Joseph Rowntree Housing Trust

Lamel Beeches

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 26 March 2015 and was unannounced. We previously visited the service on 27 November 2013 and found that the registered provider met the regulations that we assessed.

The service is registered to provide nursing or personal care and accommodation for 41 older people. The home is located in a residential area of York in North Yorkshire. People who require nursing care and residential care are accommodated in one unit. There are four double rooms but they are currently being used as single rooms. All of the rooms were occupied on the day of the inspection. There is parking space at the home for visitors and staff.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC); they had been registered since 10 October 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

The management of medicines, including storage and administration, were not robust and there was a risk that people did not receive the medication that had been prescribed for them.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, now replaced by the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

People told us that they felt safe living at the home. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take in-house if they had concerns about someone's safety. However, staff were not always clear about how to escalate the concern outside of the organisation if needed. Staff told us that they were happy with other training provided for them.

We observed good interactions between people who lived at the home and staff on the day of the inspection although some of these were functional. People told us that staff were caring and compassionate and this was supported by the relatives / friends who we spoke with.

People told us they were supported to make their own decisions and to be as independent as possible.

People told us that there were not always sufficient staff on duty to meet their needs and that, although the permanent staff were good, they were not so keen on agency / bank staff. New staff were in the process of being recruited. We saw that recruitment practices at the home were not always followed to ensure that only people considered suitable to work with vulnerable people had been employed. We made recommendations about this under the safe domain within the report.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home. People's special diets were catered for but people were not always supported appropriately by staff to eat and drink safely. We made a recommendation about this in the report.

There were systems in place to seek feedback from people who lived at the home and people's comments and complaints were responded to appropriately.

The premises were generally well maintained so that they provided a safe environment for people who lived and worked at the home, but some issues were raised by people on the day of the inspection. We made a recommendation about this in the report.

People who lived at the home, relatives and staff told us that improvements were being made to the management of the home since the appointment of the new registered manager and the deputy manager. The quality audits undertaken by the registered manager were designed to identify any areas of concern or areas that were unsafe.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The care provided was not always safe.

The arrangements in place for the management of medicines were not robust and there was a lack of evidence that people had received the right medication.

Most staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

People told us that there were insufficient numbers of staff employed and they were concerned about the high number of bank / agency staff used.

Recruitment practices were designed to ensure that only those people considered suitable to work with vulnerable people were employed although records did not always support this.

The premises were generally well maintained but some issues were identified on the day of the inspection.

Is the service effective?

Good

The service is effective.

Staff received told us that they completed training that equipped them with the skills they needed to carry out their role and this was supported by the records we saw and the other people we spoke with.

People's nutritional needs were assessed and met, and people's special diets were catered for. We saw that staff did not always provide appropriate support for people who needed help to eat and drink.

People had access to health care professionals when required. Advice given by health care professionals was followed by staff to ensure that people's health care needs were fully met.

Is the service caring?

Good

The service is caring.

People who lived at the home and their relatives told us that staff were caring.

It was clear that people's individual needs were understood by staff.

We saw that people's privacy and dignity was respected by staff and that people were encouraged to be as independent as possible.

Is the service responsive?

Good

The service is responsive to people's needs.

Summary of findings

People's care plans recorded their preferences and wishes for care and these were known by staff.

People told us they were able to take part in their chosen activities although these had not happened consistently due to staff sickness. Relatives were able to visit the home at any time.

There was a complaints procedure in place and people told us that they were confident that any comments or complaints they made would be listened to.

Is the service well-led?

Good

The home is well led.

There was a registered manager in post at the time of the inspection.

The registered manager carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff.

There were sufficient opportunities for people who lived at the home and staff to express their views about the quality of the service provided.

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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 took place on 26 March 2015 and was unannounced. The inspection team consisted of an Adult Social Care (ASC) inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authority who commissioned a service from the home. On this occasion we did not ask the registered provider to submit a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we spoke with health and social care professionals to enquire about any recent involvement they have had with the home. On the day of the inspection we spoke with twelve people who lived at the home, six relatives or friends, eight members of staff (both care staff and ancillary staff) and the registered manager.

