

North Yorkshire County Council Springfield Garth

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?

Good



Overall summary

The inspection took place on 9 and 10 June 2015 and was unannounced.

At our last inspection on 14 August 2014 we identified breaches of Regulation 11 and Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 13 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that

people had not been assessed under the Mental Capacity Act (MCA) 2005, which meant that people might not have their rights and freedoms protected. Staff appraisals and personal development plans were not up to date.

Following the inspection in August 2014 the provider wrote to tell us what they would do to make improvements to meet the legal requirements. The inspection in June 2015 was undertaken to make sure that the provider had followed their action plan, to identify that the provider met the legal requirements, and to provide a rating under the Care Act 2014.

Summary of findings

Springfield Garth is a purpose built home on two floors situated on the outskirts of Boroughbridge, with local amenities and transport links with Harrogate, Ripon and York. Springfield Garth is owned and operated by North Yorkshire County Council. It is registered with the Care Quality Commission to provide accommodation for 28 people who require personal care and support. When we visited the manager informed us that they only admitted up to a maximum of 26 people and 14 people were living there.

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 2008 and associated Regulations about how the service is run.

At this inspection we found improvements had been made to staff training and development. Staff had access to a range of training through distance learning and classroom based training. Some staff told us that they would like to have the opportunity to undertake additional training. However, records showed us that not all staff were taking advantage of the training opportunities that were on offer.

We identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risk assessments had not always included sufficient information to evidence how the decision was reached. For example, staff had not taken one person's psychiatric history into account when assessing their ability to manage their own medicines safely. This meant that staff might not monitor whether the person was taking their medicines according to the prescribed instructions, which could put them at potential risk of harm. Not all risk assessments had been updated in a timely way. We found that the provider had not put appropriate measures in place following an accident in the home. This meant that action had not been taken to make the situation safe and prevent a similar incident reoccurring. There was incorrect information in the file which held the people's emergency evacuation plans, which meant that essential information might not be readily available in the event of an emergency. You can see what action we told the provider to take at the back of the full version of the report.

Action had been taken to assess people in relation to the Mental Capacity Act (MCA) 2005. However, people's care plans needed updating to ensure they included key information about deprivation of liberty safeguard authorisations that were in place. This would alert staff to the need to monitor changes in the person's care or treatment, or their overall situation, which may mean that they may no longer require such measures in place. We found that the provider had failed to submit two notifications to CQC as they were required to do. This meant that the provider had not complied with the specific duty placed on them to inform CQC where a standard authorisation was approved under deprivation of liberty safeguards. Not all of the staff had completed training on the MCA and DoLS. We have made a recommendation about staff training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure they understand their role and responsibilities under the Act. This will help to ensure people receive safe, consistent care that protects their rights and freedoms.

People who used the service and managers and staff confirmed that staffing difficulties had impacted on the home's ability to drive forward improvement. However, we saw that the staff team had worked well together to minimise the effects of the reduced staffing levels to keep people safe.

Information about people's life history and their likes and dislikes was not fully reflected in their support plans. However, people told us they were well cared for and we observed staff were kind and patient throughout our visit.

Mealtimes were well organised and we identified that people received nutritious food that met preferences.

People's daily records were maintained and referrals were made to healthcare professionals when necessary. The local GP practice held a surgery each week in the home. This meant people's healthcare needs were kept under review and changing healthcare needs were identified and met. Care plans included individual assessments in relation to falls, mobility, skin integrity and nutrition and we saw that appropriate referrals had been made to community healthcare and social care professionals as needed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Although there were policies and procedures for managing risk these had not always been applied in a consistent way to ensure people were protected.

Processes were in place to protect people from the risk of abuse. Staff were aware of safeguarding adults procedures.

There was a medicines procedure in place and care workers were trained on safe administration and recording of medicines.

Safe recruitment practice was followed, which minimised the risk of appointing someone unsuitable for the job.

Although the home was experiencing staff shortages we found that the staff team worked together to make sure that there were enough staff to provide the support people needed.

Requires improvement



Is the service effective?

The service was not effective.

Action had been taken to assess people in relation to the Mental Capacity Act (MCA) 2005. However people's care plans had not been updated with key information about their status regarding Deprivation of Liberty Safeguard (DoLS) authorisations that were in place. The provider had failed to notify CQC as required.

Although care staff had a personal development plan we identified that not all of the staff had undertaken training in MCA or DoLS.

