New Forest Quaker Care Home Limited

Quaker House

Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 October 2016 and was unannounced.

Quaker House is a purpose built residential care home for up to 40 older persons. It is located in a quiet residential area, close to the centre of New Milton. The registered provider is New Forest Quaker Home Limited who is also a registered charity run by a board of Trustees. The Trustees meet on a regular basis to discuss and decide on all issues concerning Quaker House. At the time of our inspection there were 29 people living at the home. The home provides both short and long term residential care and day services. It does not provide nursing care or specialist support for people living with dementia or those who might display behaviour which might challenge others.

The home is arranged over two floors which are accessed by stairs, a stair lift or a passenger lift. There are three communal lounges and a dining room. The 40 single rooms all have ensuite facilities. There are bathrooms and a shower room on each floor and kitchenettes with fridges where residents can make their own food and drinks. Many of the people living at the home were generally quite independent and only required minimal support with some aspects of personal care or support with their medicines management and the provision of meals. Some were able to use their mobility scooters to visit the town centre and storage for these was provided.
There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Some areas required improvement. Staff displayed a commitment to protect people from harm and to protect them from abuse. However, potential safeguarding concerns had not been appropriately escalated to the local authority safeguarding teams.

The service did not have a structure to continuously monitor incidents, accidents or near misses for any trends or patterns that might allow actions to be taken to prevent similar incidents from happening again. Audits were not undertaken on a regular basis to measure the delivery of care, treatment and support given to people against current guidance.

Staff had not always taken appropriate steps to identify and mitigate risks to people's wellbeing and safety and improvements were needed to ensure that all aspects of medicines were managed safely.

People and their relatives were positive about the care and support they received. Staff knew people well and understood how to meet their individual needs. However, some people's care plans needed to be updated. Others needed to include more detailed and specific guidance about how to meet people's needs.

There were sufficient numbers of experienced staff deployed to meet people's needs at this time. The level

of dependency of people using the service was increasing however, and so the registered manager would benefit from having a more systematic approach to determining staffing levels. We have made a recommendation about this.

Staff had received an induction and on-going training. However, the registered manager was not able to demonstrate that staff had received an annual appraisal. Supervision had also not been taking place on a regular basis. This was however, an improving picture.

Additional training was needed to help ensure that going forward staff fully understood the key principles of the MCA 2005 and how and when it might be appropriate to apply for a DoLS.

People were positive about the quality of food provided. They received a choice of meals and were supported to have a nutritious diet.

Staff had developed effective working relationships with local healthcare professionals to ensure that people received co-ordinated care, treatment and support.

People told us they were cared for by kind and caring staff who respected their choices, their privacy and dignity and encouraged them to retain their independence.

People received care that was responsive to their needs. Staff knew people well and had a good knowledge of their likes and dislikes.

People enjoyed the activities provided but felt further improvements could be made to ensure the activities remained relevant and were in keeping with their interests and wishes

People told us they were able to raise any issues or concerns and felt these would be dealt with promptly.

People spoke positively about the registered manager who had a good knowledge about the people being cared for within the service.

We found three breaches of the Health and Social Care Act 2008 (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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Staff displayed a commitment to protect people from harm and to protect them from abuse. However, potential safeguarding concerns had not always been escalated appropriately to the local authority safeguarding teams.

Staff had not always taken appropriate steps to identify and mitigate risks to people's wellbeing and safety. Improvements were needed to ensure that medicines were managed safely at all times.

There were sufficient numbers of experienced staff deployed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective

Staff had received an induction and on-going training. However, the registered manager was not able to demonstrate that staff had received an annual appraisal. Supervision had also not been taking place on a regular basis. This was however, an improving picture.

Additional training was needed to help ensure. That going forward, staff fully understood the key principles of the MCA 2005 and how and when it might be appropriate to apply for a DoLS.

People were positive about the food provided. People received and were supported to access healthcare services when needed.

Is the service caring?

Good

The service was caring.

People told us they were cared for by kind and caring staff and were treated with dignity and respect.

People were empowered and encouraged make decisions about how their care should be provided and staff did not restrict

people's choices and interests.

