City of York Council

Haxby Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

We carried out this inspection on 3 August 2017. The inspection was unannounced.

There was a manager in post who was registered with the Care Quality Commission. A manager is a person who has registered with the Care Quality Commission to manage the service. Like 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.

Haxby Hall is a care home that is registered to accommodate up to 49 older people, some of whom may be living with dementia. The home is situated in Haxby, on the outskirts of the city of York. Bedrooms are located on the ground and first floors and there is a passenger lift to enable people to reach the first floor. On the day of the inspection there were 43 people living at the home.

At the last inspection in May 2016 we were concerned that some staff training was not up to date and we made a recommendation about this in the report. At this inspection we found that staff had attended training that was considered to be essential by the home. This included training on first aid, medication, infection control, safeguarding adults from abuse, fire safety and moving and positioning people. This meant we were no longer concerned about staff training achievements.

At the last inspection in May 2016 we were also concerned about staffing levels impacting on people's opportunities for socialisation and taking part in activities. We made a recommendation about this is the report. At this inspection we found that people were taking part in more activities, both as a group and one to one, although some people felt there was room for further improvement. We were satisfied that the provider had taken action to improve this aspect of people's care provision.

At this inspection we found that recording needed to improve. There were some minor omissions in care records, recording in monitoring charts was inconsistent and records of how the conditions of one DoLS authorisation were being met were also inconsistent. The manager carried out audits to ensure people were receiving the care and support that they required, and to monitor that staff were following the policies, procedures and systems in place. However, these audits had not identified some of the concerns we found during the inspection.

We saw that sufficient numbers of staff were employed to make sure people received the support they needed, although some people commented that additional staff would be beneficial. The nominated individual told us that additional staff would be employed at the home as part of the current review of older people's services.

Staff had been recruited following robust recruitment and selection policies and people told us they felt safe living at the home.

Prior to the inspection we had received concerns about cleanliness at the home. The manager had asked an infection control nurse to carry out an audit to help them identify areas that required improvement. On the day of the inspection we found the home to be clean and hygienic, apart from the laundry room that needed to be de-cluttered. The following day we received confirmation from the home that this had been addressed.

People told us they were happy with the choice of meals provided at the home. People's nutritional needs were assessed and there were appropriate risk assessments in place. People's special dietary requirements were catered for.

Care planning described the person and the level of support they required. There were some anomalies in recording, although none of these had affected the care the person had received.

People were supported to have maximum choice and control over their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Risks to people were assessed and reduced where possible. Staff received training on safeguarding adults from abuse. They were confident when describing different types of abuse they may become aware of and the action they would take to protect people from harm.

Staff were kind, caring and patient. They encouraged people to be as independent as possible and respected their privacy and dignity.

Staff told us they were well supported through supervision and staff meetings.

People understood how to express any concerns or complaints and were given the opportunity to feedback their views of the service provided.

People told us that care at the home had improved since the current manager had been in post.

We found one breach of regulation. You can see what action we told the provider to take at the back of the full version of the 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?

Good

The service was safe.

Staff were recruited safely and were aware of their responsibilities to protect people from the risk of harm.

People told us they felt safe living at the home, although more staff would be beneficial. We were told how this was being addressed.

The premises were being maintained in a clean and hygienic condition.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the MCA and people were supported with decision making.

People told us they enjoyed the meals at the home and people's nutritional needs were assessed and met.

People had access to health care professionals as needed.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and there were positive relationships between people who lived at the home and staff.

People's privacy and dignity was respected by staff.

People were supported and encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive to people's needs.

People had care plans in place that described them and their

support needs.

Activities were provided so people were occupied and had social stimulation.

People were made aware of the complaints policies and procedures in place.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although regular audits to monitor the quality of the service were being carried out, these had not identified some areas that required improvement. Some improvements in recording were also required.

There was a manager in post who was registered with the CQC. People told us that the service had improved since they became the manager.

People who used the service and their relatives had the opportunity to share feedback about the service provided.

Haxby Hall

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 checked 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 a comprehensive inspection that took place on 3 August 2017 and was unannounced. The inspection was carried out by one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was not asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with nine people who lived at the home, three relatives / friends, a member of staff, the registered manager and the nominated individual. Following the inspection we spoke with two members of staff over the telephone. We asked five care professionals for feedback about the service and received two responses.