Meal times were well organised and people received the support they needed to eat nutritious food and to drink.

People received the support they needed to see their doctor and other healthcare and social care professionals. Where people had complex health care needs, appropriate specialist health care services were included in planning and providing their care.

Requires improvement



Is the service caring?

The service was caring.

People told us that they were well cared for and we saw that the staff were friendly and patient when they provided people with care and support.

Staff took time to speak with people and engaged positively with them.

People were included in making decisions about their care and were encouraged to share their ideas and views at meetings.

Good



Summary of findings

Is the service responsive?

The service was responsive.

People's care plans needed improving to ensure they fully reflected people's individual wishes regarding their care needs. However, we found that staff were knowledgeable about people and were responsive to their preferences.

From our observations and talking with people who use the service and staff we found that people were provided with activities.

Appropriate systems were in place to handle people's complaints.

Good



Is the service well-led?

The service was well led.

There was a registered manager. Although the report has highlighted areas for improvement in risk assessment, staff training and care planning there were management systems in place to assess the quality of the service provided in the home.

People who used the service were protected by a provider who had discussed the future proposals about the development of the service in an open and transparent way.

The manager had taken appropriate action to ensure that staff worked together as a team to minimise the effects that staffing levels had on people using the service.

The staff we spoke with said they received good support and they had the opportunity to discuss their practice and to report any concerns.

People who used the service were asked for their views and these were acted upon.

Good



Springfield Garth

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place over two days on 9 and 10 June 2015 and was unannounced. The inspection team consisted of two inspectors 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. On 9 June 2015 the inspector visited the service with the expert by experience. On 10 June 2015 two inspectors visited the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service, such as notifications we had received from the registered manager. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

In total we spoke with 14 people. We spoke with six people individually about the care they received and we had conversations with another eight people and observed the lunchtime experience. We spoke with staff available over both days including the registered manager, a deputy manager, and five members of care staff. We also spoke with a visiting health care professional.

We looked at all areas of the home including people's bedrooms, the laundry room and the ironing room, bathrooms and communal areas.

We reviewed a range of records including care plans for four people living at the home and the minutes from the 'residents meeting' that was held on 1 May 2015. We checked management records relating to the running of the home including recruitment records for three members of staff, staff rotas, and staff meeting minutes from 20 April 2015 and 18 May 2015. We looked at the staff training plan and an electronic training and development plan for one person with their agreement. We also reviewed maintenance records and audits including the monthly management report dated 21 May 2015.

We contacted Healthwatch to ask for their view on the quality of the service provided at Springfield Garth. Healthwatch gathers the views and experience of people about their local services, and uses that information to help improve services and influence commissioning outcomes for people living in the area.

Is the service safe?

Our findings

There were policies and procedures in place for managing risk and the provider completed an annual health and safety audit. In addition, the staff were required to complete routine weekly and monthly checks covering such areas as the hot water temperatures and fire checks. However, we saw that the weekly and monthly fire checks were overdue and the last checks were completed in April 2015.

The fire risk assessment did not take account of the location of the ironing room and the electrical appliances used in that room. This included a 'domestic' cable drum electric extension, which we saw was not fully extended to avoid overheating. A personal emergency evacuation plan (PEEP) had been completed for each person in the home. A copy was kept in both people's care files and in the main file, which would be used in the case of an evacuation. However, we saw the main folder was not up to date. It contained a PEEP for one person who was no longer living in the home and the PEEPs for two recent admissions had not been included. This placed both the people using the service and people assisting them at potential risk in the event of the need to evacuate the home in an emergency.

During our visit we observed that two fire hoses had been condemned and we saw that fire extinguishers had been provided in their place. The manager told us that the fire hoses had been 'capped off' to prevent their use. However, we were concerned that because they had not been removed this could cause confusion and delay in the event of a fire. The four fire extinguishers that replaced them were not fitted onto stands or wall brackets, which made them vulnerable to being moved, to accidental damage or of being knocked over.

People who used the service were assessed because of their mental capacity at being at risk from falling at a height, which was likely to cause harm. Although most of the windows on the first floor were fitted with restrictors there was one in a WC that could be fully opened.

