Rufus Healthcare Ltd

The Old Vicarage at Airmyn

Inspection report

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Airmyn
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 6 and 31 October 2016 and the first day of the inspection was unannounced. We arranged to return to the home for a second day to share additional feedback with the registered provider. The home was last inspected on 9 February 2016. That inspection was to check on requirements that had been made at the previous inspection on 4 June 2015. We found that the registered provider had made the required improvements.

The home is registered to provide accommodation and care for up to 19 older people, including people who are living with dementia. On the day of the inspection there were 19 people living at the home. The home is situated in Airmyn, a village that is close to the town of Goole, in the East Riding of Yorkshire. The premises have two floors; the ground floor is on two levels with a stair lift to assist people with the internal stairs. The first floor is accessed by a passenger lift. There is one shared bedroom and all other bedrooms are single, most with en-suite facilities. There are communal bathrooms or showers on each floor.

The registered provider is required to have a registered manager in post and on the day of the inspection there was no manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous manager had left the organisation and a new manager had been appointed. They had commenced the registration process with CQC.

New staff had been employed following the home's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people worked at The Old Vicarage at Airmyn. We saw that there were insufficient numbers of staff on duty during the afternoon / evenings. This had been recognised by the registered provider and they were in the process of recruiting staff to fill these gaps.

People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

We checked medication systems and saw that medicines were stored and administered safely, although some minor improvements were needed in respect of recording. Staff who had responsibility for the administration of medication had received appropriate training.

People who lived at the home and relatives told us that staff were very caring and that they respected people's privacy and dignity. We observed and were told that staff had a good understanding of people's individual care and support needs.

A variety of activities were provided to meet people's individual needs, and people were encouraged to take part. People's family and friends were made welcome at the home.

People told us that they were very happy with the food provided. We observed that people's nutritional needs had been assessed and individual food and drink requirements were met.

The premises were clean, hygienic and well maintained. We saw there was appropriate signage, decoration and prompts to assist people in finding their way around the home.

There were systems in place to seek feedback from people who lived at the home. People told us they were confident their complaints and concerns would be listened to. Any complaints made to the home had been investigated and appropriate action had been taken in response to the complaints.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them.

Some staff, people who lived at the home and relatives told us that the home was well managed. However, numerous concerns were shared with us by other staff and a relative. We addressed this by meeting with the registered provider on a second inspection day. The registered provider submitted an action plan to tell us how they would be dealing with these concerns.

Quality audits undertaken by the registered provider and the manager were designed to identify that systems at the home were protecting people's safety and well-being. When quality audits had identified that improvements needed to be made, there was not always a record of when actions had been completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time. Minor improvements were needed in respect of recording.

Staff had been recruited following the home's policies and procedures. People told us that more staff needed to be employed in the afternoons and this was being addressed by the registered provider.

The premises were clean, hygienic and well maintained.

Is the service effective?

Good

The service was effective.

Staff undertook training that gave them the skills and knowledge they required to carry out their roles. The recording of start dates and induction training needed to be more robust to evidence that staff had completed training prior to starting work at the home.

People's nutritional needs were assessed and the meals provided met people's individual dietary needs.

People's physical and mental health care needs were met, and people were supported by their GP and other health care professionals when needed.

Efforts had been made to make the premises suitable for people who lived at the home, including people who were living with dementia.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home, relatives and staff. Staff were kind, considerate and patient.

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

We saw that people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their individual care and support needs and their life history. This helped staff to have an in-depth knowledge of people's needs.

Activities were provided by an activities coordinator on three days a week and by care workers on the other days.

People were encouraged to give feedback about the service they received. There was a complaints procedure in place and people told us they were confident any complaints would be listened to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some people expressed concerns about how the home was being managed and this was being addressed by the registered provider.

Quality audits were being carried out to monitor that staff were providing safe and effective care, although there was not always a record of when identified actions had been completed.

Notifications were being submitted to CQC as required by legislation. Some improvements were needed in respect of record keeping, such as recording on medication administration record (MAR) charts and in care plans.