We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment and training records for three members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

Prior to the inspection we received information of concern from various sources about the cleanliness of the premises.

The manager had asked an infection control nurse to visit the premises to carry out an audit, and they had produced a report with numerous recommendations. We saw those recommendations that could be easily followed up had been acted on. We did not detect any unpleasant odours on the day of the inspection. We saw there were hand hygiene facilities in each toilet and bathroom and no toilet rolls were left uncovered, leaving them exposed to contamination. Mobility equipment in toilets and bathrooms was clean. We did not see any evidence of communal toiletries or hairbrushes being used and no areas of the home were cluttered, apart from the laundry room. The manager told us the following day that any items that did not require storage in the laundry room had been removed.

We received conflicting views on cleanliness from relatives and friends. One visitor told us, "The home is always clean. It's had a lot of attention – it's 100% improved" although two other visitors told us that there were sometimes concerns about cleanliness. They commented, "Sometimes the dining room floor is a bit sticky" and "It [cleanliness] is a bit hit and miss." The manager told us about the improvements they had made in respect of the prevention and control of infection since May 2017. This included adding areas to the cleaning schedule, appointing an infection control champion who had done specific training, staff had completed a training booklet, the manager's walk-around included more information about the environment and they had done 'lots of de-cluttering'. However, since the inspection we have received information from one person stating that the home is not clean. We have asked the manager to carry out regular audits on cleanliness so that this situation is continually monitored.

The home had received a food hygiene score of five from the food standards agency. Five is the highest score that can be awarded. The inspection checked hygiene standards and food safety in the home's kitchen.

People told us they felt safe living at the home. One person said, "I feel very safe. There is a security system on all of the doors." Staff described to us how they kept people safe. Comments included, "Our training keeps us up to date with moving and handling and we have regular infection control training" and "The ratio of staff to residents has improved – we now have extra staff." We saw there were keypad locks on external doors and doors to the stairs to promote people's safety. People had emergency call bells in their rooms and some people had an alarm that they placed around their neck. This enabled people to alert staff if they required attention.

Care needs assessments had been carried out, and when risks had been identified, action was taken to minimise potential risks without undue restrictions being placed on people. We saw risk assessments in respect of moving and handling, medicines, nutrition, smoking and tissue viability. The risk assessments were reviewed regularly so they remained up to date and relevant to the person concerned. We saw staff assisting people to mobilise and noted this was carried out safely.

Staff received training on safeguarding adults from abuse. They were confident when describing different types of abuse they may become aware of and the action they would take to protect people from harm. Staff told us they would pass on any concerns to the manager and were confident their concerns would be dealt with immediately. Any safeguarding incidents at the home were recorded on a spreadsheet, including any lessons learnt as part of the investigation.

On the day of the inspection there were two care leaders and four care assistants on duty, as well as the registered manager. In addition to care staff there was a cook, a general assistant (kitchen), a general assistant (laundry) and two contract cleaners working at the home. An administrator was also employed at the home although they were not at work on the day we inspected. The rotas we saw showed that these staffing levels were maintained.

We received varying responses from people when we asked about staffing levels. One person said, "There are staff available if I need them but most of the time I can look after myself." Other people said, "There are never any staff when you need them. Staffing levels are lower on weekends" and "They could possibly do with more staff at meal times." This view was supported by two of the relatives we spoke with. A care professional told us, "There appears to be a good level of staff present in the building and they regularly check on residents." We observed that people received attention from staff in a timely way and were allowed to take things at their own pace; they were not hurried by staff.

Each person's dependency level had been assessed and on the day of the inspection, 25% of people had low, 50% had medium and 25% had high dependency needs. The manager used this assessment to help determine staff requirements. The nominated individual told us about the plans in place to increase staffing levels at the home as a result of the older person's accommodation programme. This assured us that staffing levels were kept under constant review.

We checked staff recruitment records. These records evidenced that references and a Disclosure and Barring Service (DBS) check had been obtained. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults to help employers make safer recruitment decisions.