Is the service responsive?

Good

The service was responsive.

People received care that was responsive to their needs. Staff knew people well and had a good knowledge of their needs.

People enjoyed the activities provided but felt further improvements could be made to ensure the activities remained relevant and were in keeping with people's interests and wishes.

People told us they were able to raise any issues or concerns and felt these would be dealt with promptly.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have a structure to continuously monitor incidents, accidents or near misses for any trends or patterns that might allow actions to be taken to prevent similar incidents from happening again. Audits were not undertaken on a regular basis to measure the delivery of care, treatment and support given to people against current guidance.

People's care plans needed to be updated. Others needed to include more detailed and specific guidance about how to meet people's needs

People spoke positively about the registered manager who had a good knowledge about the people being cared for within the service.

CareQuality Commission

Quaker House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

This was an unannounced inspection which took place over two days on 25 and 26 October 2016. On the first day of our visit, the inspection team consisted of one inspector. On the second day, the inspector was joined by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the service tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with sixteen people who used the service and three relatives. We also spent time observing aspects of the care and support being delivered. We spoke with three Trustees, the registered manager, deputy manager, the chef, the maintenance person, a member of the reception team and four care staff. We reviewed the care records of four people in detail and checked specific elements of the care records for a further two people. We also viewed other records relating to the management of the service such as audits, incidents, policies, meeting minutes, training and supervision records and staff rotas.

Following the inspection we sought feedback from five health and social care professionals and asked their views about the care provided at Quaker House.

The last inspection of this was service was in July 2013 when we found no concerns in the areas inspected.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Quaker House. One person told us "Yes I feel safe, I could have had people in at home, but it's not the same". Another person showed us their pager, they said, "I have this thing…I feel very safe in the building, I don't go out much since my fall, the staff are very good". A third person said, I feel safe here, the staff are all very nice". A relative said, "[their family member] is very happy here, they feel safe".

Staff had received training in safeguarding adults, and displayed a commitment to protect people from abuse. The provider had a safeguarding policy in place which described the procedures and processes in place to safeguard people from harm. However, whilst we found that the care provided by the service was mostly good, records showed that a small number of people had on occasion experienced poor care some of which raised safeguarding concerns. Whilst the management team was taking action to address the concerns, they had not escalated the matter to adult services.

Staff had not followed local guidance regarding the actions that should be taken in response to concerns about abuse. This is a breach of Regulation 13 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the registered manager has spoken with Adult Services and is working with them to investigate the concerns under local safeguarding procedures.

Improvements were needed to ensure all of the environmental risks to people were assessed and managed. The provider had engaged an external contractor to monitor the safety of the water systems within the service. The records we viewed indicated that in some cases the temperature of the hot water being discharged from wash hand basins and from showers was in excess of safe limits as recommended by the Health and Safety Executive. The registered manager told us that there was an on-going programme underway to replace the thermostatic mixer valves which regulate the temperature of the water throughout the home, but no action had been taken to safeguard people from the risk of scalding whilst this was underway. The registered manager has since the inspection made arrangements for the required work to take place within one week.

Improvements were needed to ensure that all of the individual risks to people's safety and wellbeing were adequately assessed and managed. We observed that a number of people used the stairs to access the upper floor, but their ability to do so safely had not been risk assessed. Falls risk assessments were in place but we noted these were not always being completed correctly. This limited their effectiveness as a risk management tool. One person was known to be at risk of falls, but they did not have a falls prevention plan or a mobility care plan. One person had a risk assessment with regards to the use of bed rails. The bedrail risk assessment stated that there was a risk of the person climbing over the rails but there was no information about how this risk was to be managed.

Incident forms were not always completed when people experienced a fall or staff discovered unexplained

bruising. Incidents forms are important as they help to ensure that the issue has been fully investigated and any remedial actions taken to prevent similar incidents happening again. A number of people at the service had expressed a wish to manage their own medicines, but they did not have a risk assessment to determine whether this might present a risk to them or others, or to confirm that the person was able to take the right medicine at the right time and in the right way. This was not in line with the provider's policy or with best practice guidance.