There were opportunities for staff and others to express their views about the quality of the service provided.

The Old Vicarage at Airmyn

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.

The inspection took place on 6 and 31 October 2016 and the first day of the inspection was unannounced. The inspection was carried out by one adult social care (ASC) inspector.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

On the day of the inspection we spoke with four people who lived at the home, four members of staff, the manager and the registered provider. We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication. We observed the interaction between staff and people who lived at the home who were not able to speak with us.

Following the first inspection date we spoke with five members of staff and two relatives on the telephone.

Good

Is the service safe?

Our findings

People who lived at the home told us they felt safe. One person told us, "Having staff around makes me feel safe." This view was supported by the relatives who we spoke with. One relative told us, "[Name] feels safe as there's always someone to help them." Staff described how they kept people safe. One member of staff told us, "We make sure there are no obstructions and that bed sides and bumpers are up and secure" and another said, "Staff understand about the safe use of wheelchairs and walking frames. We observe people to check they feel safe."

Staff told us that they completed training on safeguarding adults from abuse, and that they completed regular refresher training. This was confirmed in the training records we saw. Staff were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse. They told us that they would report any concerns to the manager or a senior member of staff and were confident they would be listened to and that appropriate action would be taken.

We checked the folder that contained information about safeguarding adults from abuse. This included the East Riding safeguarding adult's board procedure, the home's own policy and procedure, the tool provided by the local authority to determine when safeguarding alerts needed to be submitted, a record of any incidents that had occurred and the consideration log that was used to record the action taken. The same folder contained copies of notifications that had been submitted to CQC.

We checked the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with vulnerable adults. Documents such as photographs to identify the person's identity had been retained. These checks meant that only people who were considered suitable to work with vulnerable adults had been employed at The Old Vicarage at Airmyn.

The manager told us that there were three care workers on duty each morning and that there were two staff on duty from 2.00 – 4.00 pm and again from 5.00 – 10.00 pm. There were four staff on duty between 4.00 – 5.00 pm to assist with the serving of the evening meal. Staff and relatives told us that they felt there were insufficient numbers of care workers on duty when staffing levels during the day reduced to two. Staff told us that there were usually enough members of staff on duty in the mornings, but more staff were needed later in the day (when there was only two staff on duty). One member of staff said, "We need more staff in the afternoons as there are now more people who need two staff to assist them." This was acknowledged by the manager and the registered provider. They told us they had advertised for additional staff to work from 3.00 pm until 8.00 pm and were hoping to appoint new staff shortly.

There were two staff on duty overnight from 10.00 pm until 8.00 am and one member of day staff started work at 7.00 am so there were three staff available to assist people to get up and dressed. We checked the staff rotas and saw that these staffing levels had been consistently maintained.

In addition to care staff, there was a cook and a domestic assistant on duty each day and an activities coordinator who worked for two hours on three days a week. This meant that care workers were able to concentrate on supporting and caring for people who lived at the home. The manager told us that they would like to increase the hours worked by the activities coordinator, as it was acknowledged that care workers had to provide activities on the other days of the week and this took them away from their caring duties.

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for moving and handling, falls, pressure area care and self-medication. We also saw that, when there was a risk of people's skin condition deteriorating, pressure area equipment had been provided. There was very specific information to advise staff on how to assist people to mobilise and the equipment they needed to use.

We did not see any behaviour management plans in the care plans we reviewed. The day following the inspection, the manager sent us an example of a behaviour management plan for someone who had recently been admitted to the home. This recorded the possible behaviours of the person concerned and advice for staff on how to respond to the person and help diffuse the situation.

We observed that medication was appropriately ordered, received, administered and returned when not used. Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. The blister packs were colour coded to denote the time of day when they needed to be administered and we noted that the same colour coding was used on medication administration record (MAR) charts. This reduced the risk of errors occurring.

Blister packs and medication supplied in boxes or bottles were stored in the medication trolleys, and these were stored in the medication cupboard. We saw that the packaging of eye drops was dated when opened to make sure they were not used for longer than the recommended period. The manager told us that other packaging was not dated. However, they said they received a new supply of most medications that were not included in blister packs each month. We noted that products for use externally and internally were not stored separately, as recommended. The manager assured us that this practice would be adopted.