We saw that medicines were stored safely, obtained in a timely way so that the person did not run out of them, administered on time, recorded correctly and disposed of appropriately; this included the management of controlled drugs (CDs). CDs are medicines that require specific storage and recording arrangements. We discussed with the manager that a system to ensure the medicines provided by the pharmacy were the same as the medicines recorded by the GP on the prescription would improve medicines safety even further.

Accidents and incidents were recorded, and each month a summary was prepared of the total number of accidents, whether the accident was witnessed or un-witnessed, whether the incident was an accident or a fall and whether the emergency services were called. This showed us that accidents and incidents were being monitored to identify any patterns that were emerging or improvements that needed to be made.

There was a very detailed business continuity plan in place for local authority care services. People also had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to leave the premises in an emergency. There was also a symbol on each bedroom door indicating whether people required no assistance or the assistance of one or two staff to evacuate the premises; this had been carried out following the advice of the Fire Officer.

We reviewed service certificates and these evidenced that equipment and systems had been appropriately maintained. This included the fire alarm system, fire safety equipment, emergency lighting, mobility and bath hoists, the electrical installation, portable electrical appliances, the passenger lift and gas appliances / systems. In-house maintenance was carried out on areas such as window opening restrictors and emergency lighting, and there was also a weekly fire alarm test.

Good

Is the service effective?

Our findings

At the last inspection of the home we were concerned that some staff training was overdue. At this inspection training records showed staff received induction training when they were new in post, and also shadowed experienced staff as part of their induction training. New staff were expected to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers observe. It is the minimum standard that should be covered as part of induction training of new care workers.

Staff had completed training on the topics considered essential by the home, including first aid, medication, infection control, safeguarding adults from abuse, fire safety, moving and positioning people, MCA and DoLS and person-centred dementia awareness. Records showed that staff practice was also observed by the manager to check that staff continued to have the skills they required to carry out their roles effectively.

The nominated individual told us they circulated good practice guidance documents which helped staff to keep up to date with best practice guidance. People told us they thought staff had the skills to carry out their roles. One person said, "The senior carers really know what they are doing."

Staff told us they felt well supported, in both staff meetings and supervision meetings. Supervision meetings give staff the opportunity to meet with a manager to discuss people's care needs, identify any training needs and address any concerns regarding practice. One member of staff told us, "I can discuss things that are personal or work related any time."

We observed that people's likes and dislikes and their special dietary requirements were recorded in their care plan and we saw people had appropriate nutritional assessments and risk assessments in place. People were weighed as part of nutritional screening so any weight loss or gain could be monitored. Care plans recorded referrals to speech and language therapy or dietetic services when risks of choking or malnutrition had been identified. The advice given by these professionals about people's specific dietary requirements had been recorded in their care plan.

People told us they liked the meals at the home. Comments included, "The food is okay. You get a choice for each meal and staff are aware of specific dietary needs", "Breakfast is very good – I can't grumble", "The food is lovely" and "The food is alright but sometimes it could be hotter."

We observed the serving of lunch in both dining rooms and noted there was a pleasant atmosphere. We saw that people were offered a choice of soup and / or sandwiches and hot or cold drinks. Two people required fortified drinks and one person required a soft diet and we saw this was provided. Most people could eat their meal without assistance but people were offered appropriate encouragement. There were four members of staff to assist people with their meal in the main dining room, and one member of staff to support people in the dementia area of the home (Poppyfields). Some people had adapted cups and bowls so they could eat their meal independently and we saw people were allowed to eat at their own pace.

We observed that people who could mobilise independently walked around the home without restriction.

Corridors were wide and straight with minimal obstacles, making it easy for people to move around if they wished, and giving good lines of sight for staff to identify if people required assistance. There was some signage to help people find their way around the home. We noted that efforts had been made to make the lounge in Poppyfields look like a living room in someone's own home, including a fireplace and electric fire. There was also direct access into an enclosed garden from this area of the home.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Although staff told us the conditions of one person's DoLS authorisation had been met, the records of this were inconsistent. We have addressed this in the Well-led section of the report.

Staff had received training on the MCA and DoLS and we found that they had an understanding of the principles of this legislation, including the importance of obtaining people's consent to their care. When people had capacity to do so, they had signed forms to consent to their care and support, and also to photographs being taken for their records. When people had a legal representative to act on their behalf, such as a Power of Attorney (POA), this was recorded in the person's care plan. A POA is a person who has been legally authorised to make decisions on another person's behalf.