At the staff meeting in April 2015 a member of staff reported that they had 'burned' their hand on one of the laundry products in use. The meeting agreed to keep the Control of Substances Hazardous to Health (COSHH) safety data sheet next to the container to inform staff about the risks of using the product. However, an updated risk assessment was not

available. During our visit we observed that the laundry door could not be locked, which meant that three of these containers were accessible to people who used the service and their visitors as well as staff. Although other doors in the home were kept locked we saw that the keys were stored on top of the door lintels. This included the medicine room door key, which meant that anyone was able to access the key and therefore the room where medicines were stored. We asked the duty manager to keep the medicine door key safe to ensure that only those individuals who needed to access the room could access it.

Risk assessments have been completed for people who had responsibility for managing their own medicines (we sometimes call this self-medication). However we saw for one person that staff completing the risk assessment had not included pertinent information about their previous psychiatric history and had not considered the potential impact of this on their safety and wellbeing.

These matters were a breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received a number of comments about staffing levels at the service from staff and from people who used the service. Staff felt that they were rushed at times and could not always spend the time they would like with people. Some people felt that staff were busy and said they had been told not to keep ringing the bell and that staff would come when they can. Other people reported that they thought that there was sufficient staff most of the time. One person told us that they sometimes felt that there were not enough staff, but this had not actually caused them any difficulties.

During our visit we observed the care and support people received. We saw that there was a visible staff presence in communal areas and that staff provided the support people needed. We didn't see people waiting for assistance for long periods of time or see any incidents that could have been avoided with a better staff presence. We looked at the staff rotas for a four week period. These showed that the duty managers and the independent living facilitator had all provided additional staff cover particularly during the evenings, at night and at the weekend.

We discussed staffing at the service with the manager who told us that the recent staff turnover had been high. They told us that duty managers worked in addition to the care

Is the service safe?

staff and ancillary staff that were on duty. However, owing to staffing shortages managers had also worked care shifts, when needed. At the time of our visit managers were also covering maintenance jobs such as the fire checks, health and safety checks and the gardening. The manager felt that whilst staff were busy, the staffing levels provided were safe and appropriate for the needs of the people living at the service. The home was currently running at a 50% vacancy rate and they said they carefully considered any new residents care needs before they agreed a placement. The manager told us about the steps they were taking to recruit new staff and confirmed that they had appointed a member of staff to complete maintenance jobs. The manager reported and records confirmed that systems were in place to obtain additional cover if needed to cover absence.

Safeguarding and whistle blowing policies were in place and copies of these were made available to staff on North Yorkshire County Council's website and information displayed in the home. Records showed that staff had received training in safeguarding. This helped to ensure that staff were aware of their roles and responsibilities in identifying, reporting and recording potential abuse. The staff we spoke with confirmed they had received safeguarding training and they were confident that any concerns that they raised would be acted upon. The provider had submitted appropriate notifications about incidents that had occurred in the home. These confirmed that the manager and staff had followed the proper safeguarding procedures to keep people safe.

There was a medication policy which included all aspects of safe administration and recording. Records showed staff involved in medicine administration were trained and supported appropriately. Staff we spoke with confirmed

they had received training and had their competency tested at various times. Following our last inspection in August 2014 the provider had confirmed that photographs of people using the service had been inserted into people's files. During this visit we saw that people's care records contained a photograph along with information about the medication they had been prescribed. We observed staff were not rushed and that they administered medicines in a systematic and safe way. These arrangements reduced the likelihood of errors and meant that medicines were given to people appropriately and safely.

The deputy manager we spoke with showed us the systems in place for auditing the management of medicines and this showed us that medicine records were checked and medicines could be accounted for. Appropriate arrangements were in place for healthcare professionals to review people's medicines. This showed us that people's medicines were kept under review, which helped to ensure that medicines were managed safely.

During our visit to the service we looked round the home and saw that everywhere was clean and tidy. We observed the care staff using appropriate Personal Protection Equipment, such as plastic aprons. Liquid soap and paper towels were available in all of the communal toilet facilities and we saw anti-bacterial hand gel was available in all public areas. We saw cleaning schedules for the care staff which included checking, cleaning and turning mattresses. These were signed and dated by the member of staff who had undertaken the task. Domestic staff used cleaning schedules, which they told us helped them to keep all areas of the home to a high standard. The schedules were audited to ensure these processes were maintained and that people were cared for in a clean and hygienic environment.

Is the service effective?

