Joseph Rowntree Housing Trust

Lamel Beeches

Inspection report

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Date of inspection visit:
16 March 2017

Date of publication:
13 April 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 16 March 2017 and was unannounced. We previously visited the service on 2 March 2016 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 up to 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 is parking space at the home for visitors and staff.

The home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A previous application for a registered manager was submitted to the CQC in August 2016. However, the manager at that time left the organisation on 31st October 2016. During our inspection a new manager was in post and they supported us with our inspection. The manager informed us, and records confirmed they were in the process of submitting an application to be registered with the Care Quality Commission.

Records concerned with people, care workers and the running of the home were maintained securely and were available during our inspection. Some minor areas of information in records were not always recorded or up to date. The registered provider demonstrated an awareness of the concerns we found. They had implemented a system of robust audits and quality assurance checks on all areas of the service. This included time constrained actions for the review and completion for improvement of the identified areas of concern.

People were supported to maintain good health. Care plans identified persons daily care needs which included people's night-time support requirements and daily living. We found some minor recording issues with some of the charts in place in people's rooms that were used to record activities of care; however, people told us that this care was provided and that this was a recording issue.

People usually consented to care and support from care workers by verbally agreeing to it. Records included provision for people or their representative to sign their agreement to the care and support they received. The manager told us that the organisation was looking to implement a new tool to further improve people's ability to record their consent.

Care workers received support in their role from managers and senior staff. There was a process for completing and recording supervisions and annual appraisals and we saw this was being reviewed and updated.
Where people required support with their medicines this was done safely and people received their medicines as prescribed. We identified some minor deficiencies with records however, audits were in place to identify these concerns and processes were in place that ensured they would be addressed.

Systems and processes were in place that ensured sufficient numbers of suitably trained and competent care workers were on duty to meet and respond to people's needs and provide additional one to one support throughout the day. Pre-employment checks on employees were completed that helped to minimise the risk of unsuitable people from working with vulnerable adults.

Care workers confirmed they received induction training when they were new in post and told us that they were happy with the training provided for them. Training for care workers was managed electronically and care workers confirmed they were able to manage some of this on line.

We found that people were protected from the risk of avoidable harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Care workers received training on safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

The registered provider had systems and processes to record and learn from accidents and incidents that identified trends and helped prevent re-occurrence.

Systems and processes were in place that helped to identify risks associated with the home environment and when providing care and support with people. Associated support plans enabled people to live in the home in line with their wishes and preferences with minimal restrictions in place and care workers could provide the service safely.

Care workers had received training and understood the requirements of The Mental Capacity Act 2005 and the registered provider was following this legislation.

People were supported with a choice of food at meal times and any special food requirements were catered for. Snacks and hot and cold drinks were available for people throughout the day.

All care workers demonstrated a clear understanding of people's individual needs and preferences. They were caring and put people at the front of everything they did, treating them with dignity and respect and clearly communicated their intentions for people's comment and agreement.

Comprehensive packages of activities to meet both people's individual requests and as a group were provided by a dedicated activities co-ordinator. People spoke with enthusiasm about these changes and we found day trips were popular and in demand from people.

Staff told us that improvements at the home were evident since the new manager had commenced in post and that morale had improved. People told us they felt well supported and able to raise issues with the management team. We observed a warm and friendly atmosphere and it was evident that the manager and deputy were working hard to review all aspects of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient numbers of skilled care workers employed that ensured people received the service that had been agreed with them.

Care workers received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse to the relevant people.

Risk management plans were in place for the home and enabled people to receive safe care and support without undue restrictions in place.

People received their medicines safely as prescribed.

Is the service effective?

Good

The service was effective.

People were supported to remain healthy and choices of food were available. Drinks and snacks were available throughout the day.

Care workers received appropriate support and training that equipped them with the skills and knowledge to carry out their roll and meet with people's individual needs.

Care workers received supervisions and appraisal and the recording process was being improved.

The manager and care workers understood their responsibilities in respect of the Mental Capacity Act 2005 (MCA). Care workers supported people to make choices and decisions.

Is the service caring?

Good

The service was caring.

The feedback we received and our observations confirmed that care workers cared about the people they were supporting.

People's individual care and support needs were understood by care workers, and people were encouraged to be as independent as possible.