Staff told us that they always asked people what they would like to do and offered them choices, and that people were able to make day to day decision for themselves. We saw this on the day of the inspection; people were offered choices in respect of food and drink and how they wanted to spend their time. One member of staff said, "We ask people. If they have difficulty understanding verbal communication, we use hand gestures and write things down." We saw evidence of best interest meetings that had been held to help people who lacked capacity to make important decisions about their life.

People were supported by GPs, community nurses and other health care professionals. They told us they could see their GP whenever they wanted to. A member of staff said, "I would know straight away if someone was unwell, as I know them so well."

People had a 'resident hospital admission' form in place that they could take with them to hospital admissions when they were not able to communicate information about their care and support needs to hospital staff. We were told that the person's current MAR sheet would also be sent to the hospital. These documents provided hospital staff with information about the person to enable them to meet their needs.

Good

Is the service caring?

Our findings

We observed that people were relaxed and comfortable in the company of staff and that staff were polite and sensitive to people's needs. People told us they felt staff really cared about them. Comments included, "The staff are amazing", "I can talk to my allocated carer about anything and they know me well" and "Nothing is ever too much trouble for the staff."

Staff told us they felt staff who worked at the home genuinely cared, although one member of staff said, "But the recruitment and selection process doesn't give people a bedside manner or passion." Another staff member said, "We have amazing staff." Comments from care professionals included, "Staff are friendly and take the time to talk with residents", "I've observed staff adapting their conversations to the particular needs of residents" and "There have been incidents I am aware of where some individual staff go the 'extra mile' for the residents."

We saw people who lived at the home looked well cared for, were clean shaven (when this was their choice) and wore clothing that was in keeping with their own preferences. People's bedrooms were personalised with their own furniture and photographs to make them feel 'at home'.

Staff told us that the small team of staff who worked in Poppyfields had a positive impact on the people who lived there, as it provided consistency.

Relatives told us their family members were treated with dignity and respect. Staff were able to describe how they promoted people's privacy and dignity, such as knocking on doors before entering and closing curtains. One member of staff said, "I explain what I am going to do step by step. I cover people with a towel and I'm discreet." Information about the Dignity Charter was displayed on the home's notice board. This explained how the home promoted dignity throughout its staff group by respecting people's privacy and dignity, promoting their welfare and keeping them safe from harm.

Relatives told us that their family members were encouraged to be as independent as possible. We saw that staff encouraged people to walk when they were able to do so, and that people were provided with adapted equipment so they could eat independently. The manager said that staff promoted independence and this had resulted in some people's general health improving to the extent that more independent living arrangements were being sought for them.

Staff has also completed a virtual dementia tour as part of their training. The purpose of a virtual dementia tour is to help staff understand dementia from the person's point of view in the hope that staff can change their practice, reduce issues and improve the lives of people who are living with dementia.

Some people who lived at the home were supported by an Independent Mental Capacity Advocate (IMCA). IMCAs provide support for people who lack the capacity to make their own decisions and have no-one else to represent them.

People had a key worker. A key worker is someone who takes a special interest in the person and is their main link with the staff group. We noted that key workers recorded when they had assisted people with personal care and tasks such as tidying their wardrobes.

The homes notice board included information for people who lived at the home, such as how to report abuse, advice from Mencap, details of social activities and a leaflet about Healthwatch. Healthwatch is the independent national champion for people who use health and social care services. They help to make sure that people running services put people at the heart of care.

We saw that written and electronic information about people who lived at the home and staff was stored securely. This protected people's confidentiality.

Good

Is the service responsive?

Our findings

At the last inspection of the service we were concerned that staffing levels impacted on people being supported to take part in activities both inside and outside of the home. At this inspection we saw that more activities were being provided and that people were supported to take part in the local community. One the day of the inspection two people were having a day out with staff.

The board in Poppyfields recorded the activities for the day as 'music, hair care and facial care' and we saw there were musical instruments around that people were encouraged to use. There were also 'twiddle muffs' and 'twiddle aprons' around. These are muffs and aprons that have items attached such as ribbons, buttons and zips that provide people with a tactile activity.

