Coach House (Carleton-In-Craven) Limited

The Coach House Residential Home

Inspection report

Carla Beck Lane
Carleton
Skipton
North Yorkshire
BD23 3BU

Tel: 01756798097

Date of inspection visit:
18 January 2017

Date of publication:
21 March 2017

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

We undertook this inspection of The Coach House Residential Home on 18 January 2017. The inspection visit was unannounced.

The Coach House Residential Home is registered to provide personal care and accommodation for up to 15 people. The home focuses on providing care to older people and people who may be living with a dementia. At the time of this inspection the home was providing care to 14 people.

At the time of our inspection The Coach House Residential Home had a registered manager. 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.

Our previous inspection of The Coach House Residential Home took place in December 2014, when the service was given an overall rating of good.

People told us they were happy with their care and would recommend the home. Staff knew people well and told us that they enjoyed working at the service. People felt safe at The Coach House and relatives told us they thought their relations were safe and well cared for.

The registered provider's recruitment process reduced the risk of unsuitable staff being employed. Staff knew what to do if they had concerns or suspicions of abuse and felt able to raise any concerns they might have with the registered manager or provider.

Overall we found that staffing arrangements met people's needs, but that this needed to be kept under constant formal review to ensure that people were safe. We have recommended that the registered provider implements a formal system for calculating and monitoring dependency based staffing levels at the home, based on current best practice guidance.

There was a lack of clarity about some medicines that were being given 'as required' or 'as directed' and medicine administration records did not always evidence that medicines had been given as prescribed. The policies and procedures relating to medicines would benefit from updating to reflect current best practice guidelines.

Most maintenance and inspection checks had been completed as required. We found that inspection of manual handling equipment and fire equipment was overdue, but was arranged and completed when prompted by our inspection.

On one occasion during 2016, staff had not identified a serious injury after someone fell and as a result had

not sought prompt medical attention. Training for staff on what to do after someone had a fall had been provided in response to this incident, but we found that a competent first aider was not always on duty in the home. The registered provider may wish to refer to good practice documents for example, The Health and Safety (First-Aid) Regulations 1981. Guidance on Regulations and decide that if a first-aider is not required in the care home, a person should be appointed to take charge of the first-aid arrangements. The role of this appointed person includes looking after the first-aid equipment and facilities and calling the emergency services when required. To fulfil their role, the appointed person does not need first-aid training, though emergency first-aid training may be beneficial.

We had concerns about fire safety and night time staffing arrangements, which have been shared with the local fire safety officer.

We saw that people were involved in day to day decisions regarding their lives and the support they received. However, staff had limited understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), which had not been fully implemented at the home.

Staff told us they received appropriate training and support. Records showed that staff had received supervision and appraisal, but there were gaps in some staff members training and some training was old or out of date.

People received enough to eat and drink throughout the day. If people asked for alternatives these were provided, but there was no formal menu choices available. One relative did not feel that their relation's dietary preferences had been catered for, but the registered manager agreed to make arrangements for this. We have recommended that the registered provider considers ways of providing people with more choice and ensuring that dietary preferences are identified and catered for.

People told us that all staff were very kind and caring in their approach. We saw pleasant and positive interactions between people and staff during our visit. There was a friendly and homely atmosphere and people told us they were happy at The Coach House Residential Home. People were treated with respect and staff understood the importance of maintaining people's privacy and dignity while providing care.

End of life care was provided in accordance with people's wishes and with support from relevant health professionals.

People were satisfied with their care and felt able to discuss things with staff if they needed or wanted to. Each person had a personal care record, which contained information about their needs and preferences. Staff knew people well. People spoke positively about The Coach House Residential Home being a small home, where everyone could get to know each other well.

An activities coordinator visited the home once a fortnight. They organised a range of activities and events which people enjoyed. Some people told us they would enjoy more activities and entertainments. The registered manager told us that additional care staffing was provided three or four times a week to support activities and that they were developing links with local organisations who could support events in the home.

A complaints procedure was in place. People told us they would feel able to discuss any issues or concerns with staff and could approach the registered manager if they wanted to.