The failure to assess and plan for risks affecting people's safety is a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks associated with the environment were well managed. Tests took place to ensure people were protected against the risks associated with legionella. Records were available which detailed the assistance each person required for safe evacuation of the home. The fire risk assessment and fire equipment tests were up to date and staff were trained in fire safety. There were current certificates for gas and electrical safety. The provider had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service.

Some improvements were needed with regards to medicines management. Whilst staff undertook medicines awareness training every three years, the provider was not able to demonstrate that staff administering medicines had an annual review of their knowledge, skills and competency to do this safely. Medicines were not always stored securely or in appropriate conditions. One medicines trolley was not secured to the wall and not kept within a locked room when not in use. This practice makes the trolley and its contents vulnerable to theft. Other medicines trolleys were stored securely in locked cupboards. A locked medicines fridge was also available and used to store medicines which needed to be refrigerated. Whilst the temperature of the fridge was being checked daily, the temperature of the trolleys and cupboards used for storing excess medicines was not. This was not in line with the provider's policy or with best practice guidance and is important as it provides assurance that medicines are being stored within their recommended temperature ranges. The registered manager is taking action to address this.

The service had recently introduced the use of electronic medicines administration records (eMARs) stored on a hand held tablet to record the administration of people's medicines. The eMAR included the person's photograph, date of birth and information about any allergies they might have. We randomly checked the stock of two people's medicines against that recorded on their eMAR and found that these were not consistent. For example, one person's eMAR stated they should have six of a particular medicine in stock but they had seven. We could not be confident therefore that people were always receiving their medicines as prescribed. We spoke with the registered manager about these anomalies. They undertook an investigation which showed that improvements were needed with regards to staff following correct procedures when administering medicines. The eMAR system had only been operational within the service for two months and staff were still adjusting to this. The system provided the opportunity for a range of audits and safety reports to be provided. The registered manager told us that going forward these would be carefully monitoring to ensure medicines were always being administered safely.

The failure to ensure the proper and safe use if medicines at all times is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Controlled drugs were stored securely. We completed an audit of the controlled drugs in stock and found the records were accurate. Controlled drugs are medicines that require a higher level of security in line with the requirements of the Misuse of Drugs Act 1971 as there can be a risk of the medicines being misused. Care

workers were responsible for administering prescribed topical creams and used topical medicines administration records kept in people's rooms to record when these were applied.

People told us they received appropriate support to manage their medicines with many remaining in control of their own medicines. One person said, "My pills are issued to me, they have to sign to say they have gone in". Another person said, "Yes my tablets are given to me, one in the morning and one in the evening which helps me go off nicely". We observed staff administering people's medicines. People were asked whether they would like any pain relief. Staff remained with people, until they were confident that the medicines had been taken. All of the people we spoke with felt that their medicines were managed safely and helped them to remain in good health and pain free.

Overall people told us there were sufficient staff available to meet their needs. One person said, "When I ring at night, I get a response within two to three minutes, sometimes, instantaneous". All of the relatives and healthcare professionals we spoke with all felt that the staffing levels appeared appropriate. One healthcare professional said, "There always seems to be plenty of staff".

Currently day shifts were led by a senior carer supported by three care staff. During the hours of 7am to 11am and 6pm to 10pm, an additional care worker was being rostered to support with helping people to get up in the mornings and retire in the evenings. This was a relatively new development and so not all shifts were yet covered. Night shifts were staffed by two waking night staff and one sleeping in. We reviewed the rotas for a four week period; these confirmed the home was usually staffed to these target levels. In addition, the full time registered manager and deputy manager were available during weekdays and on call at weekends. The provider also employed a team of housekeeping staff, receptionists, a chef and kitchen staff and a maintenance person. Staff told us there was usually sufficient staff to meet people's needs unless staff had rung in sick at short notice. Even so, they said the management team always tried to cover the shift with agency staff where able. One staff member said, "More often than not there are enough staff, they do their utmost to find cover".