There was a notice on display about the 'Breath of Fresh Air' challenge. This was an initiative introduced by the local authority to encourage staff to support people to spend time outdoors on the year's longest day. There was no budget; staff had to use their initiative and find volunteers to come up with ways of making sure every person who lived at the home spent some time outside. There were photographs of this event around the home, plus other events such as Yorkshire Day (when people were invited to sample 'Yorkshire' foods), visits from entertainers, an art project and a visit from local nursery children.

Each person had an activity sheet in place and this recorded any activities they had taken part in, both one to one with a member of staff and as part of a group. A visitor told us they regularly saw music classes taking place at the home and they had joined in these themselves. However, a care professional told us, "More activities which are catered to the needs of the residents could improve this service." This was fed back to the manager at the end of the inspection.

People were supported to keep in touch with family and friends and visitors were made welcome at the home; we observed this on the day of the inspection. Relatives told us they felt involved in decisions about their family member's care and that there was good communication between themselves and the home. A care professional told us about one person who had requested that their family should not visit them until they were settled into the home and that this request had been followed by staff at the home.

Managers completed an initial assessment of people's needs before they moved into the home; this included the use of recognised assessment tools for tissue viability and nutrition. A care plan was developed from these assessments. Care plans contained information for staff about how to meet people's needs in a variety of areas, including moving and handling, nutrition, medicines and pressure area care.

We saw that care plans contained sufficient information to ensure staff were aware of people's specific care and support needs, and to enable staff to provide care that was centred on the individual. This included their hobbies and interests, their likes and dislikes and family relationships. We saw that staff chatted to people about what they wanted to do or about their families; it was clear they knew about people and their likes and dislikes. A member of staff told us, "We spend all of our time with the service users so it's like our 'work' family." A relative told us, "The regular staff know what [name of relative] likes and dislikes and that

they do not like to get up early, so they are left in bed until after lunch." A care professional told us about one person who lived at the home who had a particular sense of humour. They said, "Staff have grasped this very well. The rapport between this resident and staff is excellent." However, one relative commented that there were staff working on a weekend who did not know their family member as well as other staff.

A care professional told us about a person who displayed behaviours that challenged the service when they were first admitted to the home. They said, "Over the course of the following few weeks several issues were raised about their behaviours particularly to other residents but after I visited several times, liaised with the care staff and manager as well as their family, solutions were found. Strategies were discussed and methods of management were put in place that enabled the staff to manage them appropriately and they were able to remain there until their expected death several months later." This demonstrated that staff sought solutions to enable them to meet people's individual care needs.

Most people and relatives who we spoke with told us they had been involved in a review of their care. We saw that care plans were reviewed regularly in-house and more formally by local authority care managers. We saw that some information had been added to care plans at the time of monthly reviews to ensure they were reflective of the person's current needs.

However, we saw there were some minor anomalies in care plans. For example, some people's care plans did not include a capacity assessment and some assessments such as the malnutrition universal screening tool (MUST) had not been updated each month. Some people had been assessed as requiring positional changes to prevent the development of pressure sores. We saw that these records were inconsistent so were not an effective record of the support provided. The records of food and fluid intake were more consistent but the amount of fluid intake per day had not been totalled and there was no target amount recorded. This has been addressed in the Well-led section of the report.

Daily handover meetings provided staff with up to date information. Records showed staff discussed the well-being of every person who lived at the home and any tasks that staff needed to carry out, such as contacting health care professionals and changes in prescribed medicines.

There was a comments book in the reception area and a notice encouraging people to share any concerns. This notice also included the contact details for CQC. We checked complaints information held at the home; there had been one complaint during the previous 12 months. Following the complaints investigation, staff had a 'reflective practice' session where they discussed how things could have been done better. This showed there was a willingness to learn from mistakes that had been made.

People told us they would speak to the manager or a member of staff if they had any concerns, but they had not needed to. A relative told us, "I would speak to someone if I had any concerns or saw something that concerned me, but I have never had reason to." A member of staff told us they would explain to someone they had to break their confidentiality if they disclosed something to them that needed looking into, such as a complaint or a safeguarding allegation.

Requires Improvement

Is the service well-led?