People's privacy and dignity was respected by care workers.

Care records were being reviewed to ensure where people had any protected characteristics under the Equality Act 2010 that these were clearly recorded in an accessible format.

Is the service responsive?

Good

The service was responsive.

People were happy with the care they received and confirmed care workers were responsive to their individual needs.

People's care plans recorded information about their individual care needs and their preferences.

There was a complaints procedure in place and people told us they knew who to speak with if they had a concern or a complaint.

People were encouraged to participate in activities of their choosing both as groups or on their own and they spoke highly of the activities coordinator and the programme in place.

Is the service well-led?

Good

The service was well led.

Where we found records and paperwork was not always up to date, the registered provider had an awareness of the shortfalls and had systems and processes in place to bring about improvement.

Everybody spoke highly of the manager at the home and the organisation.

The registered provider sought the views of people and implemented actions where the service fell short of expectations.

Lamel Beeches

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 16 March 2017 and was unannounced. This meant that the registered provider and staff did not know we would be visiting.

One Adult Social Care (ASC) inspector, one ASC inspection manager and an expert by experience undertook the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of people in the early stages of dementia and older people who use regulated services.

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 eleven people who lived at the home. We spoke with five relatives, three care workers, two ancillary staff, the deputy manager, the head of quality and compliance and the 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 five people who lived at the home, staff recruitment,

medicine records and training records and records relating to the management of the home.

We observed people's experiences of the home that included, the dining experience, medicines administration process, an activity session in the lounge area and care interactions in the communal lounges and dining area.

Good

Is the service safe?

Our findings

People we spoke with who lived at Lamel Beeches told us they felt safe living there. One person who used the service said "I feel very safe and comfortable. I know if I need help someone will come when I press my buzzer".

Care workers had received safeguarding training and understood the types of abuse to look out for and how they would escalate their concerns. A care worker said, "I receive regular training in safeguarding, we discuss people's needs regularly and document important events after each shift, where I have any concerns I would report those to our manager or if I had concerns about bad practice, I would report that to the whistleblowing email at the CQC [Care Quality Commission]".

The registered provider had a 'Safeguarding Adults Policy & Procedures' document that set out the responsibilities of all staff, volunteers and managers who worked within Joseph Rowntree Housing Trust to protect adults from abuse or neglect. We reviewed information the registered provider had submitted to the CQC since our last inspection. This included four safeguarding referrals. We found that reviews had been concluded in line with the services policy and procedures and where appropriate guidance from the City of York Council safeguarding team. Appropriate investigations and actions had been implemented that helped to prevent re-occurrence and to keep people safe.

We saw that people had risk assessments in place for falls, infection control and administering of people's medicines and that these were reviewed and updated with the involvement of people, families and professionals.

The registered provider had a health and safety file and staff wellbeing file. This included a monthly fire safety inspection record and information on the safe control of substances hazardous to health (COSHH). Additional information included risk assessments that identified a particular hazard, the person in danger, measures in place to reduce the risks and this information was reviewed. Identified hazards included, cleaning, kitchen areas, caring for people and those associated with the premises and hazards associated with people such as abuse, alcohol, falling and pressure areas. This information ensured that where risks were identified measures were in place to help everybody stay safe.

The home benefited from a maintenance team employed by the organisation. This meant where repairs and ground keeping were required, the registered provider had access to a team to provide repairs in a timely manner. Other contracts were in place to keep the home safe and these included, portable appliance testing (PAT), gas and electric test certificates, equipment for the moving and handling of people, test certificates and maintenance of water outlets to control the risks from legionella. All of these checks were up to date.

We were shown around the home and we saw that some people had bed rails in place to keep them safe. People's care plans contained an assessment of suitability to use bed rails and where they were in place risk assessments ensured they were managed safely. Where assessments of the suitability of bed rails had been completed and the equipment was not deemed appropriate, alternative low profile bedding was in place to

keep people safe from avoidable harm. This information and consent forms for use of bed rails by people was signed and reviewed. The person or a family member signed where the person was unable to sign these. We saw that equipment was assessed for safety and that this was recorded. A care worker told us, "We visually check bed rails and the associated equipment as part of our daily routine and any concerns are documented". We looked at this documentation which included recorded weekly checks. Where any concerns were recorded we saw these had been actioned in a timely manner.