A registered manager and deputy were in place and feedback from people who used the service and

relatives was positive about their approach. The registered provider had clearly displayed their last inspection rating at the home.

We found that statutory notifications had not always been made in line with legal requirements. Systems for monitoring quality and risk had not always been effective at identifying areas for improvement at the home or ensuring that appropriate improvements were made. We also found that some aspects of record keeping needed to improve.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we took at the end 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 required improvement to be safe.

Medicine management needed to improve to ensure that all medicines (including topical) applications were given consistently and as prescribed.

Some required maintenance and inspection checks had not taken place until prompted by our inspection.

On one occasion during 2016 staff had failed to identify a serious injury and seek prompt medical attention. There was not always a competent first aider on duty in the home and arrangements were not in place to mitigate the impact this could have on the safety of people who used the service.
We had concerns about fire safety and night time staffing arrangements, which have been shared with the local fire safety officer.

Recruitment processes ensured staff were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service required improvement to be effective.

The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) had not been fully implemented, but people were involved in day to day decisions about their care.

Staff received supervision and appraisal, but there were gaps in some staff members training and some training was old or out of date.

People received enough food and drink, but there were limited choices available.

Is the service caring?

Good

The service was caring

The staff were caring in their approach. We saw pleasant and

positive interactions between people and staff.

People were treated with respect and staff understood the importance of maintaining people's privacy and dignity while providing care.

End of life care was provided in accordance with people's wishes and with support from relevant health professionals.

Is the service responsive?

Good

The service was responsive.

People were satisfied with their care and felt able to speak with staff if they needed or wanted to.

Each person had a personal care record, which contained information about their needs and preferences.

A complaints process was in place and people felt able to approach the registered manager if needed.

Is the service well-led?

Requires Improvement

The service required improvement to be well led.

Statutory notifications had not been made in line with legal requirements.

Governance systems had not always been effective at identifying areas for improvement or ensuring that appropriate improvements were then made.

A registered manager and deputy were in place and feedback about their approach was positive.

People said they were happy with their care and would recommend the home.

The registered provider had displayed their inspection rating in the home.

The Coach House Residential Home

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 registered 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 inspection took place on 18 January 2017. The inspection was unannounced. The inspection was carried out by an 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 service.

Before our inspection, we reviewed all the information we held about The Coach House Residential Home. We reviewed our previous inspection report, and any other information or notifications we had received. A statutory notification is information about important events, which the registered provider is required by law to send to the Care Quality Commission.

We contacted the local authority for feedback, and gathered information from the local fire authority and about the home's most recent food hygiene ratings. We used this information to plan our inspection.

We spoke with a total of six people who lived at The Coach House Residential Home. We also spoke with two relatives who were visiting at the time of the inspection. Some people were living with a dementia and were not able to effectively communicate with us verbally, so we spent time observing the care people received and the interactions between staff and people who lived at the home. We also observed the lunch time meal.

We spoke with six staff, including the registered provider, registered manager, care workers and the administrator.

We looked at documents and records that related to people's care and the management of the home. This included a range of training records, medicine records, quality assurance records, policies and procedures. We looked at two people's care plan records and two staff files in detail.

Some information was not easily located during our inspection visit, so the registered provider and registered manager sent us additional information following our inspection visit.

After our visit we discussed our findings with the local fire safety officer.

Requires Improvement

Is the service safe?

Our findings

We received mixed feedback about staffing levels at the service. Four people who lived at The Coach House Residential Home told us they thought there were enough staff to meet their needs. However, two people living at the home and one relative told us they felt that there were not enough staff. They said staff were always busy and did not have the time to spend with them, because they were always rushed to get other tasks done. People also said they did not feel there were enough staff at night, when there was only one carer on night duty. One person said, "If staff could spend more time with me – just to have a chat it would make me happier." Another told us, "We could do with some more [staff], especially at night as there is only one member of staff. All the staff are always busy." A relative commented, "They could do with more staff."