We looked at bedrooms (with people's permission) and communal areas of the home and also spent time looking at records. This included the care records for three people who lived at the home, staff recruitment and training records and records relating to the management of the home.

Requires improvement

Is the service safe?

Our findings

We spoke with twelve people who lived at the home and they told us they felt safe. We saw that one person had a call button on a pendant around their neck. They told us that someone came to them if they pressed the button. They told us that this made them feel safe. A relative told us, "I feel confident that (my relative) is in safe hands. I can come and visit any time I like – there's no restrictions. They're very responsive to suggestions."

We spoke with people who lived at the home about the topic of abuse and they told us that they would not hesitate to speak to one of the staff if they had any concerns. They were able to name members of staff who they would be happy to speak with.

Staff had completed training on safeguarding vulnerable adults from abuse and most staff were able to describe different types of abuse and the action they would take if they became aware of an abusive situation. However, one of the staff we spoke with was not confident about the action they needed to take if they became aware of an incident of abuse. Although most staff were clear how they would report any concerns within their organisation, some staff were not clear about who to report matters to outside the organisation, such as the local authority, the Police or the Care Quality Commission.

Prior to the inspection we consulted with the local authority who commissioned a service from the home. They told us that the organisation used a dependency scoring tool to advise on adequate staffing levels for the needs of people who lived in each service.

The registered manager was supernumerary to the staff rota unless she was required to cover short term sickness. A deputy manager had been appointed; they covered some nursing shifts as well as assisting with management duties. The standard staffing levels on a day shift were one registered nurse and six care assistants. In addition to care staff, there was a cook, a kitchen assistant and domestic staff on duty each day, plus an administrator and a part time activities coordinator. This meant that nursing and care staff could concentrate on supporting the people who lived at the home.

There were vacancies for two night care assistants but these posts had been filled; one person was due to start the week after this inspection and one was going through the recruitment process. In the interim period, agency staff were being used to cover some of the uncovered shifts. The registered manager told us that they were aiming to be overstaffed and to employ people on flexible contracts so that they would not have difficulty covering the rota when staff were absent. There were also vacancies for two kitchen assistants. The registered manager told us that staff vacancies had created a period of unsettlement but that this was now improving.

We asked people who lived at the home if they thought there were enough staff on duty. One person told us, "I think they're understaffed to cover the needs of the more poorly residents. The staff are overstretched. However, the care staff are exceptional. At least two sets of mothers and daughters work here – that says something" and another person said, "I don't think there's enough staff. Every shift could do with at least one more carer. They're rushed off their feet sometimes. I'm very conscious that they're very busy." People told us that staff did not come immediately when they rang the call bell, but that they did come quickly.

At lunchtime we observed that the dining room was not supervised; one care assistant attended the room intermittently. This meant that people did not receive the assistance they required and one person was not been protected from the risk of choking. This indicated to us that there were insufficient numbers of staff on duty to meet the needs of people who lived at the home.

Some people who lived at the home told us that they liked the permanent staff. One person said they were "A good team." They told us that the registered manager and the deputy manager interacted well together and that the registered manager was "Always available." However, some people expressed concern about the high number of agency staff used. They mentioned that they were aware that new permanent staff were currently being recruited. One person said, "I think once we've got the extra staff settled in, things will get better. You don't get to know agency staff and some of them aren't so good."

We recommend that managers review staffing levels in view of the comments made by people who lived at the home.