The registered provider had systems and processes to record and learn from accidents and incidents that identified trends and helped prevent re-occurrence. Information was recorded on an electronic system and we saw these were processed and evaluated centrally. This meant the manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed.

We saw people were kept safe from the risk of emergencies in the home. People had a risk assessment in their care files for the environment and a personal emergency evacuation plan (PEEP). PEEPs are documents, which advise of the support people need to leave the home in the event of an evacuation taking place.

We looked at staffing levels across the home. The registered provider used an electronic staffing dependency tool to calculate the appropriate staffing levels to meet the dependency needs of the people using the service. We looked at staff rotas; we saw there were sufficient numbers of suitably trained and competent care workers, and that staffing levels were regularly reviewed. The manager told us, "We have sufficient care workers to meet people's needs and to support them". A care worker said, "We have enough care workers to provide care and support people with chosen activities, it has improved a lot and moral is really good". Another care worker told us, "We do use agency which can be difficult if they are new to the home as we have to train them, but usually we have the same care workers which provides consistency of support for people". People we spoke with who lived at Lamel Beeches told us they thought there were enough skilled care workers to deal with their needs. One person said, "They [care workers] do everything for me, I depend on them totally". Comments from the relatives we spoke with aligned with this view. One relative said, "Knowing that my relative is safe, is a big thing for me as they tend to wander about and the care workers know how to deal with this".

The registered provider had a robust recruitment process. Checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. These checks help employers make safer recruiting decisions and help to minimise the risk of unsuitable people from working with children and vulnerable adults. It was clear that these checks had been undertaken and that the registered provider had received this information prior to the new employees starting work at the home. We saw nursing staff registration checks were maintained with PIN numbers, expiry dates and appropriate qualifications and that these were up to date. The manager monitored when nurse registrations were due to be renewed, to verify they were safe to practice.

People had records of assessments in their care plans that provided information with the amount of support they required with their medicines. This was reviewed and people signed to agree to any support they required. The registered provider had a medication policy and procedure in place and along with information on handling medicines in social care, provided care workers with guidance to administer medicines safely. We observed a medication round and an additional administration of a controlled drug (CD) at the service (controlled drugs are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001).

We saw medication administration records (MAR) charts were kept in people's rooms and that care workers did not sign the MAR chart until they had observed that the person had taken their medication. Weekly audits were completed to check that care workers were recording people's medicines accurately. The deputy manager told us if a care worker missed three recordings, they would receive a supervision and additional training. The registered provider had taken steps to ensure care workers were competent with the correct skills to deliver and record medication in a safe way to people. We identified some minor deficiencies with records in regards to stock balances and administration of creams. However, the registered provider was addressing these concerns and despite the recording issues we found that people received their medicines safely and as prescribed. We have reported on this further under the well led section of the report.

We checked the storage and recording of CDs and found these followed appropriate guidance. These medicines were stored in a locked CD cabinet within the medication cupboard in line with regulations (misuse of drugs [safe custody] regulations). Access to CD's was restricted and the keys held securely. Temperatures of storage were taken and recorded daily. We saw that recording was accurate and the amount of medication held matched the balance recorded in the CD book. We saw that the deputy manager checked the CD book regularly to ensure that the records and the amount of medication held in stock balanced.

Good

Is the service effective?

Our findings

People and relatives we spoke to were content with the care workers at Lamel Beeches. One relative said "There are regular care workers on duty who know [person's name] and their likes and dislikes". One person confirmed, "They [care workers] care for me very well". Another said, "I am happy, safe and well fed what more could I ask for".

People usually consented to care and support from care workers by verbally agreeing to it. Care workers confirmed they discussed care and support with people and asked them if they understood and were happy with what they were doing. We found people had been involved in their care plans and although it was clear their consent had been sought, it was not always consistently recorded. The manager told us that they had recognised this and that the organisation was looking to implement a new tool to record people's ability to consent.

Where people received support with their medicines, records included a support plan and a consent form. Both records had the provision for the person to sign their agreement but we found only the consent form had been signed. The deputy manager told us they only encouraged people to sign their consent as this was the overriding agreement with the person that they were happy with the care and support in place. They told us, "We are updating care plans and we are reviewing the way we record people's consent to their care and support".

