tailored to people's individual preferences.

We saw evidence that care files were reviewed and updated if people's needs changed. Care files also contained copies of review meetings with the local authority showing that staff were involved in reviewing people's placement to ensure it continued to meet their needs. These records showed that people who used the service, their families or important people in their life were involved in reviews where appropriate.

We asked staff how they ensured that they provided person centred care and support. One member of staff told us, "You get to know people's likes and dislikes based on your familiarity with the service users." A visiting health and social care professional told us, "They [staff] seem to know the residents really well; all the staff I have spoken to know the residents well."

We observed a handover meeting between staff on the morning shift and staff working the afternoon shift. We saw that each person who used the service was discussed, an update given of any recent changes and important information handed over to staff on the next shift. Where someone had been unwell this was handed over to staff coming on shift so that they could continue to monitor and support this person. We saw that a written record of handover meetings was kept for staff to look at during the shift. This was an effective system to share information and ensure staff had up-to-date details about people's needs.

We reviewed the support provided for people who used the service to engage in meaningful activities. At the time of our inspection, the service did not employ an activities coordinator. The registered provider

arranged for a 'musical connections' session to be held each week during term time in the home. This involved interactive music sessions with people who used the service. Other staff and people who used the service told us they had jigsaws, played cards, dominoes, did colouring or went out into the garden. A person who used the service said, "A lot of them play dominoes, you can walk about a bit or go outside if you want...You can go where you want or do what you want there's plenty of activities." However, a member of staff commented, "We do 1:1's, hand massages and play music, but with only two staff upstairs they don't always have the time as it's so busy."

The head of service spoke with us about 'reminiscence pods', which had been introduced across the registered provider's homes in York. These consisted of retro 'sets' with objects to support reminiscence and included a 1940s shop, a pub scene and a garden shed. At the time of our inspection the tool shed reminiscence pod was set up at Windsor House.

The head of service told us about how they had worked with 'York Cares', a voluntary organisation, to make improvements to the garden at Windsor House. We saw that as part of the 'breath of fresh air challenge', a project run across the registered providers home to encourage people who used the service to spend time outdoors, a beach day garden party had been held at the service. This was evidence of a positive commitment to providing stimulation and meaningful activities for people who used the service. However, feedback from staff showed us that staffing levels, at times, did impact on the support available for people to engage in meaningful activities.

We recommend the registered provider continues to develop the support available for all people who use the service to engage in meaningful activities.

People who used the service told us they felt able to speak with staff if they had any issues, concerns or wanted to complain. Comments included, "Any problems, you just ask" and "I can't complain about anything...if there is something that has upset you, you tell them."

Residents and relatives meetings were held within the service to share information and gather feedback about any issues or concerns. We saw minutes for the last resident meeting held in April 2016. Topics discussed included issues with the laundry, improving communication, a visitor's board in the entrance introduced to share information, the availability of a tablet computer to take and share photographs and to enable people who used the service to speak with relatives over the internet. The residents and relatives meeting showed that the service was responsive to feedback and provided information about action that had been taken in response to comments or concerns.

The registered provider had a policy and procedure in place outlining how they managed and responded to complaints. We reviewed records of complaints and saw that a response was provided and action taken to address any concerns. We saw examples where issues or concerns had been discussed with staff at the next team meeting. This showed us that the registered manager was proactive in responding to complaints and taking action to resolve the issue.

Staff at Windsor House had also received a number of compliments and cards thanking them for the care and support provided. We saw a recent compliment care recorded 'We would like to thank the staff at Windsor House for the excellent care our [relative] is receiving.'

Requires Improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration for Windsor House. At the time of our inspection, the service did have a registered manager; however, they were not at work. The service was being managed by a registered manager from another of the registered provider's home.

We asked people who used the service what they thought about the home. Comments included, "I think it's brilliant", "I like it here" and "It's a happy enough place...everything is all there." Another person who used the service told us, "I would recommend the home. They [staff] help you as much as they can and they are there if you want them."