We asked one member of staff to describe the recruitment process they had gone through. They told us that they had completed an application form on which they had recorded the names of two referees. The employee had

attended the home for interview and had been offered the post subject to appropriate checks. The registered manager had requested a Disclosure and Barring Service (DBS) check on their behalf, and the employee had received a notification with the results. They shared the outcome of the check with the home, and provided the registered manager with copies of documents to confirm their identification. However, we checked the recruitment records for another employee and saw their application form was incomplete. The registered manager told us that they had received this person's DBS clearance but there was no record held to evidence this. In addition to this, the references returned by referees were not robust. This meant there was a lack of evidence that only people who were considered suitable to work with vulnerable adults had been employed.

We recommend that managers follow the organisation's policies and procedures in respect of the safe recruitment of staff.

The registered manager told us that the nurse in charge administered medication, although there was one senior care worker who was also trained to carry out this task. The keys for the medication room and cabinets were held securely.

We checked the medication records for two people who lived at the home. We saw that these were accompanied by a photograph to aid new staff with identification and reduce the risk of errors occurring. We checked the balance of medication held against records on medication administration records (MARs). We saw that there were some gaps in recording and it was not clear whether the medication had been given and the member of staff had forgotten to sign the records, or whether the medication had been refused and the member of staff had forgotten to record the appropriate code. For one person the tablets were not in storage so we assumed that they had been given but not signed for. On three occasions we saw that medication had been taken from the compartment for the wrong day. When people had refused medication there was no explanation to define this on MAR charts. One person had been prescribed a pain relief patch to be administered once a week. There was no instruction about what time the patch should be

administered or where on the body it should be adhered to.

We checked 'as and when required' (PRN) medication for two people and it was not possible to reconcile the records with the balance of tablets held. One person had returned from hospital with two prescribed medicines. It was not clear if they had taken any of these medicines whilst they were in hospital and they had not been counted when they arrived back at the home so there was no evidence that the balance held was correct. These omissions in recording or administration meant that there was a risk people had not received their prescribed medication at the right time.

One person was prescribed an anti-coagulant therapy medicine and we saw that this was recorded in a 'yellow book' as required. We were told that the clinic telephoned the home to report current dosages and then sent a fax through to the home as confirmation. We saw that the dosage was made clear in medication records. One person had been prescribed an antibiotic medicine. The records completed by staff for this additional medicine were not satisfactory.

When people had been prescribed creams, there was a chart on the back of their bedroom door so that staff could sign the chart as soon as the cream had been administered. One person had a care plan for the application of steroid cream to their legs. However, we noted that this medication was not recorded on their MAR chart.

One person told us that they had a Ventolin inhaler but they were not able to use it. We did not see any reference to this in the person's care plan. One person told us they received their evening medication "Pretty regularly" but things were not as organised when bank staff were on duty. At lunchtime we saw that the medication for two people was left next to them in a pot; there was a risk that this medication could have been taken by the wrong person in error.

We saw that care plans recorded details of any 'time critical' medication; this is medication that the person has to take at a specific time of day. This information was also recorded on a medication check list held by the person responsible for administering medication each day. There was a checklist for day staff and one for night staff. This checklist acted as a reminder for staff about each person who took medicine at each time of the day, and was designed to reduce the risk of errors occurring. Any temporary medication such as antibiotics would also be recorded on these checklists.

Requires improvement

Is the service safe?

The home were not following the medication policies and procedures of the Joseph Rowntree Housing Trust or the National Institute for Health and Care Excellence (NICE) Managing medicines in care homes 2014 guidelines, which states that staff must consider the six R's: right resident, right medicine, right route, right dose, right time and a resident's right to refuse.

We found that the registered person had not protected people against the risk of receiving the wrong medication. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, which corresponds to regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a team of maintenance staff employed by the organisation and the home was generally maintained in a safe condition. Portable appliances had been checked and there was a current gas safety certificate in place. We saw there was a fire risk assessment in place and the 'fire cupboard' in the reception area included the details of everyone who lived at the home. However, we noted that the details for some people had not been updated appropriately so the emergency services may not have been provided with up to date information.

