Plymouth Age Concern

Patricia Venton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 22, 29 and 31 March and 2 April 2016 and was unannounced on the first day.

Patricia Venton House provides care and accommodation for up to 25 people, some of whom are living with dementia. The service is run by Plymouth Age Concern. On the days we visited 19 people lived at the home and five people were staying for short stay respite care.
The service has been without a registered manager since May 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection on 25 June and 2 July 2015 we asked the provider to take action to make improvements to staffing levels, staff training, risk assessments, emergency plans, and documentation in relation to the completion of charts and daily records including people's skin integrity charts and food and fluid charts, to help monitor people's wellbeing.

Prior to this inspection we received information of concern about the service, saying temporary staff did not have full information on people's personal details, for example who the person's GP was.

People's medicines were not always managed and administered safely. The system of checking in new medicines, recording their use and assessing any risks was not robust enough to keep people safe. For example, records showed a GP had decided to stop two of one person's medicines. However, one of these medicines had been administered on two occasions following instructions by the GP to cease its use. The medicine was still showing as current on the medicines administration record (MAR). There was conflicting information about people's medicines in their care plans and daily handover notes. There were gaps in people's MARs where staff had not signed to confirm medicines had been administered so it could not be guaranteed people had been given their medicine as prescribed. If people declined medicines, the reasons were not always documented which meant any patterns or issues could not be identified and referred to the appropriate professional. Information about people's allergies was not always recorded on people's MARs. This could lead to them being given a medicine to which they are allergic.

People had their medicines given covertly (without their knowledge) in their food. There was no recorded evidence of a mental capacity assessment and best interest meeting, if those people lacked mental capacity to make their own decisions in relation to how the medicines were given.

Medicines were not always stored at the correct temperature. For example, the fridge temperature record for February 2016 showed that temperature reached minus three degrees, meaning some medicines may have been frozen and so were not suitable for use.

People's health, nutrition and hydration needs were met however, the recording of this was not complete or did not hold enough detail to ensure consistency of care. People's health care records were inconsistent, incomplete, disordered and in some cases contained incorrect information. For example, one person who had diabetes and was living with dementia had conflicting information recorded about how staff should manage their diabetes. The manager stated they would review this person's care and update this person's records so staff were clear how to support this person.

Records of people's care were not always complete and lacked essential details to ensure care given was appropriate and as desired by the person. People's individual risk assessments were not reviewed regularly to ensure they reflected people's current risk. People did not have risk assessments for individual health needs in place therefore we could not be sure staff had full information to meet those needs.

Staff said they felt unsupported by senior management and had not received regular individual meetings to enable them to raise issues. Staff meetings had not been held to offer support to staff. Staff said they did not feel valued or listened to.

Not all staff were trained to meet people's needs and keep them safe. For example the staff confirmed and the training matrix showed not all staff had completed training in fire safety. Staff had also not completed additional training, for example in the Mental Capacity Act (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Staff understood how to identify and report abuse.

Staff spoken with confirmed there were insufficient staff. They expressed concerns about times when they had not been able to meet people's needs. Staff felt people receiving respite care had higher care needs which were not assessed to ensure there were enough staff available to meet their needs. Staff then had little time to spend with other people. Staff said one person had managed to leave the building unaccompanied. It was unsafe for them to leave alone and there was a high risk of it happening again as staff were unable to monitor them at all times. We observed this person leaving the residential area and going down the stairs. Assistance from staff was sought to help keep this person safe. Staff felt this person was at risk of falling.

The provider did not have robust quality assurance processes in place to identify the issues raised. Systems of auditing aspects of the service had lapsed or were not currently in use. The service had introduced quality monitoring forms. This included audits on medicines. At this inspection we found audits were not conducted regularly. Audits of medicines, infection control, care plans and falls were not completed as often as the provider stated they should be done and did not identify themes or areas to improve practice. The service had not notified the Care Quality Commission of all significant events as required. There were systems in place to maintain the passenger lift, lifting equipment and utilities in the service.

People could see their GP and other health professionals as required. However records showed the staff did not always record the advice given or follow up health care issues. District Nurses told us they were happy with how the service provided for people's health needs.

People said they were happy with the care they received. People told us staff treated them with respect and ensured their dignity was respected. People and visitors spoke highly of the staff.

There was a complaints policy in place. People's concerns were dealt with when they arose. People, staff and visitors described the nominated individual as approachable and people told us they felt comfortable speaking with them if they had any concerns. However staff described the senior management as unapproachable.