Several people told us they had experienced incidents when a person had wandered around the home at night and into at least one person's room, which they had found un-settling and frightening at the time. This issue was mentioned by three people living at the home and one member of staff. We discussed this with the registered manager and they agreed to monitor the situation.

We spoke with the registered manager about staffing levels and looked at rotas. There were usually two carer workers on duty each day, with three care workers on the early shift three or four days a week . The carer workers were supported by the registered manager, administrator, domestic staff and maintenance person. However, the hours worked by the registered manager did not appear on the rota, so it was not possible to see when they had been at work and available to provide additional support.

One care worker was on duty at night and carried an emergency alarm that sounded in the registered manager's home (located just across the courtyard). The registered manager had carried out a test to see how quickly they could respond in an emergency and insisted that they could be in the home within three minutes if required. This arrangement had been discussed in depth during our last inspection, with advice sought from the fire safety authority. The registered manager told us that the night time situation had not changed since our last visit and that, "The night situation is monitored carefully, depending on resident's needs ."

During our visit we saw that staff were busy, but available to meet people's needs. We also looked at a selection of night time records and saw that these evidenced that people had received the care their care plans said they needed. The registered manager told us they were not called upon to assist night staff very often, but was available to do so if and when required. They also told us that they made alternative arrangements if they were not going to be available or if anyone needed additional support. Overall we found that staffing arrangements, during the day, met people's needs. However, this needed to be kept under constant formal review to ensure that people were safe. We had concerns about the fire safety and night time staffing arrangements. Our concerns were shared with North Yorkshire Fire and Rescue Service. A fire safety audit was carried out at the service on 17 February 2017 by officers from the North Yorkshire Fire and Rescue Service. We have a copy of the audit and have asked for an action plan from the Provider detailing what action will be taken to address the issues highlighted with fire safety at the service.

We recommend that the registered provider implements a formal system for calculating and monitoring dependency based staffing levels at the home, based on current best practice guidance.

During 2016, North Yorkshire County Council (NYCC) undertook a safeguarding investigation into why there had been a delay in identifying a serious injury and seeking medical treatment after someone had a fall. Although the NYCC investigation found that the fall and injury could not have been prevented, the investigation substantiated neglect of the person involved, because staff had not identified the injury or taken timely actions to meet their medical needs. As a result of this, the registered provider had reminded staff of the procedures to follow when someone fell and the importance of seeking prompt medical advice. At the time of our inspection, training records showed there was only one staff member with an up to date first aid training qualification and arrangements had not been put in place to appoint a member of staff to take charge of the first-aid arrangements.. We spoke with the registered manager about this. They told us staff covered basic first aid during induction training, but confirmed that when the one staff member with a first aid qualification was not on duty, there was no one at the home with an up to date first aid qualification or identified to take charge as noted above. This meant that appropriately trained and qualified staff may not be available if a person required first aid .

We saw example's where risks to individual people's wellbeing had been identified and appropriate actions taken in response. For example, staff had involved a speech and language therapist after identifying concerns regarding a person's ability to eat and drink safely. This resulted in the person receiving a more specialist diet to help keep them safe. Another example showed how staff had identified concerns about the safety of a person's bed and bedrails. Staff had worked with an appropriate healthcare professional to assess the situation and provide replacement equipment that would help keep the person safe. We saw that individual risk assessments had been completed to identify the risk of falls and of using bedrails.

There were no specific individual risk assessment tools in use to help staff identify and respond to risks associated with manual handling. The registered manager informed us that the community nurses supported them to monitor people's nutritional needs and skin integrity where this was felt to be a risk. There was currently no one with any pressure sores at the home and the weight records we viewed showed that people had maintained their weight over the last six months. This suggested that care was being provided appropriately.

However, we recommend that the registered provider and registered manager implement current best practice guidance in relation to individual risk assessments around manual handling, to help ensure that risks to people's wellbeing are always proactively identified and responded to.

People who lived at The Coach House Residential Home told us they usually felt safe living there. One person said, "Yes, I absolutely feel safe here. The staff attend to you quickly when you need them." One person told us, "I am safe in here as staff help me to get to my room safely." People acted in a way that showed they were at ease and there was a pleasant and comfortable atmosphere apparent on the day of the inspection.