Care plans we looked at included a 'Do Not Attempt Cardiopulmonary Resuscitation, (DNACPR). We saw these were available at the front of peoples care plans with the rationale for this decision. However, we found the duration of the decision had not always been completed with a review date or checked to indicate the decision was for life. This was the responsibility of the GP and the manager told us they would follow this up to ensure the records included all the relevant information required. DNACPR orders are a decision made in advance should a person suffer a cardiac or respiratory arrest about whether they wished to be resuscitated.

Care workers told us they were supported in their role and records of some supervision and appraisals were evidenced from documentation in care workers files. This process was confirmed from discussion with care workers. A care worker said, "I do have one to ones, I had one about three weeks ago and they are every couple of months". Another care worker said, "I had supervision in December and one in February". The deputy manager told us, "Staff support, including supervisions and appraisals will be structured into the year and will include observed supervisions where we can assess their competencies". We were provided with a new matrix that the manager intended to implement to record this support for care workers. We saw this included planning for three supervisions, one group supervision, one observed supervision and an annual appraisal.

All care workers completed an induction to their role and the home. Where care workers had started their role and this had not been completed we were provided with dates when this was due. New care workers completed a new induction process that incorporated the Care Certificate. The Care Certificate is an

identified set of standards that health and social care workers adhere to in their daily working. We looked at care workers files and saw the induction covered eight principles of care that included, duty of care, person centred approaches, positive behavioural support, equality and diversity, privacy and dignity, health and safety and infection prevention and control. This demonstrated how care workers were supported to understand the fundamentals of care.

The registered provider had systems in place that ensured care workers received the training and experience they required to carry out their roles. Care workers confirmed they were able to manage their own on line training. We were provided with records for four care workers that confirmed details of training completed and where any was due to expire refresher training had been booked. The manager showed us a 'Training and Learning and Development Plan' that included daily scheduled training between January and July 2017. This included areas of learning the registered provider considered to be mandatory such as moving and handling, safeguarding and medication along with other training that included dementia awareness, end of life, challenging behaviour, food safety, diabetes, nutrition and hydration, fire safety and infection control.

We saw from care worker files that they received certified training in dementia awareness that included a 'Virtual Dementia Tour.' This provided care workers with an understanding of what it is like for people to live with dementia. A care worker told us, "The dementia awareness training is really good and provides an insight into how people live with dementia which enables us to provide better support to meet their needs".

Care workers had received training and understood the requirements of The Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked and found the registered provider was working within the principles of the MCA and any conditions on authorisations to deprive a person of their liberty were being met. One person was deprived of their liberty to leave the building unaccompanied for their own safety. A previous DoLS approval had expired for this person and a new application had been submitted by the manager for a further assessment and authorisation to the City of York Council. A DoLS provides a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm.

We observed lunch time at Lamel Beeches. The dining rooms were clean and spacious and the atmosphere was pleasant. The tables in the dining room were laid with place mats, paper napkins and fresh flowers.

Six carers served lunch to 21 people in the dining room and to eleven people in their own rooms. Most people were assisted into the dining room in their wheelchairs and ate their lunch sitting in their wheelchair. However, some were offered the choice of sitting on a dining chair.

People were asked what they wanted for lunch; all had a choice of hot meals including a vegetarian option and choice of desserts. The home also offered the choice of a hot meal, soup or salad at tea time. People ate their food at their own pace and were not rushed by care workers. People were offered clothes protectors and several had adapted cups and bowls rather than plates that helped them to eat independently. Care workers were aware of people's likes and dislikes and where people needed help they encouraged them to

eat. Where support was required staff demonstrated sensitivity.

The manager told us the chef had been away from work and the registered provider had relied on the use of agency staff in the kitchen. This had resulted in a decline in the expected standards at meal times but the manager assured us this had been addressed. When asked about the food they received, views from people were varied. One person said, "The lunch today was nice but the food isn't always cooked that well". Another said, "The food here is the best I have had and they go out of their way to give you what you want". We saw hot and cold drinks and snacks, such as biscuits were available during the day. New menus were due to be implemented following people's feedback.