Approximately half of the people living at Quaker House needed minimal assistance with their personal care such as support with their medicines, taking a bath or with the provision of meals. An increasing number of people needed what the service termed 'extra care'. This meant they required full assistance with most aspects of personal care and might have poor mobility or be at risk of falls. However, our observations indicated that care was completed in a timely manner and throughout the morning, alongside the provision of practical care and support, staff had time to stop for a chat with people or provide reassurance when needed. We spoke with the registered manager about the nature of people using the service and how staffing levels were determined. They did not currently use a specific tool for determining staffing numbers and acknowledged that where once the service had been for what they termed the 'Active elderly', the people coming to live at the service now, were often more dependent, and had increasingly complex needs. They were also admitting an increasing number of people for respite or short term care which also had an impact on the staffing requirements. We recommend that the registered manager use a systematic tool to assist them in determining on-going staffing numbers and ensure these reflect the needs of people using the service and their changing dependency.

The provider had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. However a full employment history had not been obtained for either of two staff whose recruitment files we viewed. We discussed this with the registered manager who took immediate action to ensure this information was obtained.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us the service provided effective care. They all said they would recommend the service to others. Comments included, "We were lucky to find this place" and "Yes absolutely [would recommend the home] It's so peaceful". A relative told us their family member had "Flourished" at the service, whilst another said, "The staff are wonderful, I have total confidence in them". A health care professional told us, "It's one of the better homes; I've never had any concerns".

Staff sought people's consent before providing assistance, for example, staff asked a person, "Would you like me to help you with that [cutting up their meal]" and another person was asked if they would like to take part in the art and craft session that was taking place. This helped to ensure that people remained in control of their care and support. Care plans noted which people might need additional support to make some decisions and records were kept of which people had made a Lasting Power of Attorney authorising a family member of friend to make decisions on their behalf when they were no long able to. No-one currently using the service had been assessed as lacking capacity make decisions about their care and support.

However, some improvements were needed. Only a small number of staff had completed training in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The MCA 2005 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. The Deprivation of Liberty Safeguards (DoLS) are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. When we spoke with staff during the inspection, they lacked confidence and knowledge regarding the MCA 2005 and its key principles. We noted that staff had inappropriately applied for a DoLS for one person who actually had capacity to agree to the proposed restriction on their liberty which in this case was the use of bed rails. This demonstrated a lack of knowledge and understanding about how and when to seek a DoLS. We spoke with the registered manager about this. They told us that in-house training sessions were planned on the MCA 2005. They were confident that this would ensure staff understood their responsibilities with regards to the Act and would be able to effectively undertake and document mental capacity assessments and best interests' decisions when needed.

During the first half of 2016 supervision had also not been taking place on a regular basis. Records did show, however, that this was an improving picture. Supervision is important as it helps to ensure staff receive the guidance required to understand their role and responsibilities. The registered manager told us that a new structure had now been put in place with seniors care workers also being trained to provide supervision and appraise the care workers. The registered manager was confident that once embedded this would ensure staff received appropriate support and professional development. All of the staff we spoke with felt well supported in their roles and were confident they could approach the registered manager or deputy manager at any time with concerns or issues they might have. One staff member said that if they needed advice or support, the management team would "Stop what they are doing and advise me". Another said, "I feel very

well supported".

New staff completed an induction during which they learnt about their role and responsibilities and spent time shadowing the more experienced staff. They also read people's care plans which helped to ensure they were able to develop their understanding of people's needs. We were advised that staff who were new to care were being supported to complete the Care Certificate in conjunction with a local further education college. The Care Certificate which was introduced in April 2015. The care certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. Agency staff also underwent an induction to the service which included a tour of the home and reading about people's needs and the fire procedures.

Staff completed training in a range of subjects such as infection control, health and safety, first aid, fire safety, safeguarding and manual handling training. Where relevant to their role, staff had completed training in medicines awareness and other subjects such as record keeping, person centred care and providing supervision and appraisals. Whilst the service was not a specialist dementia care service, most staff had also completed dementia awareness training. All of this training, except the manual handling training, was refreshed every three years. There were also opportunities for staff to study for nationally recognised vocational qualifications. Staff told us the training provided was adequate to enable them to perform their role effectively and records we viewed showed that this training was generally up to date. One staff member said, "We have a broad base of skills…I learn something from each training session, [the deputy manager] helps us to apply the learning".