There were safe recruitment and selection processes in place. This helped to reduce the risk of unsuitable staff being employed. The two recruitment records we viewed contained completed application forms, which included details of past employment, and interview records. Two references and a Disclosure and Barring Service (DBS) check had been obtained prior to staff starting work. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

There were policies and procedures to guide staff on the action to take in response to allegations or suspicions of abuse and how to whistle blow (tell someone) if something was wrong. These procedures were dated 2010, and needed review to ensure they followed current best practice guidance and the local authority's current alert process. Seven out of the eight staff members whose training records we looked at had received safeguarding training during 2015, All the staff we spoke with told us people were well treated, but were aware of reporting procedures and said they would speak to the registered manager if they had any concerns about the practice of colleagues.

Everyone we spoke with told us they received their medicines on time and that they were administered by staff. One person said, "I always get them [medicines] on time. The staff have never missed giving them to me." At the time of our visit, no one managed their medicines independently and staff assisted people to take their medicines. We observed a care worker administer people's lunchtime medicines. This was done pleasantly, with appropriate explanations given to people. The staff member explained they had updated their medicine training in November 2016 and showed us how they used good practice techniques to administer and record medicines safely.

Medicines were stored securely and a refrigerator was available for medicines requiring cold storage. Fridge temperature checks had been recorded daily up until June 2016, but not from then on. It is important for medicines to be stored within the correct temperature ranges, to ensure they remain safe and effective. We asked the registered manager about this, but they did not provide an explanation.

Arrangements were in place for the safe storage and recording of controlled drugs (CDs). CDs are medicines that require increased monitoring due to the risk of their misuse. Only one person was using CDs at the time of our visit. We checked their medicine records in the controlled drugs register against medicine stock and found that these tallied. This showed that these medicines had been administered in accordance with prescribing instructions.

We found that there was a lack of clarity around the administration of medicines and topical applications given on an 'as required' or 'as directed' basis. Topical applications are medicines applied externally, such as creams. Some prescription instructions stated that medicines should be given 'as directed', 'as required', or 'as needed', but there was no individual guidance available to explain what this meant or to support care workers in making safe and consistent decisions about their use. The current medicine administration records for many of these topical applications were blank, meaning it was unclear if they had been administered at all.

In addition, we found other examples where people's medicines were not given in accordance with their prescriptions or where there were unexplained gaps on the MAR. For example, one person had not had their eye drops administered on the morning of our visit because they were out of stock. Another person had a cream prescribed for a medical condition, which should have been applied two or three times daily. The person's MAR showed inconsistent administration, with the cream administered twice on some days, once on others and not at all on one day.

The registered provider had in place a policy and procedure for the safe administration and management of medicines and provided a copy of this to us during the inspection. We observed that this document was dated 2010 and did not reflect to current best practice guidelines. For example, the National Institute for Health and Care Excellence (NICE) guidelines on managing medicines in care homes issued in 2014.

We looked at a selection of maintenance records. These showed that some of the service's premises and equipment, such as gas appliances and electrical installations, had been serviced and inspected

appropriately. However, according to the available records, the home's fire equipment had last been inspected in December 2015 and was now overdue. We asked the registered manager about this. They followed this up with their maintenance company and booked the service for 20 January 2017.

Some records were difficult to locate at the time of our inspection. For example, up to date fire alarm service records and inspection records for lifting equipment, such as bath hoists, the stair lift and hoist. The registered manager explained that this was due to an office re-organisation. We asked the registered manager to provide evidence of these records following our inspection. The fire alarm had been serviced in December 2016. The inspection records provided for lifting equipment were dated 26 January 2017, with the inspection prompted by our request for information .

The service had an up to date fire risk assessment which had been completed by a specialist company in November 2016. This had resulted in an action plan, but there was no record of any progress being made against this. We asked the registered provider about this. They told us that in their opinion the report was "over the top". They had completed some actions, such as replacing fire doors, and informed us that they would look for a new contractor to review the previous risk assessment .