Controlled drugs (CDs) were also stored in a CD cabinet within the medication cupboard. CDs are medicines that require specific storage and recording arrangements. There was a suitable CD record book in use. We checked a sample of entries in the CD book and the corresponding medication and saw that some recording errors had been made. The new supply of pain relief patches had not been entered in the CD book for one person, and the Oramorph that had been prescribed for another person was in the CD cabinet but not recorded in the CD book. However, we saw that this information had been accurately recorded on MAR charts.

There was a medication fridge available to hold medication that needed to be stored at a low temperature. We saw that the temperature of the medication fridge and the medication room was checked to ensure that medication was stored at the correct temperature. Medication that needed to be returned to the pharmacy was stored securely and recorded in a returns book. There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy.

We looked at MAR charts and found that they were mostly clear, complete and accurate. The MAR chart recorded the person's name, address, date of birth, GP and any known allergies. MAR charts recorded where on the body creams needed to be applied to avoid confusion. However, we noted that there were a small

number of gaps in recording and that the code 0 (other) had been used to record when people had not taken their medication, with no explanation being added.

Only senior care workers and the registered manager were responsible for the administration of medication. The training record showed that these people had completed medication training, and this was confirmed by the staff who we spoke with.

We checked the accident and incident records in place at the home. We saw that the folder contained the accident book and advice for staff on how to deal with accidents and incidents, such as 'A body map must be included even if no injury at the time', 'Call 111, GP or 999 as required' and 'Service users to be observed for 72 hours. All head injuries should be closely monitored'. We saw that accident records were accompanied by body maps so that staff could monitor the person's recovery.

We checked the arrangements in place for fire safety. There was a fire risk assessment in place that was accompanied by a list of each person who lived at the home, their room number and details of their mobility needs, with instructions to evacuate people away from the fire if it was safe to do so. Weekly fire tests were taking place, emergency lighting was checked every month and fire drills were carried out six monthly (although we saw these were behind schedule). There were current maintenance certificates in place for the fire alarm system, emergency lighting and fire extinguishers.

In addition to fire safety, there was a 'What If' folder in place that advised staff on the action to take in respect of a missing person and in the event of emergencies such as flood, heat wave and power cuts. The information also advised staff on how to reduce any associated risks. We discussed how it would be useful to add some of the information held with fire records with the contingency plan, such as the names of each person who lived at the home and other important contact numbers.

We saw that the premises had been well maintained and the entrance hall and corridors had been re-decorated. We looked at service certificates to check that the premises were being maintained in a safe condition. There was a gas safety certificate in place and there were current maintenance certificates in place for portable electrical appliances, the passenger lift, the stair lift, mobility and bath hoists and the electrical installation. We noted that water temperatures were checked monthly to reduce the risk of people being scalded. These measures helped to monitor that the premises remained safe for the people who lived and worked at the home.

One relative expressed concerns about the cleanliness of the premises and said that it had recently deteriorated. However, other relatives told us that they found the premises to be clean and free from offensive odours. On the day of the inspection we saw that the home was maintained in a clean and hygienic condition. We saw the home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

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 MCA 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. The manager told us in the PIR document that some DoLS applications had been submitted to the local authority for authorisation. We saw the details of one of the DoLS application that had been submitted to the local authority for consideration.

The training record showed that some staff had completed training on the MCA and some staff had completed training on DoLS. Staff who we spoke with understood the principles of the MCA and DoLS although one new member of staff said, "I am in the middle of doing the on-line training and haven't done MCA yet."

We observed that staff asked people for consent before they assisted them with any aspect of their care, such as assisting them to transfer or assisting them with meals. There were forms in care plans that recorded people's consent to their care and treatment. Some of these had been signed by a relative and, in the care plans we reviewed, there was a record that the person had the authority to do this as they acted as the person's appointee or power of attorney (POA). A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf.