Overall people were positive about the food provided. People's comments included, "The food is exceptional", "Couldn't do much better myself" and "It's such a lovely taste". People were offered a choice of foods at each meal. At lunch one of the options was always a vegetarian option. Supper was soup followed by a salad, jacket potato or sandwiches. At lunch, the majority of people came to the dining room for their lunch. A small number had their meal taken to their room on trays. We joined people for their lunch time meal on the first day of our inspection. The meal appeared to be a pleasurable experience for people. The tables were laid with clothes and serviettes and a range of condiments were available including gravy boats which allowed people to choose for themselves how much gravy they would like. People were also asked what portion size they would prefer. Four staff were available to support with serving the meals or to help people with cutting up their food if this was needed. Most people were however, able to eat and drink independently. People and staff readily chatted throughout lunch, following which people returned to the lounge for tea and coffee making the mealtime quite a social occasion.

Hot and cold drinks were readily available throughout the day. One person said, "I have to drink lots of water and the staff make sure I do". Biscuits were available in the morning and home-made cakes were served in the afternoon. Fresh fruit was readily available in the kitchenettes throughout the home and we saw this being offered to people during our inspection. One person told us, "There is always a banana or a satsuma you can have". Relatives told us they were always able to join their family members for a meal if they wished. One relative said, "We shared Christmas dinner with Mum, the staff dressed up, it was good". People were weighed on a regular basis and monitored to help identify whether they might be at risk of malnutrition.

Where necessary a range of healthcare professionals including GP's, chiropodists and community nurses had been involved in meeting people's health care needs. We were able to see that staff referred people for review by the GP if they were concerned about their dietary intake, or due to showing signs of having chest or urine infections. People were offered flu jabs. One person told us, "Yes they [staff] recognise when I am unwell, they call the doctor immediately". This helped to ensure that people received co-ordinated care, treatment and support. People's care records contained information about their medical history and

records were maintained of the outcome of medical appointments and visits from the GP or other healthcare professionals.

Good

Is the service caring?

Our findings

People told us they were cared for by kind and caring staff. One person said the care workers were, "Absolutely" caring, "Very much so". Another person said, "The staff are all very kind and caring". A relative told us, "The staff are very good, there is a good atmosphere, they are the people that make it". Another relative said, "They [the staff] couldn't do more, they are very caring, very helpful and patient, nothing is too much trouble". A third told us how a staff member had shown their family member a "Special kindness, above the call of duty" and "Had taken the greatest care". The service had received a number of compliments about how kind and caring staff were, one read, "I would like to express in the highest terms, my thanks and gratefulness for the care and compassion shown".

Our observations indicated that staff interacted with people in a kind and caring manner. The atmosphere in the communal areas was good natured and sociable. For example, we saw a care worker approach a person and say, "Good morning, how are you today, you have a lovely pink top on". When the care worker had moved on to other tasks, we heard the person tell another person, "She [the care worker] is very good and very kind". People looked relaxed and happy in the company of the staff who throughout our visit appeared jovial, attentive and happy in their work. We observed a staff member interact with one person who was feeling a little poorly. The staff member was kind and patient and supported the person in a sensitive manner. A staff member told us how the best bit of the job was "Making friends with the residents, they are real characters; we have a nice mix, some enjoy banter". Another staff member said, "There is a good atmosphere here, the residents and staff care about one another, we are like a little family".

Promoting people's independence was valued. For example, they were encouraged to take walks into town. A relative told us their family member had until recently managed their own laundry. People with more complex needs were also encouraged to be as independent as possible in the knowledge that staff were on hand to assist if needed. Staff told us how they encouraged people to complete small tasks such as washing their own face. One staff member said, "You encourage people to do their own personal care, even if it's walking a few steps or cleaning their teeth, it is a little something, we are here for them. We say come on, a few little steps". The importance of promoting people's independence was also reflected in people's care plans with staff being prompted to 'only offer support when needed'. One person's care plan said, 'I like to be independent as it gives me freedom and choice'.