There was a record of fire drills taking place during 2014, but no record of any since then. The registered provider confirmed that fire drills were no longer completed, but that the fire alarm and fire doors were tested weekly. They also informed us that fire marshal training had been arranged for staff during February 2017. Personal emergency evacuation plans and an evacuation procedure were in place, but the personal evacuation plans we viewed were dated 2015 and needed to be reviewed to ensure they were up to date and reflected people's needs.

We identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment. This related to the safe management of medicines, ensuring premises were safe and suitable, ensuring staff had the necessary skills and competence to provide safe care, and assessing and mitigating risks to people receiving care and treatment.

Requires Improvement

Is the service effective?

Our findings

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

We checked 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. During our last inspection, we noted that staff had not received sufficient training to ensure a good understanding of the MCA and DoLS, but the registered provider and manager were arranging training to address this. During this visit, we looked at the training records for eight staff and found that none had any training in the MCA or DoLS recorded, although the registered provider told us this training was being arranged.

At the time of our visit, no-one living at the home was subject to a deprivation of liberty authorisation. This was unusual for a home caring for people living with dementia, following the Supreme Court judgement in 2014 regarding what can constitute deprivation of liberty. The home had a policy for DoLS, but this was dated as last reviewed in 2010. When we asked the registered manager about MCA and DoLS at The Coach House, they told us, "As we are a small home and have very little turnover of residents we have never required to use the MCA or have a meeting for best interest decision making." They also confirmed that there had been no DoLS authorisations at the home since they took over in 2008. We found that the home's policy and staff understanding of the MCA and DoLS did not adequately reflect the Supreme Court judgement or current best practice guidance. We could not be sure that people's legal rights were adequately protected.

This was a breach of Regulation 1813 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding people from abuse or improper treatment.Staffing

During our visit, we observed staff offering explanations and gaining informal consent from people before caring out care tasks. People spent time in their rooms or communal areas depending on their preferences and were also asked if they wanted to join in activities by the visiting activities coordinator. People moved freely about the home, spending time where they wanted.

People told us that they felt that their needs were being met by staff who were competent and knew what they were doing. One person told us they had been unwell, and how the staff had supported them on the days they felt well to come downstairs to sit in the lounge so that they did not feel isolated. One person said, "I like it here because it is a small and friendly place." Another person told us, "I am happy here." Somebody else said, "I am quite content here."

We spoke with two members of staff who told us they felt they received appropriate training to do their job

well. Both members of staff told us they had received moving and handling training. One told us, "I have recently completed my medication refresher training and a few weeks ago completed some training in foot care." A new member of staff told us they were booked to complete their induction training course which was over two days.

We looked at training records for eight staff and spoke with the registered manager about arrangements for training. The registered manager described how face-to-face training was provided through local companies and relevant healthcare professionals. New staff completed an induction when they started in their role, which included key topics and care certificate standards.

All staff whose records we viewed had either completed a formal qualification in care or were working towards one. Training records showed that staff had completed training on manual handling, medicines and falls during 2016. Some staff had also completed foot care training during 2016. Other training, such as safeguarding had last been completed in 2015, and there were gaps in the training records for some staff for fire, MCA, DoLS, first aid and food safety.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

The registered manager informed us that six staff were undertaking training on dementia awareness and two staff were completing training so that they could become qualified manual handling trainers within the home. We were also informed that a new training monitoring system was about to be implemented to help ensure staff training was kept up to date, but paper training records were still in pace at the time of our inspection and evidence that staff had received appropriate training.

One member of staff told us they had received regular supervision from their line manager. Another said that they had only worked at the home for two months and had not received any supervision, but would like this. Both staff told us they felt supported and happy in their jobs. We looked at the supervision records for four staff. All four had received an appraisal of their performance during 2016. In addition to their appraisal, three staff had received two supervision sessions during 2016. The other staff member had received one supervision session.