One person told us that they were worried the thermostat in their room did not work. An engineer had checked it but said it could not be mended. They had been given an electric fire which they unplugged when not in use. This created some concerns for them as they had poor vision and had difficulty putting the plug in and taking it out, so had to use the call bell to ask staff to do this for them. The flex also created a trip hazard. Some people told us they felt the showers in the en-suite bathrooms were not the correct type for wet rooms and that they left pools of water on the floor. This created the risk of slips and falls.

We recommend that people are provided with equipment and facilities that meet their individual needs.

One person told us that they felt the code used to enter the premises should be changed from time to time to tighten security. They told us, "I do feel safe but I think they should change the codes on the main door from time to time. I don't like the idea that so many people know the codes." We were told that one person had left the home unaccompanied and that they were not safe to do so. As a result, bed sensors and door sensors had been fitted in their room. There had been no incidences of them leaving the home unaccompanied since they were fitted. However, we were concerned that a member of our inspection team entered the premises without having to wait to be admitted by a member of staff. They signed the visitor's book and no-one asked who they were. This raised concerns about the security of the premises.

Good

Is the service effective?

Our findings

People told us that they thought the staff who worked at the home had the skills they needed. However, people told us that they preferred the permanent staff to bank nurses. One person said about the permanent staff, "They are very pleasant and they listen to me." Another person told us that the permanent staff were competent and well trained.

We saw that people had been asked to sign a form to consent to the content of their care plan. However, one of the forms we saw did not include the person's name, apart from their signature. People had also been asked how often they would like to be checked whilst in their own room and this information was recorded in their care plan. Staff told us that they asked for consent before the started to assist people.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. We did not receive any information during this inspection to raise concerns about people being deprived of liberty unlawfully.

One new member of staff told us about their induction process. They said that, when they were new in post, they had shadowed an experienced member of staff for a week before they worked unsupervised. They had spent time with the deputy manager discussing moving and handling and were due to spend one day at the head office undertaking induction training, including safeguarding vulnerable adults from abuse. This member of staff told us that they had to work a six month probationary period and that they had already had a three monthly meeting with the registered manager, plus informal meetings with both the registered manager and the deputy manager.

The registered manager told us that they were in the process of introducing a new induction programme for staff; we saw the documentation on the day of the inspection.

Staff told us about the training courses they had attended. This included the topics of first aid, moving and handling, fire safety, health and safety and safeguarding vulnerable adults from abuse. Staff told us that they attended some training at the head office and some on-line. Staff told us that they had different trainers for different topics, and that there was usually a questionnaire for them to complete at the end of the training to evidence they had understood the content. One member of staff told us that they had not recently undertaken any training on dementia care and we did not see evidence of training on this topic in other staff records that we checked. This training would assist staff in providing appropriate care for people living with dementia.

Staff from the local authority who we consulted prior to the inspection told us that staff records were not well organised, for example, there were no file separators and documents were not in date order. The records did not consistently contain evidence of regular staff supervision, staff induction and individual training achievements.

People's specific health care needs were recorded, and we saw that this included any concerns about their level of pain. Appointments with health care professionals were recorded in the person's care plan, including visits by the GP and visits to the dentist.

The care plans that we checked included nutritional assessments that scored a person's level of risk. We saw that one person who had been admitted to the home in December 2014 had been weighed in December 2014 and February 2015. It was not always clear what action was going to be taken when someone was considered to be at high risk of malnutrition or weight loss.

We saw that one person's nutritional assessment identified that they were considered to be at 'high risk'. Their care plan recorded, "(The person) can cough and choke when eating. They drink Stage 1 thickened fluids. They will often refuse a drink if a thickener is added. Staff need to make her have a drink without the thickener and stay with her to monitor her drinking in case she chokes. If she is choking and coughing the drink needs to be removed." There was some general guidance about swallowing difficulties in the care plan but nothing specific to the person.

Any assistance a person needed with eating and drinking was recorded in their care plan, such as, "(The person) has difficulty using a knife, so needs their food cutting up." In addition to this, people's likes, dislikes and choices were recorded. One person's care plan recorded, "(The person) would like to be asked what they want for breakfast."