Staff told us that they supported people to make decisions about their day to day lives. Comments included, "I show people clothes and offer a choice of meals. I offer reassurance and explanation" and "I show people different outfits but guide them to wear a suitable outfit for the season and that fits them well." People who lived at the home confirmed that they were able to make decisions about their day to day lives. One person who lived at the home told us, "I can get up any time I like and go to bed any time."

We saw the home's induction training pack. This contained information about the organisation's aims and objectives, health and safety, dealing with accidents, fire safety, confidentiality, privacy and dignity, equal opportunities, infection control and safe working practices. The pack also contained a job description. We checked one person's training records and saw that the member of staff had signed to show they had read this information. The registered manager told us that new members of care staff had commenced the Care Certificate; the Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards.

Although staff told us that they had completed induction training before they worked unsupervised, as well as shadowing an experienced care worker, records of the date staff commenced work and the date they carried out induction training and shadowing needed to be more robust to evidence this.

We checked the home's training record; this was difficult to follow as it consisted of a list of people's names and each topic they had completed training on. However, we determined that most staff had completed training on safeguarding vulnerable adults from abuse, food hygiene, first aid, infection control, fire safety, dementia care, MCA and moving and handling. All of the training had been completed during 2015 or 2016. The registered manager told us that staff received a letter to remind them when refresher training was due and we saw examples of these letters on the day of the inspection.

The staff who we spoke with told us they were offered sufficient training opportunities to give them the skills to carry out their roles effectively. Two members of staff who we spoke with confirmed they had completed all of the on-line training that had been allocated to them and one person told us they had commenced the Care Certificate.

A separate training record showed the names of seven staff who had achieved NVQ Level 2, 3 or 4 in Health and Social Care. Five staff were working towards the Qualifications and Credit Framework (QCF) training. The QCF award replaced the National Vocational Qualification (NVQ) and is the national occupational standard for people who work in adult social care. In addition to this, the two cooks had qualifications in food safety or catering.

Some staff confirmed that they had supervision meetings with the manager and that they felt well supported by both the manager and the senior care workers.

We saw that any contact with health care professionals was recorded in the person's care plan.
People told us that they could see their GP and other health care professionals when they needed to. One person told us that their diabetes was now well controlled by medication and the special diet provided by the home, and that the 'diabetic' nurse no longer needed to visit them. Relatives told us that they were kept informed of any changes in their family member's general health. We saw that, when staff assisted people with a bath or shower, they recorded the condition of their skin to monitor that tissue viability was being managed.

We saw that people's nutritional requirements were recorded in their eating and drinking care plan. One person's care plan recorded, '[Name] needs a well-balanced, low-cholesterol diet'. The care plan also included a nutritional assessment, a record of people's likes and dislikes, any special dietary requirements and any allergies. Charts were used to record people's food and fluid intake when this was identified as an area of concern so that their nutritional intake could be monitored, and people were weighed so that weight gain or loss could be monitored. We noted that referrals had been made to GPs, dieticians and the Speech and Language Therapy (SALT) team when this monitoring had identified significant weight loss or difficulty with swallowing. We saw that advice given by these health care professionals was recorded in care plans.

We spoke with the cook who told us that people were asked each day about their choices for lunch the next day. They said that care plans recorded people's special diets and that they catered for diabetic controlled diets and reduced gluten diets, as well as fortified diets for people who needed to gain weight. When people required a fortified diet they added full fat milk and cream to their diet. They gave an example of a person who had cream added to their soup and dessert with extra cream for lunch that day.

We observed the serving of lunch in the dining room. We saw that tables were set with place mats, cutlery,

napkins and condiments. There was a large board on the dining room wall that recorded the day's menu as well as the season, the day and date and the weather. Staff created a social atmosphere and encouraged people to chat to each other. We saw that people were able to eat at their own pace.

People told us that the meals were nice and that they had a choice of foods at each mealtime. They confirmed that they were asked each day what they would like for lunch the next day. One person said, "Meals couldn't be any better" and another told us, "The meals are fine – I like them."