The kitchen had a food hygiene rating [FHRS] award of 4. The rating was awarded on 12 January 2017. Ratings are based on how hygienic and well-managed food preparation areas were on the premises. A food preparation facility is given "FHRS" rating from 0 to 5, 0 being the worst and 5 being the best. An FHRS rating of 3 is acceptable.

People were supported to maintain good health. Care plans contained detailed information to ensure people were not at risk of malnutrition. We saw the use of 'Malnutrition Universal Screening Tool' ('MUST'). These were completed monthly and where risks were identified, we saw the person's care and support plan had been updated.

People were clear about how they could get access to their own GP and that care workers in the home would arrange this for them.

The home was easy to navigate. The corridors were wide and mainly straight with no obstacles, making it easy for people to move around if they wished and gave good lines of sight for care workers to identify if people needed assistance. There were key pad locked doors on the main exit.

There were signs on rooms such as the toilets and bathrooms and some minimal directional signage around the home which would help people to move around independently; especially people living with dementia. During discussions with management it was clear that plans were being considered to make the environment more dementia friendly.

The communal areas and rooms were clean and there were no unpleasant odours.

Good

Is the service caring?

Our findings

People we spoke with expressed the view that they were well cared for. Comments included; "The care workers are marvellous they look after me really well," and "I feel very well cared for". When asked if care workers cared about people who lived at the home, one relative said, "Yes the care workers are very caring".

We observed care workers interacting with people throughout the day. We saw care workers were polite and sensitive to people's needs. For example, they knocked on people's doors and asked if people were happy for them to enter. A care worker told us, "It's important we respect people's privacy, this is their home and should be treated accordingly". Relatives said that they felt care workers encouraged people to be as independent as possible and treated their relatives with dignity and respect. People who used the service also confirmed this. One said "I can get up when I like, the care workers are good at letting me decide when I want to do things".

Care workers showed patience and empathy as they helped people around the home, including taking them to the dining room or lounge. During interactions with people we noted care workers would chat about what they wanted to do or about their families. It was clear they knew about the people and their likes and dislikes. Care plans included this information and a care worker told us, "People have fascinating histories and always have a tale to tell, some information is available in their care plans as a starting point but we really get to know people by chatting with them and their families". They continued, "We treat them as we would one of our own families". People were comfortable in the presence of care workers and other staff at the home. We observed many instances of effective care and support including care workers providing support and reassurance to a person who was upset.

At the time of our inspection, the service was providing care and support to people who had some of the protected characteristics as defined under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). We were told that those diverse needs were adequately provided for. The manager provided us with a copy of a 'diversity and equality' statement. This document helped to define and champion equality, diversity and human rights as defining values of the organisation. The document promoted equality of opportunity for all. Records confirmed care workers had completed training in equality and diversity. Records included some limited information to provide people with care and support appropriate to their needs. For example; people had access to religious services of their choice. The deputy manager confirmed new records were to be developed to reflect this information and record it in a more accessible format.

People's preferred methods of communication were acknowledged in their care records. For one person, care workers were made aware the person had suffered a stroke, wore varifocal glasses and no hearing aids. The record confirmed the person's speech could be easily understood. Another person had a documented hearing aid and guidance for care workers to ensure they checked this was on when having a discussion.

Where people were unable to communicate and make bigger decisions, we saw the registered provider had included family members in the decision making process or where this was not possible the use of an

advocacy agency had been sought. For example, we saw from care plans, that where people did not have full capacity or were unable to express their views they were provided with information and assisted to make a referral to an advocacy service. Advocacy is a process of supporting and enabling people to express their views and concerns and enables people to access information and services to promote their rights and responsibilities.

People were supported to make their preferences for end of life care known and these were recorded where they had agreed.

Good

Is the service responsive?

Our findings

The people we spoke with were happy that care workers understood how to meet their care and support needs. Everybody who lived at the home had a care plan in place. We saw regular reviews were carried out and people using the service and their relatives were involved in these. People and their relatives confirmed they had seen their care plans and some confirmed they had been involved in review of the information. This helped to ensure that the care provided was consistent and met people's changing needs.

We looked at five care plans and saw they contained a one page person profile; 'What is Important to Me'. This provided a background of information centred on the individual. Information included what the person liked to be called, a personal history, current and past interests, keeping in touch with people and information on doing things the person liked to do. We also noted records included information on the person's next of kin, contacts and information on any allergies. A care worker told us, "The care plans are really good and provide us with a holistic overview of the individual, their lives and how to provide care and support in line with their preferences". We saw this information had been completed with and in some cases agreed to, by the person or their relatives.