Staff respected people's choices. The people living at Quaker House were able to understand and make decisions about how their care and support was provided and we saw they were empowered and encouraged to do this on a daily basis. For example, some people chose to manage their own medication; others were supported to maintain an active life in the community. Others who were perhaps a little more dependent were encouraged to make choices about the clothes they would like to wear, what they would like to eat or whether to take part in the activities provided. One person said, "You are left alone if you want to, you can go to bed when you want to and do what you want". A healthcare professional told us that staff were all very good at respecting people's choices. They said, "All staff listen to the residents, take them seriously, don't brush them off".

Staff respected people's dignity and privacy. Staff told us how they knocked on people's doors before entering, or placed a towel across the person's lap when assisting them with personal care. Again care plans were written in a manner that reminded staff of the need to provide intimate care in a 'Discreet way'. Two people did comment that they did not like be referred to as 'dear' or 'darling'. One said, "I don't mind my Christian name being used, but I don't like being called dear or darling by these youngsters….this is ridiculous".

New people were welcomed by the service and efforts were made to integrate them with those already living at the home. A number of people did mention to us that they felt the increasing number of admissions for respite care was changing the nature of the service. They were concerned that this not detract from the familiar nature of the service. For example, one person said, "I like to sit next to the same person and get to know them, now its strangers all the time". Families were welcome to visit or where this was difficult, people were supported to use the internet to speak with their family members. Birthdays and special occasions were celebrated as were people's skills and talents with paintings completed by people decorating the walls throughout the home. People were supported to follow their religious and spiritual beliefs. People living at the home did not have to be Quakers, or indeed belong to any denomination, but a Quaker meeting was held once a week and once a month, holy communion was held.

Good

Is the service responsive?

Our findings

People and their relatives told us they received care that was responsive to their needs. One person said, "They [staff] do everything you want". A relative said, ""When [their family member] was poorly earlier this year, they couldn't give her enough attention". Most people told us their complaints or concerns were taken seriously and that their views were listened to. One person told us that if they had a concern they would "Go to the top dog, the manager".

Each person had a care plan which described their needs and how these should be met. The level of detail contained within the plans we viewed was variable but most contained basic details about the person's cognition, their social and emotional needs and their physical health needs such as the support they needed with personal care and eating and drinking. Most care plans included a history of the person's life before coming to live at the home and some information about their preferences, likes and dislikes and choices about how their care should be delivered. This supported staff to know and understand what was important to each person and to deliver responsive care. Our observations indicated that staff knew people well. For example, we heard one staff member say to a person during lunch, "Would you like some bread and butter pudding, oh no you don't like that do you". Staff were able to tell us which people were at risk of falls or were for example, prescribed fortified drinks or having milkshakes to increase their calorific intake due to concerns about weight loss. Care plans contained some information about people's wishes in relation to their end of life care which was provided in conjunction with specialists from a local hospice. This helped to ensure that staff were aware of what was important to people approaching the end of their life. For example, we saw that one person had expressed a wish to remain at Quaker House for their end of life care, to have their family around and to be kept comfortable and pain free.

A handover was held three times a day at each shift change which helped to ensure staff were kept up to date with people's changing health and welfare needs. Some staff felt that it would be helpful for care staff to be involved in providing the handover in addition the senior care staff who were less hands on with the day to day care provision. When concerns were noted about a person's health or behaviour, there was usually evidence that staff had responded by undertaking health checks, for example, checking to see if the person had a urine infection. We also saw that relevant referrals were usually made to healthcare professionals. A healthcare professional told us staff were, "Very good, they contact us immediately regarding pressure areas". We did note that reviews of people's care were not always taking place monthly, and those that were, could be better documented to demonstrate more clearly how the person and their relatives had been involved in these. However, people told us they felt listened to and had no concerns about sharing their view or comments with the management team. This was echoed by the visitors we spoke with. They felt that staff kept them well informed about all aspects of their relatives care and that there were plenty of opportunities to have regular dialogue with staff and the management team. The registered manager explained that a key worker system was in the process of being implemented. They were confident that this would also help to further improve communication between people and their care workers.