Our findings

At our last inspection in August 2014 we identified breaches of Regulation 11 and Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 13 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Compliance actions were made in relation to assessing individuals under the Mental Capacity Act (MCA) 2005, staff appraisals and personal development plans.

We asked the provider to send us an action plan outlining what actions they would take to bring the service up to the required standard. At this inspection we identified improvements had been made in line with the provider's action plan in relation to staff support and training. However, sufficient progress had not been made for us to be able to identify sustained good practice in relation to the MCA.

The provider told us in their PIR that two people were subject to Deprivation of Liberty Safeguards (DoLS). During our visit we checked the standard authorisation under DoLS that was in place for one person. Although the staff could clearly describe the steps they were taking to provide care in the least restrictive way possible for this person, the person's care plan had not been amended to reflect this important change. This means that staff might not recognise a change in the person's circumstances that might trigger a review of the DoLS in place. We discussed the need to keep the authorisations under review through care planning so that they could be removed if no longer necessary.

People we spoke with told us that staff checked their preferences out with them before providing care and we observed this in practice. We saw that staff were kind and patient with people when they offered support. Discussions with staff showed us that they knew people's care needs well and this helped to ensure that people's rights were respected and taken into account.

However, we found staff did not fully understand their duties and responsibilities under the MCA. For example, the manager had not notified CQC about applications that had been made to deprive a person of their liberty under the MCA. We advised the manager of the requirement that when an application was made for a deprivation of liberty

authorisation, they must inform the CQC once the outcome of the application was known. We also advised that if a person subject to a deprivation of liberty authorisation should die whilst subject to the authorisation they must also inform the local Coroner and the CQC. This is because these notifications inform our statutory Mental Health Act monitoring duties as well as our functions under the Health and Social Care Act 2008.

The training spreadsheet we were given showed us that training in relation to MCA and DoLS was not up to date. This means that people may not receive consistent care that supported their rights and freedoms.

Staff had access to an electronic system, which recorded their individual learning and development. The electronic system being used also alerted staff and managers when essential training was due. We looked at the electronic training record for one person, which showed us that there was a range of training in place. Managers also kept a staff training planner that allowed them to monitor staff training. Records showed us that the manager reminded staff at team meetings about the importance of keeping up to date with their mandatory training. Staff were asked to keep the office staff informed so that the training planner could be updated in a timely way. The manager also told us about additional training that could be provided when a training need was identified. For example, we spoke with one member of staff who had accessed oral health training, which they told us they had enjoyed. Another member of staff had accessed computer training independently to enable them to increase their confidence and access on line courses that were available to them.

We received some conflicting evidence in relation to staff training and development. Some staff we spoke with cited the lack of training as a key factor in the recent staff turnover. Staff told us that they would like to complete NVQ qualifications at a higher level but that the council did not support them to do this. However, there was some evidence to show that not all staff were taking up the training opportunities that were on offer.

From records we verified that staff had undertaken an induction programme. Staff said and records confirmed that they had monthly supervision sessions, with a member of senior staff. They told us they could ask for further support at any time.

Is the service effective?

During our visit we also checked the arrangements for providing people with a choice of suitable nutritious food and drink. The meal times and the menu were displayed in the home and food was discussed at the residents' meetings. People said they would like more fresh fruit to be provided. However, we saw that the menus were varied and included a variety of nutritious foods. People could take their breakfast in their rooms if they wanted. One person we spoke with told us that the food was good. They said that they only liked certain vegetables and the cook was happy to accommodate their preferences. We observed the lunchtime experience. People told us about the recent introduction of tureens at mealtimes, which people told us they liked. One person said. "It is a good idea we can help ourselves."

Care plans provided us with evidence to show that appropriate action was taken when people were at risk of losing weight and how people were supported to eat and drink. During our visit we saw that people were offered support discreetly, people were not rushed and the mealtime was a pleasant, sociable event. We saw that

people were offered drinks during meals and throughout our visit. Where concerns had been identified staff said they would discuss these with the GP who made a weekly visit to the home so that the appropriate referrals could be made.

During our visit we also saw evidence in care plans of consultation with other healthcare and social care professionals such as community psychiatric nurses, opticians and dentist. We spoke with a visiting chiroprapist who told us that the staff were quick to involve them if needed. They told us that they provided staff with an update following treatment and we verified from people's care records that staff recorded any changes in a timely way. This helped to make sure that staff had the right information to provide people with consistent and up to date care.