We observed the serving of lunch. We had seen in one person's care plan that they were at risk of choking. They needed to be reminded to sit upright, required their fluids

Good

Is the service effective?

to be thickened (Stage One) and needed to be provided with a teaspoon to eat with. We saw that they were not assisted to sit up straight and were given a fork to eat their meal. In addition to this, neither of the drinks they were provided with looked as though they had been thickened.

There were four people in the dining room. One person was asleep, one person was calling out for help, one person had finished their meal and one person was 'doubled over' trying to eat; this was the person who had been identified as being at risk of choking. One person was asked by staff if they would like a plate guard; they said they would and one was provided. However, the dining room was not supervised; one care assistant attended the room intermittently. This meant that people did not receive the assistance they required and one person was not being protected from the risk of choking.

One person told us they were happy with the food provided and said that they received enough food. Other people told us, "The food is absolutely marvellous" and "The cook and her team are superb." People told us that they were provided with a varied diet and that there were always alternatives available, including a vegetarian option. On the day of the inspection we saw that people who had not chosen either of the options on the menu had been provided with a jacket potato with cheese. They said the food was served hot. People told us that they were provided with ample drinks and that snacks were available if they wanted them, such as sandwiches, biscuits and cakes. One person said, "They listen to what we like to eat and there's a pantry on each floor where we can make snacks and things." We also saw that there was a large bowl of fruit available for people on the dresser in the dining room.

Staff were able to explain to us what a person's thickened drinks should look like and how the supplied the correct foods for someone who required a soft diet. We spoke with a cook who told us there was always enough food supplied and that they were able to provide a varied diet. They said that no-one was currently in need of a special diet but they described how they would provide an enriched diet for someone who needed to gain weight, such as adding cheese, cream or eggs into soup. They told us that they reviewed menu choices every six months and there was a comments book in the dining room so that people's suggestions could be taken into consideration. We saw that there was a food 'comments book' on the dresser in the dining room and that most comments were complimentary. The most recent comment dated from 2013 which indicated that people were not encouraged to make suggestions.

Good

Is the service caring?

Our findings

People told us that staff at the home were caring. One person told us, "Yes, we get the care we need. Staff are very pleasant and they listen to me" another person said, "The care is very good. The girls here are exceptionally good. They work very hard. I don't like the bank nurses so much though" and a third person told us, "Staff are kind, thoughtful and helpful." Two visitors who we spoke with on the day of the inspection told us that staff were kind. We spoke with a person's family members who told us they visited every other week to check that their relative's clothes were in good repair and to replace them with new clothes when necessary. They said they felt confident they were well looked after, and that the laundry took good care of their clothing.

We spoke with a GP who visited the home on the day of the inspection. They told us that they had no negative comments to make about the care provided and that staff made appropriate referrals to the surgery.

Staff who we spoke with told us they believed they provided the right care. One care worker told us, "It is how we have been trained. We always read through the care plans and we discuss people's needs at handover meetings." We saw that staff were friendly and pleasant but that their interactions with people who lived at the home were fairly functional.

We observed courteous and pleasant interactions between people who lived at the home and staff on the day of the inspection and it was clear that staff knew people well. However, we observed that there was little time for staff to chat with people. We also saw that one person was approached by a member of staff over lunchtime to tell them that their dentist had been in touch to change the time of their appointment and to ask for their account number with the taxi company so that a taxi could be booked. We felt that this exchange did not support the person's privacy and dignity and could have taken place after lunch.

The GP who we spoke with told us that they were always able to see people in a private room and that they were able to find staff to assist them. We asked staff how they promoted a person's privacy and dignity. They told us that they knocked on bedroom doors before entering and that they "Protected the person's modesty." One member of staff said the way they spoke with people was important; they always told people what they were doing next but they also encouraged people to do things for themselves whenever possible. People told us that they could lock their door from the inside, but staff could open their door in an emergency. This promoted their privacy but allowed them to remain safe.