Care plans identified a person's daily care needs which included people's night-time support requirements and daily living; including bowel movement, blood pressure, weight and skin integrity plans. We saw these were reviewed at least monthly and as appropriate, involved multi discipline team visits to help support and care for people.

We found some minor recording issues with some of the charts in place in people's rooms that were used to record activities of care for example, repositioning of the person, which were not always up to date. However people told us that this care was provided and that this was a recording issue. We have made further reference to this in the well led section of the report.

We saw other recorded information which helped care workers and others involved with people's care and support to provide care and support that encouraged people's independence. We saw areas of need associated with people's personal care, mobility, eating and drinking and medication was recorded that included the level of support required to assist the individual. A care worker said, "The care plans enable us to empower people to remain as independent as they can for example when I wash [person's name] I encourage them to wash their face and hands whilst I wash their back and neck, so I am really assisting them and not doing it all for them". Another care worker said, "[person's name] likes to take their own medicines but they like us to prepare it and record it, so that's what we do and it works very well".

We saw people were supported to follow their interests and take part in social activities. We looked at people's care plans and we saw they included a risk assessment and associated support plan to ensure people could undertake activities of their choosing safely and without unnecessary restrictions in place.

The activities co-ordinator and care workers undertook activities with people and people were encouraged to join in if they wished. On the morning of the inspection we observed an exercise class taking place. People

spoke to us with excitement in their voices about what was happening. The activities co-ordinator spoke to people individually, they provided humour, and encouraged a sense of involvement for everybody. Care workers were on hand to assist anybody and ensured drinks were available where people needed one. It was clear everybody enjoyed the session with people asking about the date of the next event. In the afternoon there was bingo in another area of the home. We observed care workers encouraging people to be involved.

The activities co-ordinator provided us with a copy of weekly activities, events, visitors to the home and outings. Activities were varied to try to encourage as many people to get involved as possible and took into account that women and men might want different types of activities such as knitting or indoor bowls. A visit from a music education group was planned and involved a sing along and African drums. The activity co-ordinators also undertook activities with people who did not leave their room to ensure that they had social interaction if they wanted it and remained free from isolation. The home organised trips out, for example to a local garden centre. There was quite a high demand for trips and care workers tried to ensure that different people had the opportunity to go on trips. People spoke highly of the improvements with activities on offer and the manager told us the introduction of a dedicated activities co-ordinator since January had made a real impact on improving people's lives and wellbeing.

People using the service were encouraged and supported to develop and maintain relationships with people that mattered to them. Friends and relatives were able to visit at any time. Relatives said they felt welcome and had a good relationship with care workers and management. They told us they felt involved in decisions about the health and welfare of their loved ones and that communication between the home and themselves was acceptable. A relative said, "I always get an invite to meetings where I can express any views or provide feedback and the manager is very approachable".

Care workers we spoke with told us they encouraged people to raise any concerns or complaints and people confirmed they would speak with a member of staff or the manager if they wanted to complain. A care worker said, "I always ask people how they are and encourage their feedback, if they raised any concerns I would ask them if they wanted them escalating or I might be able to sort out a small concern immediately". The registered provider had a complaints policy and we saw this was available on a noticeboard in the home. The document included guidance on how to complain and what to expect as a result. We evidenced six complaints had been recorded since our last inspection. These had all been responded to appropriately with clear actions recorded. The complaints policy confirmed 'Any actions that are taken are reviewed to help us improve our service and learn from any mistakes we make.' We saw a process of evaluation was completed centrally at the head office that enabled actions to be implemented that helped mitigate any reoccurrence and improve the service for everybody.

Good

Is the service well-led?

Our findings

During our inspection we looked at records and paperwork that was used to manage the service and to ensure care workers received appropriate support to provide people with safe care and support appropriate to meet with their needs whilst respecting their choices and preferences. Information was maintained securely and was available for us to inspect.