We observed lunchtime in the dining area. Two care staff served food to ten people. Most people sat in the dining area. We saw that that other people had their lunch in their bedrooms. Two people we had spoken with told us they preferred to eat their meals in their rooms. One person who was sat in the dining room needed some support with their meal. We saw staff supporting them pleasantly and encouraging them with their meal in a discrete and appropriate way. We saw that most people had the same food apart from two people who had a vegetarian option.

People told us that the food was nice. One person said, "The food here is very good." Another person told us, "The food is good. I am never hungry so it must be keeping me alive." People we spoke with told us that they were not offered choices at mealtimes. However, people made comments such as, "The food is very good, there is a variety and if there is something you don't like they (staff) will make you something else." Another person said, "It is not like being at home. There are no choices at lunchtime, but there is always the pudding. If I fancy anything my relative brings it in for me." Another person told us, "There is not much choice at teatime."

One relative we spoke with told us they felt that, although there was plenty of food and drink available, their relative's dietary preferences were not always met. The example they gave us included the provision of the

person's preferred milk and salad not being available. This was fed back to the registered manager, who said this was not an issue they had been made aware of and that they would sort it out for the person.

We recommend that the registered provider considers ways of providing people with more choice and ensuring that dietary preferences are identified and catered for.

We saw throughout the day that drinks were offered. A drinks trolley was taken around the home by care staff during the morning and afternoon. Whilst speaking with people in their rooms we saw that there were jugs of juice or water in their rooms.

People told us that their health care needs were being met. One person said, "I have to attend the hospital regularly for appointments and they [staff] make sure I go and the district nurse visits me." Another person said, "If I am ill they [staff] would get the doctor out. I have also had my eyes tested recently." On the day of our inspection, someone had a hospital appointment they needed to attend. We observed that the registered manager provided transport and accompanied the person, so that they had support during their appointment.

Care records included information about the different healthcare professionals people had been involved with. We saw that people had received treatment and support from a range of professionals, including the optician, chiropodist, GP and community nurse.

Good

Is the service caring?

Our findings

People we spoke with told us they thought that the staff were kind, caring and treated them with respect. Comments included, "The girls are very nice. The staff are all caring and very good. They are all patient and kind. If you want anything from the shop they will go for you. I can't speak any higher – they [staff] are all first class", "The staff are all very nice, very kind" and, "The staff are alright, they go that extra mile…I have to say most of the staff are very good." One relative said, "The care staff are all very good. They are very attentive." Another relative told us, "All the staff are gracious – they are all very kind. They [staff] always make me feel welcome when I visit. I find them all lovely here."

People living at the home told us staff always knocked on their bedroom doors before being asked to enter. We observed throughout the day that staff did knock on doors and waited to be asked to enter the room. Staff knew how to respect people's privacy, dignity and confidentiality. During our inspection, we saw that staff respected people's privacy and dignity when they were assisting and supporting people. For example, staff responded to requests and were sensitive and discreet. We saw that staff were patient and people were able to do things at their own pace and were not rushed. We saw that assistance with meals was done pleasantly and in a way that respected and maintained the person's dignity.

Both members of care staff we spoke with knew the people they cared for well. There was good interaction between people living at The Coach House Residential Home and the staff. For example, we observed people laughing and joking with staff. One person came and talked with the registered provider, asking them if they had any sherry. They were obviously comfortable and at ease and their requested sherry was quickly provided. The registered provider confirmed that this was an established routine the person enjoyed. We did not see any poor interactions during our visit and everyone appeared to be relaxed in their surroundings.

People were supported to maintain relationships that were important to them. Friends and relatives were able to visit freely and we saw people coming and going during our visit. People we spoke with all confirmed that their friends and relatives could visit at any time and there were no restrictions. Relatives we spoke with also confirmed that they were able to visit at any time and were made to feel welcome. The registered manager told us, "Relatives are able to visit at any time of day, or night (if the resident is ill), and can ring and speak to them at any time ."

Training records showed staff had received training during 2015, to make them aware of potential discrimination and help them recognise and respond appropriately to people's individual needs and preferences. We were told that newer staff had covered equality and diversity during induction training.