The service did not employ staff to specifically lead the activities provision within the service. Instead most

of the activities were led by external entertainers or professionals. The entertainment booked for October included, Tai-Chi, a harpist, jazz band, guitarist, a quiz, crafts, a clothing sale and an exercise class involving mental stimulation, exercises and games. People were also supported and encouraged to continue to access the local community and links had been forged with other local groups and charities who were able to support the home in a variety of ways. For example, one local group had offered to provide cream teas at the service throughout the year. A local supermarket had offered to support the service with events and the provision of any items they need. People were being offered the chance of a trip to a local theatre performance and four to five outings took place each year for activities such as boat trips and afternoon teas using local community transport.

Whilst people told us they enjoyed the activities offered, many felt there could be further improvements. One person said they would value more opportunities for simple companionship, they told us, "I would just like three or four of us to get together in the evening and play a game or chat sometimes, I go to bed as early as 7pm, this is not when I want to go, I have never been to bed that early". This person told us they would also like more opportunities to just go for walks in the garden and take time to just look at the plants. They said, "I have lost confidence to do it on my own". This was echoed by another person who said, "The staff are very good, but I wish that I could go out in the garden but that would take too much time with the staff". Other comments included, "Activities? Yes, but not as much as you might think" and "Musical things probably twice a week, maybe something in between, never anything in the evenings". A relative also told us, "They could do with a few more activities". One of the reception staff had recently taken on the role of booking the external activities offered and was looking into a number of new options to try and ensure the activities remained relevant and were in keeping with people's interests and wishes.

People told us they were able to express their views and to give feedback about the service. People could join the 'Residents Committee'. It was their role to speak with people and highlight issues or suggestions that could then be discussed at the quarterly 'Residents Meetings'. This was a relatively new development but it was envisaged that that it would be an opportunity for people to make suggestions and to comment on how the service could be improved. We reviewed the minutes of the last two 'Residents Meetings'. Topics such as the quality of food, the introduction of a key worker system and the activities were discussed. One suggestion from the meeting in May 2016 was that a summer fete be held. Minutes from the meeting in August show that this took place and was deemed to be a great success, enjoyed by all. We did note that a catering survey had recently been undertaken. Whilst most of the feedback was positive, we were concerned that some of the responses from the catering team appeared to be dismissive of people's views. For example, one person had said, 'I would love to have porridge sometimes made with milk'. The response from the catering team was, 'some can't have milk'. This did not reflect a problem solving approach aimed at meeting people's individual wishes.

There were other systems in place to listen and learn from people's experiences. There was a comments box in reception and an annual survey was undertaken with people. We looked at a copy of the provider's welcome pack; this provided a clear, user friendly description of what people could expect from the service including information about the complaints procedure. People told us they were confident they could raise concerns or complaints and these would be dealt with. One person said, "Sometimes, things slip, but if you say something, they put it right". Another person said, "I think I have made the odd suggestion, I have never had to complain, but I would start in the office".

Requires Improvement

Is the service well-led?

Our findings

The registered manager had worked at the service for 11 years and had a good knowledge of the people living there, their needs and of the staff team. People, their relatives and staff spoke positively about their leadership of the home. One person said, "The manager is very good". A relative said, "It seems to run well, it's down to [the registered manager]". A staff member told us, "You couldn't wish for a nicer boss".

Improvements were however, needed to the care governance arrangements within the service. The provider had a range of policy and procedures in place, but these did not always reflect what was happening in practice. For example, the provider's medicines policy stated that 'self-medication by service users should be authorised by the prescribing GP following a risk assessment', this was not in place. The policy also said 'medication should be stored in a dry separate room where the temperature is monitored and does not rise above 25C'. This was not in place. We found similar issues with regards the recruitment and supervision policies.