People who lived at the home told us that they could have a bath or shower when they wanted one. Most said they had a bath or shower every week, with washes in between, but told us this was their choice. We saw that people appeared reasonably well groomed and clean, and were wearing clean, well-fitting clothes.

People's preferences for assistance with personal care, including their preference for a bath or a shower, was recorded in their care plans. One person said, "I can have a bath when I want one. If a carer came in and I said I wanted a bath, they would need a bit of notice but they would give me one." One person's care plan recorded that they liked to have a shower at a specific time on a specific day of the week. This evidenced that people had been consulted about their preferences for assistance. However, one person's care plan recorded that they liked a bath in one of the assisted baths on a Saturday. However, records seen in this person's care plan recorded that they had been helped to have a shower on four days in January and to have a bath on two days in February and one day in March. This evidenced that people had been consulted about their preferences for assistance but these preferences had not always being adhered to.

We saw that most people had their own telephone; this promoted their independence and their involvement with family, friends and the local community. People who lived at the home and relatives told us they could the visit the home at any time.

We saw that there was information on notice boards about living with dementia and information about local Healthwatch matters. One person told us that the latest CQC report on the home was available in the library, plus the home's policies and procedures manual. This meant that the home kept people informed about information that affected their lives at the home.

Good

Is the service responsive?

Our findings

We saw that care plans included an assessment of the person's care needs and that this information was used to develop an individual plan of care for the person which included information about their specific support needs, their likes and dislikes, their life history and family relationships.

Prior to the inspection we consulted with the local authority who commissioned a service from the home. They told us that current care plans referenced individual needs, preferences and wishes, as well as the aim of the care which, where relevant, referenced dignity and respect. They had noted that there were some examples of information not being cross referenced with other parts of the care plan, and parts of the care plan not being used to their full potential such as mental health and communication care plans. They told us that the organisation were in the process of 'rolling out' comprehensive new care planning paperwork. They said, "This should provide an opportunity to update care plans to ensure they incorporate the good elements of the existing system but address those areas where things could be better."

We saw that the information recorded in care plans would help staff to understand the person and provide more individualised care. One member of staff told us, "I love it (here). It's changed over the years. People tend to have much higher needs when they arrive here now. You do get to know people really well."

However, we did not see information to evidence that people's care plans were reviewed on a regular basis. One person's care plan recorded that they had been admitted to hospital with a fracture in February 2015. They were discharged from hospital almost one month later but there was no record of a review of their care needs since their discharge. We noted that this person's care plan recorded that they were fully continent but also that they had a catheter, which could have created confusion for staff.

People told us about the level of support they needed with their mobility. One person told us that they needed the support of two staff to help them out of bed and that they also required support to help them to the toilet and with their personal care needs. They were happy with the support they were receiving. People had been provided with equipment they needed to prevent the development of pressure sores, such as air mattresses and cushions.

We checked the complaints log and saw that there were three complaints recorded; two of these were classed as 'niggles' and one was classed as a complaint. The 'niggles' were in respect of missing clothes and furniture in the person's room. The complaint was about medication not being given. When asked, people said that they would feel comfortable raising concerns or complaints with the registered manager or another member of staff. One person who lived at the home told us, "I love it. I've loved it from the moment I walked in. I've got no complaints."

Two visitors who we spoke with on the day of the inspection told us that they were aware of who was in charge of the home and they would speak to them if they had any concerns. They said that they had no concerns but they were confident any problems would be "Sorted out."

Staff told us that, if people mentioned concerns or raised a complaint with them, they would initially try to sort the problem out themselves. If they were not able to solve the problem, they would report it to the registered manager or the deputy manager. We asked staff if they understood the principles of whistle blowing. One person explained the principles to us but was not able to explain the local processes. However, they did tell us they would report any concerns to a senior member of staff.