There was no-one receiving end of life care at the time of our visit. Where people wished to remain at The Coach House Residential Home, rather than going into hospital, arrangements were put in place to provide end of life care. We saw that the home had worked closely with healthcare professionals to discuss and record people's advanced wishes, so that arrangements could be made to meet these. This included decisions about resuscitation and where people wished to receive care at the end of their lives.

The registered manager also told us that they wanted to introduce the Gold Standard Framework for end of life care, to help train and support staff further in this role. The Gold Standard Framework supports homes to provide good quality end of life care.

Good

Is the service responsive?

Our findings

People we spoke with who lived at The Coach House Residential Home told us they felt the care they received was focussed on their individual needs. People told us their routines and wishes were respected. For example, they were able to get up and go to bed as they wished. One person said, "I can get up and go to bed as and when I like." Another person said, "I do what I want."

One person we spoke with confirmed that they knew all about their care plan and contributed to what had been written. The registered manager was able to describe their approach to assessment, care planning and involving people in this process. They told us, "We have individual care plans for each resident. These are written with the help of the resident and their families, but also observing and talking in general helps towards putting together a caring plan. As relatives know the resident better than the care staff on admission, talking to them and getting their views is important."

Each person had their own care record, containing their assessments, care plans and records relating to their care. We looked at two people's records in detail and another record in less detail. The records we looked at included person centred information and details about people's needs and preferences. For example, one person liked their door left ajar at night. Another person's records contained information about their particular healthcare needs and the treatment they were receiving. Another person's record included information to help staff understand their mental health and related behaviours.

People who lived at The Coach House Residential Home were not sure how often their care plans were reviewed. However, care staff told us that they reviewed people's care plans regularly and updated people's records daily. The care plans we looked at had been reviewed regularly and were up to date. There was a monitoring sheet in the office used by staff to schedule care plan reviews and monitor that these had taken place.

A daily record provided information about people's wellbeing and the care that had been given. For example, one person's daily record included details about the care and support they received during the night, showing that their night time care plan was being implemented by staff.

People we spoke with told us that some activities did take place in the home and this was usually one day every fortnight when an activities organiser visited the home. People told us they enjoyed this very much. The activity organiser visited the home during our visit. We saw that they engaged people in games and there was a lively and happy atmosphere during their visit.

People were able to tell us about events and activities they enjoyed. Recent activities had included a visit by local nursery children who had performed a nativity play and songs. One person said, "We have had someone who reads poems, we have had a few musicals, exercise class, afternoon tea outside. We are also planning a boat ride when the weather is better." Another person said, "I am very lucky as I go to the local church every week. I get picked up and brought back. I go out to lunch with my relative so I do get taken out." One person told us they enjoyed doing their knitting and another person told us they liked to listen to

Radio 4's gardener's question time.

Some people said they would like more activities to be provided. For example, one person told us, "Not much goes on, we have had the occasional singer." This had also been raised as a possible area for improvement in the most recent survey completed by relatives. The registered manager told us that although the activities organiser only visited once a fortnight, it was the expectation that care staff would also support people with activities on the days when three members of care staff were on duty. They also showed us how they were working to develop links with local groups, such as the Alzheimer's Society, to help arrange visitors and events.

People we spoke with knew who to speak to if they had a complaint or any concerns. One person said, "I would speak to my little nurse [staff member's name] if I had a complaint/concern. She has been a dear little friend to me. She looks after me." Another person said, "I would speak to [registered provider's name] the owners." One person gave a good example where they had raised an issue with the registered manager which had been dealt with to their satisfaction.

The registered provider had a complaints procedure and kept a record of any complaints or commendations they received. There had been one complaint since our last inspection, which had been investigated through local safeguarding procedures. The manager described how they maintained contact with people and their families to encourage open feedback. They told us, "As we are a small home, 14 beds, I see and speak to relatives and visitors regularly; if they have concerns they know I am always available."

Requires Improvement

Is the service well-led?