We recommend that the service finds out more about training for staff, based on current best practice, on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Our findings

The people we spoke with told us they were happy with the care they received. One person said, "Staff will do anything to help you." Other people said staff were 'kind' and 'caring'. We saw people were well dressed and they appeared relaxed throughout our visit. We observed people chatting with others and staff talked to people in a kind and professional manner. People were not rushed and we saw staff gave people sufficient time to respond when they asked a question.

Staff told us that they took time to understand people with communication difficulties and we saw that they knew the best way to communicate with people to make choices and retain as much independence as possible. We saw that appropriate arrangements were in place to promote people's independence in everyday tasks. For example, the dining room had a kettle, microwave and toaster, which people could use to make snacks and drinks independently.

During our visit we observed the care staff speaking with people respectfully. We saw that personal care was provided promptly and discreetly as needed. We saw that the staff in the home protected people's privacy by knocking on doors to people's private areas before entering. They ensured doors to bedrooms and toilets were closed when people were receiving personal care.

We saw that staff communicated when supporting individuals and checked people's preferences out with them before they provided care. This helped to ensure the people who lived in Springfield Garth had their needs met and their dignity maintained.

The home had an 'independent living facilitator' whose main responsibility was to provide leisure and social activities. They told us that they provided activities on an individual or group basis. They said that they encouraged people to maintain their existing interests, develop new ones and maintain a stimulating social life. The 'independent living facilitator' told us that they tried to

provide people with meaningful activities linked to their previous hobbies and interests. They recognised that activities such as taking a walk, cooking or painting could be used to support people's dignity and promote their wellbeing. During our visit we saw examples of people's craft work displayed in the home.

People were encouraged to contribute their ideas and comments in the 'residents meetings,' which the independent living facilitator held every other month. Along with other things we saw from the records that meetings were used to discuss topics such as the menus, staffing, fire evacuation procedures and staffing as well as plans for forthcoming events. This provided people with a forum in which they could air their views. The newsletter was also used to keep people informed about the home. The manager told us that they also used events such as the forthcoming summer fete as an opportunity to speak with families to gain their views.

People told us that there were no restrictions on the times their relatives or friends could visit. People also had internet access and one person told us that they regularly used this to chat with family. They told us this was an integral part of their life and greatly enhanced their life by allowing them to keep in close touch with family.

We saw cards and letters from relatives and friends of people who lived at the home, thanking staff for their support and the excellent care provided. Another relative had also provided positive feedback through the internet. The independent living facilitator told us that families also received copies of the newsletter and they had planned a relatives meeting for September 2015.

No one was receiving end of life care at the time of the inspection. However, we saw that people had advance care plans in place, which showed that they were involved in decisions about their end of life care. In the case of one person we saw this had been updated after their hospital discharge. This gave us evidence that advanced care plans were relevant and up to date.

Is the service responsive?

Our findings

During our visit we checked to see how people's needs were assessed and care and treatment was planned and delivered. We saw each person had a pre admission assessment that included details about their life history and their likes and dislikes. We found that some of the information being recorded was not individualised. For example, for one person their care plan stated 'requires assistance with their personal care needs' without specifying what that care entailed. People's preferences regarding their care such as rising and retiring times were recorded. However, we identified that not all information that was collected on people's life history sheets was accurately reflected in their support plans. This meant that people might not receive personalised support according to their likes, dislikes, abilities, needs and wishes.

We saw that assessments were completed in relation to falls, mobility, skin integrity and nutrition, and these had been reviewed each month. This helped staff to identify people's changing or emerging needs at an early stage. During our visit we observed staff were constantly updating people's daily records. This helped to keep staff coming on duty and visiting health and social care professionals informed about any changes, or emerging changes, to people's care needs. When we spoke to staff we found they were knowledgeable about people's needs and preferences. For example, a member of staff told us in detail how one person liked their bed to be made so that it was comfortable for them.

We received conflicting information regarding the routines and regime in the home. One person told us they would like to do more, particularly during the evening. However staff felt that whilst they were busy they also encouraged people to maintain their relationships and daily living routines wherever possible. For example, they supported one person who enjoyed music to attend evening events at the nearby Cathedral.