Records related to people's care needed to be more detailed. We found examples where there was a lack of guidance in the care plans for staff about matters such as the care of people living with diabetes or other health conditions. For example, the care plan for one person living with insulin dependent diabetes did not include information about the signs and symptoms which might indicate the person's diabetic control was becoming unstable. The plan did not include a clear escalation plan which described the action that should be taken if their blood sugar levels were outside of certain parameters. Escalation plans are important as they help staff to provide appropriate interventions and also assist them to recognise and respond to changes in people's health. Some of the skin care plans viewed needed to be more detailed and more accurately reflect the person's needs.
The service did not have a robust structure in place to continuously monitor incidents, accidents or near misses. Audits were not being undertaken on a regular basis to help the registered manager measure the delivery of care, treatment and support given to people against current guidance and to allow organisational learning. For example, the last audit of accidents within the service took place in December 2015. However in August and September 2016 there had been over 40 falls within the service, but the registered manager had not undertaken an overarching analysis to identify, in a timely manner, any themes or trends that might be contributing to people falling. The last infection control audit took place in June 2015. The concerns we found in relation to people's care plans had not been identified through a regular and effective programme of audit. A review of records held within the service indicated that in September 2016 there had been some potential medicines errors; however there had been no root cause analysis to establish the facts or to ensure that if quality or safety was being compromised that a robust response was made. Records relating to consent had not always been completed accurately and did not reflect the care and support being provided.

The failure to maintain adequate care records and to ensure there were robust care governance arrangements in place is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some systems in place to allow the provider have scrutiny over the service. The provider met on a monthly basis to review issues related to the running of the service such as the financial records, the budget for the forthcoming year. The home manager submitted a report to this meeting which updated them on operational issues within the service such as occupancy, staff training and feedback from people using the service. In 2015, the provider had undertaken a number of 'mock inspections'. They had produced a report of their visits which highlighted what the service was doing well and areas where improvements could be made. This helped to ensure that the provider remained informed about issues or concerns relating to the service.

Central to the philosophy of Quaker House was the belief that each person should be able to live in a safe and comfortable environment, where they are treated with respect and equality, irrespective of their needs and backgrounds and in an environment of trust and familiarity. People, their relatives and staff told us the registered manager led the service in a manner that was in keeping with these values. A number of people spoke to us of the positive and relaxed atmosphere within the home. One person said, "The best thing about Quakers is the gentleness". Another person said, "I am not a Quaker, but I do like their values". Staff spoke of the registered manager being a good role model. A staff member said, "He [the registered manager] is always there sitting with the residents, talking with them, they are all on a first name basis". Another said, "They [the registered manager] has always listened, made me think, they have a wicked sense of humour but a serious side too, they do take on board what we say". A relative said, "He is a good manager in a quiet way".

Staff told us that the service was a good place to work and that they enjoyed their job. One staff member said, "It's a very, very nice working environment". Another said, "They treat you nice". Staff meetings took place periodically. These meetings were used to share developments with staff and to discuss how the delivery of care could be enhanced. A staff member said, "If you have a concern they [the registered manager] will act on it". Another staff member told us how they had suggested the service buy a piece of equipment to support people with showering. They said the management team researched the options and gave them a choice of two. They said, "I got the expensive one, if we need something, we get it".

The provider and registered manager had a good understanding of the challenges facing the service. They were aware that people were coming to live at the service with increasingly complex and long-term conditions which had implications for a range of areas such as staffing numbers, their skills and knowledge and the physical environment of the service. The provider and registered manager were updating their business plan to ensure it was resilient to these challenges in the future, for example, plans are in place to extend the building to provide additional office space, better staff facilities and treatment and medicines rooms. Research was also underway to explore options for an electronic care planning system that would suit the needs of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There had been a failure to adequately assess and plan for risks affecting people's safety. Regulation 12 (2) (b). Safe Care and Treatment. There had been a failure to ensure the proper and safe use if medicines at all times. Regulation 12 (2) (g) Safe care and Treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff had not followed local guidance regarding the actions that should be taken in response to concerns about improper treatment. Regulation 13 (3) Safeguarding service users from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to maintain adequate care records and to ensure there were robust care governance arrangements in place. Regulation 17 (2) (a) (c).