Our findings

We found some anomalies in recording in care plans, such as missing MCA assessments and assessments that had not been updated. Food and drink monitoring charts and positional change charts had not been completed consistently. One person had some conditions on their DoLS authorisation and staff had not consistently recorded how these were being met. This meant that some care plans were not a current reflection of the person's care provision.

The registered manager carried out quality audits to monitor systems at the home were working effectively and that people received appropriate care. These included audits on care plans and infection control. We saw the care plan audits included some improvements and also a record of when corrective action had been taken. However, no corrective action was recorded in the in-house audit in April 2017 yet the infection control nurse identified numerous shortfalls in May 2017.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

The manager told us that their daily 'walk-around' now included checks on hoists, security, the deployment of staff, and the cleanliness of bedrooms, bathrooms, toilets and sluices. In addition to this, the service manager carried out quality checks, which entailed them visiting the home at various times of the day. The nominated individual also carried out periodic audits of the home. Lessons learnt were discussed at weekly manager meetings; managers were required to submit figures each week on areas such as staff sickness, staffing levels and the use of agency staff. We were told that managers were able to (and did) challenge each other's practice at these meetings.

There was a manager in post who was registered with the Care Quality Commission as required by a condition of the provider's registration. 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 2008 and associated Regulations about how the service is run.

The provider is required to display their inspection rating following a CQC inspection. The rating for the inspection conducted in May 2016 was clearly displayed within the service and on the provider's website.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

We found the registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. The submission of notifications allows us to check that the correct action has been taken by the registered persons following accidents or incidents.

Staff spoke positively about senior staff and the manager. One member of staff said, "We have a strong care leader team. Since [name of manager] has been the manager, things have improved" and another said, "I have a lot of faith in [Name of manager]. They have fought for us to have extra staff." Comments from care professionals included, "The manager knows the residents very well and I have always found her to be very approachable" and "There now seems to be an effective and stable management structure in place which I feel promotes a more stable relationship for all parties concerned."

Staff described the culture of the service as "A person centred approach", "First class care" and "Lovely staff."

The care plans we checked included a 'customer review of the service' form. Care staff approached people every month to ask if they were happy with the care they were receiving, and their response was recorded in their care plan. People who lived at the home had also been asked to complete a survey about mealtimes. The outcome was that 50% of people wanted the main meal to be at lunchtime and 50% wanted the main meal to move to the evening. As a result, the meal had been moved to the evening for a trial period.

Meetings were held for people who lived at the home and their relatives. At the last meeting, 18 people who lived at the home, two relatives and two members of staff had been present. Topics discussed included fire alarms and visitors, food menus and choices, activities, 'Breath of Fresh Air' day, Yorkshire Day and staffing levels. These minutes were displayed on the home's notice board so they were available for people who lived at the home and visitors. Relatives also told us they felt comfortable speaking directly to the manager.

Surveys had also been distributed to relatives and friends. Two of the 11 respondents mentioned the lack of staff and other feedback was positive. We saw that staff had received numerous thank you cards from relatives of people who had received care at the home.

However, one relative said they were concerned that, when their family member was admitted to hospital, they were not able to get there for an hour and their family member was sent in the ambulance on their own. On the day of the inspection a person had a fall. They were well supported by staff until the ambulance arrived, and a member of staff accompanied them to the hospital. The nominated individual acknowledged that they were not always able to do this, as they had to balance the safety of the people living at the home with the safety of the person being admitted to hospital.

Staff meetings were held on a regular basis and staff told us they could raise concerns or make suggestions at these meetings. One member of staff said, "If [Name of manager] can't answer a question there and then, they will try to get us an answer" and another told us, "We are asked if we have any questions. The care leaders are really good - we are listened to." We saw that topics discussed included health and safety, confidentiality, nutrition, music, staffing, key working and training. Staff were told they would be receiving a hand-out on the ten principles of infection control and that completion of the Care Certificate was a requirement for new starters.

Quality surveys had been distributed to health care professionals. The responses had not been analysed as the survey was on-going. We saw that one professional had commented that staff were 'sometimes overstretched' but all other responses we saw were positive.

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 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems had not been established to assess, monitor and improve the quality and safety of the services provided. Accurate, complete and contemporaneous records in respect of each service user had not been maintained. Regulation 17 (1) (2) (a)(c).