Our findings

Notifications about certain events and changes must be made to the Care Quality Commission in accordance with legal requirements. Since our last visit, we had received notifications about deaths at the home, but had not been notified of any other events. Accident records at the home and safeguarding information we had received from North Yorkshire County Council informed us that there had been three serious injuries and a safeguarding investigation, which the registered provider and manager had failed to notify us about in accordance with legal requirements. We are addressing this issue with directly the registered provider.

At the time of our inspection, we were informed by the registered provider and registered manager that they were in the process of re-organising the office. This meant that some paperwork was not readily available on the day of inspection. Some information we asked for during our visit could not be located and the registered provider and registered manager agreed to send the required information to us after our visit. They did this in a timely way, but the information provided showed that some health and safety related servicing and inspection work (inspection of lifting equipment and servicing of fire equipment) had been overdue. This had not be identified and rectified until we asked for evidence of the work having taken place during our inspection.

People's care records were up to date and included relevant information. However, we found that people's records did not currently include risk assessments to assist staff in the assessment and monitoring of risks related to manual handling. We also found that records related to the administration of 'as required' medicines and topical applications could be improved.

The registered provider informed us that they used a specialist company to review and update the home's policies and procedures. The registered manager had implemented a local process to ensure that staff were made aware of any changes. For example, focusing on a particular policy and procedure during staff supervision sessions. During our inspection, we requested and were provided with a number of important policies and procedures. However, some of these (such as the policies and procedures covering the management of medicines, safeguarding and DoLS) were dated and marked as last reviewed in 2010. They did not adequately reflect recent changes in best practice guidance or case-law and needed to be updated.

There were no formal monitoring visits or reports completed by the registered provider and manager. The registered provider explained, "As I am the registered provider and the registered manager I have no records of quality visits. I am on site most days so therefore have a good overview of the day to day running of the home and any problems that may arise ."

The governance systems in place had not been effective at identifying these issues or ensuring that improvements had been made. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

The service had a registered manager, who was one of the home's owners and lived in the grounds of The

Coach House Residential Home. The registered manager did not have set working hours and the rota did not contain any information to show when they had been at work or available to staff. They told us that, because they lived on site, they were often working in the home or available if needed and did not want to limit this flexibility with set working hours. The registered manager was in the process of introducing a deputy manager role at the home. The new deputy manager member had completed a relevant management qualification and was being 'mentored' by the registered manager, to help them develop in their new role.

Most people living at service told us they thought that the service was well run and that the registered manager was approachable. One person said, "I would definitely recommend The Coach House, because it is a small and friendly place. You get to know the staff and their families." Another person told us, "I would recommend living here to people, if they can live with people who have dementia." Another person said, "Yes, to a certain extent the home is well run." One relative told us, "It is not 100% perfect, but I would recommend The Coach House."

Staff we spoke with told us that they liked working at the service. One member of staff said, "I like the home, because it is small and you get to know the residents well. People are given plenty of encouragement, support and choice. Management are definitely approachable. I am happy working here. I would recommend the home to family and friends." Another member of staff said, "I love it here. Staff are great. The residents are lovely." Some of the staff we spoke with had worked at The Coach House Residential Home for many years and said they are very happy there.

The people living at the home and relatives we spoke with said they could not remember if they had completed any surveys about their experiences or care or attended recent meetings. However, people we spoke with told us they could raise any issues directly with care staff or the registered manager if and when they needed to. The registered manager showed us that a relative surveys had been completed during 2016. Seven surveys had been returned and gave mostly positive feedback about the home. For example, "Home from home, everyone helpful and friendly, (relative) very happy," "Small, friendly, personal, and, "Warm, friendly and caring staff."

It is a legal requirement for providers to display their current inspection rating and we saw that this information was clearly displayed in the home's reception area. At the time of this inspection the registered provider did not have their own website.

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 The registered person did not ensure that care and treatment was provided in a safe way to service users. This related to the safe management of medicines, ensuring premises were safe and suitable, ensuring staff had the necessary competence to provide safe care, and assessing and mitigating risks to people receiving care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems had not been established to assess, monitor and improve the quality and safety of the services provided. Effective systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate training to enable them to carry out their duties.