Although we received positive feedback from people who used the service, feedback from staff was less positive. Feedback from staff raised concerns regarding staffing levels within the service. We were told this impacted on the time available to support people with activities and impacted on how long it took staff to respond to people's needs and risks. Staff we spoke with told us they were uncertain about the future as some of the registered provider's homes had closed. There had also been a number of management changes since our last inspection of the service and we found that this had impacted on staff's morale. Staff told us there had been instability and uncertainty as each manager had a different approach. Staff we spoke with told us, "Sometimes we feel we are not supported by management. We have had that many different managers there's been no consistency. [The registered manager] has been really good, but they are off at the moment" At the time of our inspection, the registered manager had been in post for five months. Feedback we received was that they were trying hard to improve the service. Comments included, "[The registered manager] is trying really hard to get things sorted, but staff feel we haven't always had good management support. From what I have seen [the registered manager] is trying to improve communication" and "Since [the registered manager] has come in it's become more structured. [The registered manager] is sorting out the challenges she was left."

The registered manager had introduced a communication file which contained copies of emails or memos sent to care leaders regarding important changes to policies or processes or issues that needed to be addressed. For example, we saw that information had been communicated to staff about the importance of answering the phone promptly and responding to answerphone messages. We also saw that where a medication error had occurred, a message had been sent asking staff to complete a competency questionnaire and providing details about the introduction of a new process to more closely monitor medication stock levels. A member of staff told us "[The registered manager] is good at sharing info. They send emails and information is shared with staff in handovers." This showed us that management were responsive to issues or concerns and were actively sharing information to try to improve the service provided. Another member of staff said, "[The registered manager] is approachable. If you've got any problems you can go to them."

During our inspection, we asked to look at a variety of records in relation to the running of the home and with regards to the care and support provided. We found that some records were not always well

maintained, for example, daily tasks sheets recording support provided for people with personal care tasks were not consistently completed and there were issues with recording where a food and fluid chart was in place. We also identified concerns about how consent to care and treatment was recorded in the care files and concerns that clear records were not always in place in relation to people's capacity to make decisions. Audits had not identified and addressed these issues.

We saw that care plans, medication, premises and workplace inspection, infection control and kitchen audits were completed. However, we found that some audits had not been consistently completed, for example care leader's monthly audits of the care plans. Where issues were identified, some audits contained details of actions required, however, this was not consistent. We also identified examples where actions had been identified, but there had been no follow-up to check whether the improvements had been made. We were concerned that the quality assurance systems had not resolved the issues we identified during the course of our inspection and documented in this report in relation to management and storage of medicines.

We saw copies of a questionnaire sent to professionals and relatives of people who used the service in May and June 2015. The head of services told us they were developing a questionnaire to gather feedback from people who used the service although this was not yet in place at the time of our inspection.

We recommend that the registered provider reviews their quality assurance process.

Meetings were held between the different staff teams who worked at Windsor House to share information and discuss changes and improvements to the service. We saw minutes for staff meetings held in December 2015 and May 2016 and we were told a further meeting had been held in June 2016. Minutes showed that specific incidents were discussed, ideas on how to improve communication, training, activities and improvements to the service. This showed us that team meetings were used to share information to drive improvements. However, two members of staff we spoke with felt that there were not enough team meetings. Comments included "No there's not enough staff meetings to be brought up to date about residents, what's going on and what changes are coming" and "They're not regular enough, should be once a month to air views and grievances." The head of service told us they had recently consulted with the care leaders about improving communication with one option including increasing the frequency of staff meetings.

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

The management team responsible for the registered provider's homes, which included the registered manager for Windsor House had won City of York Councils' management team of the month award for May 2016.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not ensured that consent to care and treatment was sought in line with relevant legislation and guidance. Clear and complete records were not in place in relation to people's capacity to make decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not done all that is reasonably practicable to manage risks including where it related to the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured that sufficient numbers of staff were deployed in order to meet people's needs.