Most people ate their meals in the dining room but three people remained in the lounge in the 'lower' ground floor and two people who remained in bed had their meals taken to their bedroom. Three people needed assistance to eat their meal and these people had their lunch at an earlier time so that staff were available to provide this support. We discussed with the manager that 11.30 seemed early for people to eat their lunch, especially if they had not had their breakfast until 9.00 am. They told us they would consult again with people and staff about meal times.

People told us it was easy to find their way around the home. We saw that there was signage to assist people to find toilets and other key areas of the home. Bedrooms doors had a photograph of the person, their name and a room number. Memory boxes had been purchased and fitted next to some people's bedroom door, and consideration was being given to the items to include in these to help people identify their own room more easily. There were patterned carpets and the manager recognised that these were not ideal for people who were living with dementia, and told us that plain flooring would be provided whenever existing flooring needed to be replaced. Walls were plain and this made handrails stand out against them, making them easy for people to see and recognise. These prompts helped people who were living with dementia to orientate themselves within the home.

There was an enclosed courtyard that had raised flower beds and tables and chairs. It was acknowledged that access into the outside areas of the home needed to be improved and there were plans in place for this work to be carried out.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff really cared about them. Comments included, "I'm definitely well looked after", "Everybody here is lovely. Staff really care about me and I have recommended the home to other people" and "[Name] and [name] are very good. One or two were not so good but they have now left." A relative told us, "Staff genuinely care – it varies from good to excellent" and another relative said, "I think staff genuinely care. I've never seen anything to indicate otherwise." Some relatives mentioned staff by name who they thought were very good care workers.

Staff told us they were confident everyone who worked at the home genuinely cared about the people who lived there. One member of staff said, "Staff look after people as if they were their family" and another said, "We would definitely identify any new employee who wasn't right for the job."

We saw positive interactions between people who lived at the home and staff on the day of the inspection. We noted that people were comfortable in the presence of staff, and that staff were patient and sensitive to people's needs.

We saw that staff encouraged people to be as independent as possible and only assisted them with the things they found difficult or could not achieve. One person's care plan recorded, '[Name] can make their own drinks in the kitchen' and this person told us that they regularly went out and liked to spend time in their room on their computer. A relative told us, "[Name] has very poor mobility but staff bring them little jobs to do that I suggested, like folding serviettes and tea towels"

There were areas of the home where people could see their visitors in private. We saw that staff respected privacy by knocking on doors and asking if they could enter the room. Staff told us that they respected people's privacy when they were assisting them with personal care, such as making sure doors were closed and by covering people up when they were undressed. One person told us, "Staff respect my privacy and dignity. They sit on my bed whilst I get a shower just to make sure I am ok" and another said, "Personal care is done privately. I don't feel embarrassed."

However, we did note that staff sometimes used inappropriate language, such as the word 'feeders' to describe people who required assistance to eat their meals. We discussed this with staff, the manager and the registered provider and it was acknowledged that the issue of language needed to be addressed.

Discussion with staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. We saw that assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included communication, family and friends, personal hygiene, continence, mobility, eating and drinking, sleeping and rest, mental health, socialising / activity, end of life and medication. When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk. In addition to this, the Abbey pain scale had been used to help measure people's pain levels when they were not able to verbalise this. There were some minor omissions in care plans; some key worker records had ceased and some care plans did not include patient passports. The manager told us that some people's key workers had left and new staff were taking on these roles, and key worker notes would then recommence.

Each person's care records included a photograph, information about their current health conditions and the involvement of other health and social care professionals. A document called 'It's all about me' included information about the person's family history, previous employment and friends. This meant that care records were person-centred. For example, one care plan recorded, '[Name] likes clean nails and likes them painted' and another recorded '[Name] enjoys reading a daily newspaper'. We saw that people were dressed and groomed in their chosen style. Men were clean shaven if this was their choice and some women were wearing makeup and jewellery.

We asked staff how they got to know about people's individual needs. They told us that they were encouraged to read care plans and that they also spoke with family and friends to gather further information. Comments included, "We read care plans and visitors also share information with us. Key workers would add any additional information into the person's care plan" and "We get to know people – their personalities and interests."