We identified some missing areas of information in records that was not always robustly recorded or up to date. This included some records in regards to people's consent to care, some errors and omissions of some recording on medication administration records. Charts and documents to record people's treatment for example turn charts, stool charts and records relating to administration of people's creams were not robustly recorded or up to date and some lacked guidance for care workers to follow. Despite electronic monitoring of training for care workers we found some training had expired before refresher training had been implemented.

We discussed our concerns with the head of quality and compliance, the manager and the deputy manager. There was awareness of the concerns we raised and we were shown action plans to address the issues we highlighted. The manager said, "We are keen to get things right and will implement any changes required". After our inspection we received further evidence of the actions being taken to address any shortfalls we found. The registered provider confirmed the dates the outstanding training was booked and confirmed this had been completed.

We were provided with audits and quality assurance checks the registered provider completed to monitor and improve the way the service was delivered. Information for the associated action plan dated March 2017 was comprehensive and identified a number of actions for implementation as a result of the audits completed. The list of proposed changes to improve the service was comprehensive across the service and included areas of concern we had identified in our inspection. We found areas including care planning, recording, medications administration and management, survey responses, feedback mental capacity assessments and consent to care and treatment had actions for improvement with defined timescales for review and progress.

Staff told us that improvements at the home were evident since the new manager had commenced in post and that morale had improved. People told us they felt well supported and able to raise issues with the management team. We observed a warm and friendly atmosphere and it was evident that the manager and deputy were working hard to review all aspects of the service.

The home is required to have a registered manager in post. A previous application for a registered manager was submitted to the CQC in August 2016. However, the manager at that time left the organisation on 31st October 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of our inspection a new manager was in post and they supported us with our inspection. The manager informed us, and records confirmed they were in the process of submitting an application for registered manager and expected to have this completed within the six month timeline for completing the registration process, by 30th April, 2017.

The manager had a good understanding of their role and responsibilities. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. Important events include accidents, incidents or allegations of abuse. We had received four notification from the registered provider since our last inspection and the manager was able to discuss these and we were provided with outcomes and actions implemented as a result.

Everybody we spoke with spoke highly of the manager and the organisation as a whole. A care worker said, "The manager is brilliant, I can approach them with anything, we have meetings and can raise issues; things get done". Relatives and people who we spoke with told us they felt they could approach the manager with any problems they had.

The registered provider had recently employed a deputy manager and along with senior care workers ensured there was a staffing structure at the home. All care workers we spoke with confirmed they had a clear understanding of their roles and responsibilities and understood when they needed to escalate any concerns or issues.

The manager held regular staff meetings and we looked at minutes of the last two meetings. Topics for discussion included new care workers, care planning and reviews, timesheets, holidays, people Christmas presents, medication, supervisions structure, training and development. Care workers confirmed they attended these meetings and found them helpful. A care worker told us, "We have regular meetings, they are a useful point to be updated on what is going on in and around the home and we can raise any issues for discussion".

We saw that people's care was person centred and empowered people to make choices and encouraged their independence in a safe, managed way. Care workers told us they were supported and kept up to date with changes, not just for people but also in best practice and organisational changes. A care worker told us, "We receive updates about people's needs at staff meetings and during reviews and we also document information after each shift in daily hand over notes in people's files".

We saw from care plans that the registered provider worked effectively with external agencies and other health and social care professionals to provide consistent care, to a high standard for people. As part of our feedback request a health professional told us, 'We have no current concerns regarding Lamel Beeches, and have had no feedback from social work or safeguarding teams about the home.'

We were shown an annual survey that had been sent out to people receiving a service at the home to gather feedback on how they perceived the service they received. The survey was based on the five key lines of enquiry inspected by the CQC. People who use the service were asked how far they agreed with a number of statements: Strongly Agree, Agree, Neutral, Disagree and Strongly Disagree. When people disagreed with a question, they were asked to comment as to the reason why. People confirmed they were offered support from care workers in the completion of the surveys. We saw that 34 people had been sent a survey and 15 were returned completed. The information was collated and evaluated. A summary provided areas of the service people were happy with for example, almost 88% of people agreed that care workers were caring and supportive and over 80% of people agreed that they felt safe. Areas that required action included only 24% of people said they had been involved in decisions about their care and only 23% of the people said

they felt they could contribute to the running of the home/service if they wanted to. Recommendations were documented and actions agreed were added to the services 'Quality Management System' action plan and monitored for completion by the service manager and head of care services.