A 'wish tree' was located in the entrance, where the people using the service had written their wishes or hopes onto a paper butterfly and hung it on the tree. The manager told us this was a recent development. Care staff had looked at

the wishes and the manager said they would try their best to make all of them come true. We saw that people had chosen to go out for a coffee. Another person expressed a wish to go fishing and another to visit a pub. The service ran a small 'shop' and a library service, which people said they appreciated. People also told us that they could order daily / weekly newspapers to help them keep in touch with local and national events.

The manager organised a range of fundraising events, which were used to pay for joint activities that they arranged in the home. Examples included the annual summer trips and entertainment during 'holiday fortnight' that involved all of the people using the service and staff. Planned outings over this period included a visit to Harlow Carr Gardens in Harrogate and a trip to Scarborough. Arrangements had also been made for a visit from a local petting farm. We saw photographs from previous events were displayed in the home. During our visit we also saw that greenhouses were set up at the back of the home to produce vegetables for use in the home and also to sell on the produce table located at the front entrance.

Although we did not see any visitors during our inspection we were told by the people in the home that their relatives regularly came to see them and were happy with their care. Results from surveys completed indicated that people agreed or strongly agreed that the manager was approachable and responded to questions or issues effectively.

We saw that where people had raised concerns or complaints these were addressed appropriately. Information on how to complain about the service was displayed in the home and people told us that they had received a copy of the home's complaints procedure when they moved in to the home. People told us if they had any concerns or complaints they would discuss them with either the manager. In addition, a senior manager also carried out monthly monitoring visits and people could raise any concerns at that point. Staff were aware of the complaints procedure and knew how to assist people if they wanted to make a formal complaint. These arrangements showed us that people's complaints would be listened to and acted upon.

Is the service well-led?

Our findings

There was a registered manager in post. At the last annual survey 100% of people using the service had agreed or strongly agreed that the manager was approachable and responded to questions or issues effectively; that the home was maintained to a good standard of cleanliness; that they were included in care planning and that their care needs were effectively met.

We saw that the service had a clear complaints and compliments system. Regular staff meetings were held, which provided staff with a forum where they could discuss changes to legislation, complex cases and good practice. People who lived in the home also had the opportunity to meet together, which relatives could attend if they wanted. We saw that the future plans for the home had been discussed at meetings and were in the home's newsletter. This showed us that the provider was being transparent and open by keeping people informed about important decisions that were pertinent to their future.

The staff we spoke with told us they felt supported by the manager and senior management team. Both managers and staff reported that they were kept busy and staffing issues meant that they had to prioritise staffing levels over some of their management tasks. However, we found that action was being taken to recruit staff to vacancies and managers had been careful to reduce the impact on staff by limiting the number of new residents being admitted. We identified that staff had worked well together to minimise the effects on people using the service and to provide people with safe, consistent care.

The manager had not notified the CQC in relation to people subject to deprivation of liberty safeguards as they are required to do. CQC has a statutory duty to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberties Safeguards through our inspections of care homes. We also need to consider whether services are

following the requirements of the wider Mental Capacity Act. However we identified that other statutory notifications had been submitted in a timely manner. During our visit we asked the manager to ensure that these notifications were also submitted.

Although improvements were needed to the frequency of the fire safety checks we found documentary evidence to show that monitoring systems were in place. Examples of audits we saw included medicines, care plans, infection control and water temperatures. These had all been completed in a timely way and were up to date. Generic risk assessments for the service had been undertaken such as the breakdown of the lift, using transfer equipment such as hoists, the stair lift, and the use and storage of walking aids. We saw that where shortfalls had been identified, then action plans had been put in place to address any issues.

We saw in the PIR that managers attended a quarterly Registered Managers Meeting with the Nominated Individual. In 2014 North Yorkshire County Council had instigated a registered managers network, which gave managers in the area the opportunity to meet together to focus on the development of good practice. Managers could also share their good practice ideas and tools on the website. The registered manager also completed an annual service improvement plan, and during our visit we saw the progress on the actions was being monitored. These arrangements enabled managers to keep up to date on good practice and to effect improvements in the home.

Management systems were in place to ensure that staff had appropriate training, supervisions and appraisal. Senior staff carried out the supervision sessions and these were audited by the manager. The manager told us that they were proactive in responding to developing performance, capability and disciplinary procedures at work. Records showed that managers had received additional training on resolving issues at work, appraisal skills and effective supervision.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>People who use services and others were not protected against risks because risk assessments and associated documentation was not being completed or updated in a timely way.</p> <p>Regulation 12 (1)(2)(a) and (b)</p>