We saw evidence that care plans were reviewed and updated each month to ensure they contained relevant information. Records evidenced that care plans had been updated accordingly. More formal reviews were held every six months and the records of these meetings showed that every aspect of the person's care was discussed. Two relatives told us that they were due to attend care plan reviews with their family member.

Daily records in care plans recorded care interventions, general information about food and fluid intake and how the person spent the day. More detailed food and fluid charts were completed when this had been identified as an area of concern.

We saw the 'handover' sheet that was used by staff to pass information from one shift to the next. The sheet included information about professional visits, people who required assistance to have a bath, the names of the staff on duty, communication with the pharmacy and a reminder that observation charts and MAR charts needed to be checked to make sure they had been completed. Additional information such as, 'District Nurse asked to visit [Name] to check graze on elbow' and '[Name] bedroom alarm is going off – faulty battery. Reported and they are coming out today' was also included.

We saw that there was a photograph of all staff displayed in the entrance hall. The most recent CQC report and the corresponding action plan were also displayed in the home's entrance hall, along with the updated Statement of Purpose. Both of the relatives who we spoke with told us they felt there was good communication between themselves and staff at the home. One relative said, "Communication is brilliant. They are straight on the phone if there are any concerns."

Relatives told us that they could visit the home at any time and were made to feel welcome. One relative told us, "I am always made welcome. Whatever time you turn up, the person who answers the door always greets you with a smile."

The notice board recorded the activities that were planned for the week; these included words and pictures to assist people with understanding this information, and another notice board recorded 'What we've been up to'. This displayed photographs of previous activities people had taken part in, as well as scarves that had been knitted by people who lived at the home. The activities coordinator worked for 2 hours on three days a week. One relative told us that they did not see activities taking place on a regular basis. The manager told us they hoped to increase the number of hours worked by the activities coordinator.

The complaints policy and procedure was displayed around the home and we saw there was a complaints form available ready for people to complete. Complaints were recorded in the complaints log and we saw there had been two complaints received during 2015 and 2016. The records showed that complaints had been responded to appropriately. There was a suggestion, comments and complaints box displayed in the entrance area of the home, which gave people an opportunity to express their views about the service provided.

People who lived at the home told us that they felt able to express their concerns. One person said, "I'm sure they would try to put things right" and another told us, "I would speak to [Name of manager] if I had any concerns but I have never needed to." Staff told us that, if someone complained to them, they would try to rectify the situation if it was minor. If the complaint was more serious they would inform the manager. They were confident people's complaints were listened to and dealt with. Relatives told us they would speak to the provider, the manager or one of the senior care workers if they had any concerns. One relative said, "I have a good relationship with [Name of registered provider] but they would all listen and try to put things right if they could." One relative expressed concerns about how the service was being managed. We have reported on this in the Well-led section of this report.

We saw the copy of a letter that had been sent to someone who had a respite stay at the home asking them for feedback about the service they had received. The registered provider told us in the PIR document that annual surveys were distributed to people who lived at the home, and the annual service report included details about the outcome. Questions were asked about catering and food, personal care and support, daily living, the premises and management. There was a clear record of the areas where people had expressed dissatisfaction and the action that had been taken to address this.

Requires Improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was not registered with the Care Quality Commission (CQC). There was a new manager in post and they had commenced the process of registration with CQC. They told us they would submit their application for registration as soon as they had received their DBS clearance.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The manager had informed CQC of deaths and serious injuries that had occurred, but no notifications had been received about safeguarding incidents. The manager assured us that they understood when notifications needed to be submitted to CQC, including notifications in respect of safeguarding incidents.

One person who lived at the home told us, "There has been a new owner and a new manager, and I am still happy here." One relative told us, "The new manager has had a positive impact. They are not frightened of making changes" and another relative said, "[Name of family member] has said she appreciates the changes made by the new manager."