There was information available for people about advocacy services, including information about funding issues and information for carers about dementia care. This ensured that people were able to obtain independent advice if that is what they preferred.

The home is part of the Joseph Rowntree Housing Trust, a Quaker organisation, and a number of residents were Quakers. Quaker meetings were held every Sunday in the home, and mid-week meetings were held in an establishment next door. Other people belonged to churches of different faiths and they told us they received visits from members of their Church.

People told us that they liked the activities coordinator but that she was currently off sick. They told us that there had been little in the way of activities organised in her absence. One person said, "There's not enough to do. I get bored" and another person told us, "Activities have come to a halt

Good

Is the service responsive?

at the moment." Most people seem to stay in their rooms apart from at mealtimes. One person's care plan recorded that they liked to take part in armchair exercises and to join in the singing group but it was not clear if these activities were still being provided.

One person told us they went into the town with a friend once a week to listen to classical music in a particular cafe. Several people said that they were able to walk in the "lovely" grounds of the premises next door, and that the gardeners would make them up pots of plants for their verandas or patios; all rooms had French windows that look out on the gardens. A mobile library visited the home and the in-house shop 'opened' twice a week. One person's care plan evidenced they had access to audio books and there was a library with a magnifying reader, which a number of people told us they appreciated.

One person told us, "I forget things sometimes. Well, quite a lot really. But the staff come and remind me about the things I like to do, like the concert, and Quaker meeting. They make sure I don't miss things."

Good

Is the service well-led?

Our findings

People who we spoke with were able to name the registered manager and the deputy manager. One person said, "(Name) is in charge. We have a new under manager – she is a very nice girl. They know what they are doing." A member of staff told us, "We have a new manager. She is approachable so I can go to ask her questions. We see her around on the floor."

A new member of staff told us that they had already attended two staff meetings. They told us that they were made aware of the agenda and were asked if they would like to add any items for discussion. Another staff member told us that the minutes of meetings were displayed so that staff who were unable to attend the meeting were aware of the discussions held and any decisions made. Staff were asked to sign to confirm they had read the minutes. Staff told us that they had an opportunity to express their views and opinions at meetings.

Staff told us that they felt supported by the registered manager and the deputy manager. They said that they had an annual appraisal but the supervision was informal rather than formal. Some notes were taken but these were more like chats than meetings.

The registered manager undertook a variety of audits to monitor that the quality of the service was being maintained. This included audits for mattresses and infection control; the most recent audit in respect of infection control was undertaken on 26 August 2014. Mattress audits were carried out in August 2014 and March 2015. The mattress in one bedroom had been 'condemned' and replaced. The registered manager told us that they intended to carry out these audits every three months in future.

A satisfaction survey had been distributed to people who lived at the home during 2014. Thirty-five surveys had been sent out and 17 had been returned. We saw that the feedback received was generally positive. We saw that two action plans had been produced but there was no record to evidence that these had been followed up, although the registered manager assured us that the appropriate action had been taken. Prior to the inspection we consulted with the local authority who commissioned a service from the home. They also told us that regular resident surveys were carried out and that the organisation actively sought to address the issues raised.

People who lived at the home and relatives told us that they knew about the 'residents' meetings and that they attended. People told us that they were more impressed with the meetings held at the home than the meetings arranged by the Joseph Rowntree Housing Trust. One person who lived at the home said, "(The manager) listens – she's made such a difference to this place. I'm not confident of Joseph Rowntree Housing Trust though – the ethos isn't there."

The registered manager told us that she attended a monthly manager's meeting within the organisation and a nursing home forum. This enabled the registered manager to keep her practice up to date and share good practice guidance with the staff team.

On the notice board in the staff area we saw that there was information displayed to advise staff about safeguarding adults from abuse, whistleblowing and CQC standards. The previous CQC report was also on display.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person had not protected service users against the risks associated with the unsafe use and management of medicines.**