However, we received several concerns from staff and one relative about how the home was being managed. Staff told us they would not hesitate to use the home's whistle blowing policy although not all staff were confident that the manager would protect their confidentiality. The relative told us that the change of manager and high turnover of staff had had a negative effect on the care people were receiving, including that they were spending more time in their bedroom therefore taking less physical exercise. We met with the registered provider on 31 October 2016 to discuss these concerns. The registered provider produced an action plan containing explanations about the circumstances that had led to some of the issues raised with us. They also told us how the identified concerns had been investigated and the action that had been or would be taken to make the necessary improvements.

Prior to the inspection we received written feedback from a social care professional who had visited the home to carry out a care plan review. They told us, 'I have now completed the audit and The Old Vicarage scored as compliant in all sections. The relative provided positive feedback regarding service provision.' We contacted the local authority quality monitoring team prior to this inspection and they told us they did not have any current concerns about The Old Vicarage at Airmyn.

The registered provider and registered manager met on a weekly basis to discuss the current care needs of each person who lived at the home and any repairs that were needed to the property. We reviewed the notes of the meeting that had taken place on 30 September 2016. This showed that the other topics discussed included staff supervision, staff meetings, moving and handling equipment and the employment of new staff.

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

securely. However, more care needed to be taken with the recording in care plans and on MAR charts.

The registered provider told us in the PIR document that annual surveys were distributed. They told us, 'These are staggered for the different audiences over the 12 months so that we are continuously getting feedback from different sources.

We saw the quality report for 2016. This included details of how quality would be measured at the home, including the home's policy on quality assurance, staff training, listening to people who lived at the home, gathering feedback, concerns and complaints, adverse incidents, duty of candour and compliments / suggestions. The quality report included a summary of complaints, comments and observations. CQC reports were included in the folder along with a report of the issues raised in our report and the remedial action taken. We saw an audit that had been carried out to monitor that complaints had been dealt with effectively, although we noted it had not been dated. A medication audit had been completed in September 2016. A number of minor concerns had been noted and we saw that there was no record of when these had been actioned. The annual QA and management report for 2016 was displayed on the home's notice board meaning that it was shared with people who lived at, worked at or visited the home.

We asked people about the culture and atmosphere of the service. One person who lived at the home told us, "This doesn't feel like an old folk's home. It feels like a hotel." This view was also expressed by a member of staff. Other staff comments included, "The home is smaller than some so is more homely. There is a loving atmosphere" and "People tell us they like living here." One relative described the home as "Very caring" and another relative said that the new manager had told people, "This is your home. We are here to help you. You shouldn't fit around us."

One relative told us that their family member had been having one or two showers a week whilst living at The Old Vicarage at Airmyn. They had showered every day when they lived at home and were missing this. The new manager had agreed that this person should have a shower every day, as they had requested. This showed that consideration was given to how people's care could be improved.

We saw that meetings were held for people who lived at the home and relatives. The most recent meeting had been in May 2016 and we saw the minutes of that meeting were displayed on the home's notice board. These showed that the principles of DoLS were explained to relatives, and that relatives were told about the use of memory boxes and photographs on bedroom doors to assist people to recognise their own room. Relatives were asked if they could provide photographs that would help in this process. Other topics discussed included activities and improvements to the premises. Both of the relatives we spoke with told us they had very recently attended a relatives meeting. They said that they were able to express their views and felt they were listened to. Issues they had raised included that the lounge was sometimes 'stuffy', that some people could not reach the jug of water due to where it had been positioned in the room and difficulties with access for wheelchair users. They were told that access was going to be made 'wheelchair friendly' and we saw plans to show that this was being addressed.

Relatives were also invited to a meeting on 9 August 2016 to meet the new manager and to thank the previous manager for her long-standing role as registered manager.

Staff meetings were held on a regular basis. An agenda was displayed prior to the meeting and we saw the minutes of meetings that were held in April and July 2016. These evidenced that the topics discussed included training, supervision, paperwork, activities and the on-going building and renovation work. Staff were informed that the previous registered manager would be leaving the home and a new manager had been employed, and other new staff were welcomed to the home. Staff told us they could raise issues and

make suggestions at these meetings, although one member of staff added, "They can turn into a battle ground."