We found a number of breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People's medicines were not always managed, stored, recorded and administered safely.

There were not always enough staff to meet people's needs at all times.

People did not have risk assessments for their individual health needs in place.

The service was clean. People were happy their rooms were clean.

Fire and environment risk assessments were in place.

People felt safe living at the service and would speak to staff if they had any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not all trained to meet people's needs.

People did not always have best interest meetings held to agree their care needs where they lacked the ability to make decisions.

Inconsistent recording in respect of people's health meant people were at risk of not having their health needs met.

Records to monitor people's nutrition and hydration needs were not always completed. People made positive comments about the food and said they enjoyed the meals provided.

The service provided equipment to meet people's individual needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People's end of life care had been discussed with them. However the records of these discussions were hard to locate. This meant people's decisions about their end of life care may not be known by staff and they may not receive the care they wanted.

Staff were passionate about the care they provided and understood people's needs.

People told us staff were caring and felt staff treated them with dignity.

People and visitors spoke highly of the staff. Visitors were welcomed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not always complete and lacked essential details to ensure care given was appropriate and as desired by the person.

People had a choice of activities they were supported to participate in if they wished.

There was a complaints policy in place. People's concerns were dealt with to people's satisfaction when they arose.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not have robust quality assurance processes in place to identify the issues raised. Systems of auditing aspects of the service had lapsed or were not currently in use.

Staff did not feel valued or listened to due to the inconsistent management since the last registered manager left the service.

There were systems in place to maintain the passenger lift, lifting equipment and utilities in the service.

Patricia Venton House

Detailed findings

Background to this inspection

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

We undertook an unannounced comprehensive inspection of Patricia Venton House on 22, 29 and 31 March and 2 April 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 25 June and 2 July 2015 had been made.

The inspection team included one inspector, one pharmacist inspector, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information held by us including notifications. Notifications are reports on specific events registered people are required to send us by law.

During the inspection we spoke with 10 people, four visitors and two health care professionals to seek their views about the service. We looked at the care of seven people in detail to check they were receiving their care as planned. We observed how staff looked after people in the lounge room.

We spoke with 13 staff members, the manager, assistant director of care and the chief executive officer. We also reviewed the training records for staff and how the service was keeping training up to date. We looked at records which related to administration of medicines. We reviewed other records including records the provider kept on monitoring the quality of the service, audits and maintenance records.

Requires Improvement

Is the service safe?

Our findings

We inspected Patricia Venton House on 25 June and 2 July 2015 and found inaccuracy in records relating to the administration and the management of medicines; low staffing levels, particularly at night; lack of risk assessments to keep people safe and personal evacuation plans (PEP) not being in place for all the people who used the service. The provider sent us an action plan detailing how they would make improvements. At this inspection we found PEPs in place but action relating to medicines and staffing had not been completed.

People's medicines were not always managed safely. Medicines received mid-month had not all been checked in by two staff as detailed in the service's own medicine policy and procedure. This meant that information may have been recorded incorrectly and may lead to, for example the wrong dose being administered. Medicines risk assessments in care plans did not contain detailed, up to date information about people's medicines, including requirements for pain relief. There was conflicting information about medicines administration in care plans and daily handover notes. For example one person had a GP letter authorising covert administration of medicines indicating the person did not have capacity to make their own decisions about medicines. However the care plan said the person had capacity to express their wishes and to make decisions in their day to day routines. One person staying for respite care had indicated that they wished to self-medicate, but was happy for the staff to store the medicines in the treatment room as there was no locked storage in the bedroom. However the staff were administering medicines to the patient and this wasn't supported by risk assessment.

People's medicines administration records (MARs) were not always signed as required so it could not be guaranteed people had been given their medicine as prescribed. If people declined medicines the reason for this was not always documented to ensure any patterns or issues were referred to external professionals. Information about people's allergies was not always recorded on people's MAR charts. This could lead to people being given a medicine to which they were allergic.

Information received from other healthcare professionals, including the GP, was not always recorded properly and acted upon. For example one person had a faxed change of medicine form from their GP in the MAR folder. The GP had decided to stop two medicines. One of these medicines had been stopped, however the other medicine was given once a week and had been administered on two occasions following instructions to stop its use. It was also still showing as a current medicine on the MAR chart. Another person had a dose of an injectable medicine administered by a district nurse. This medicine was recorded on the handover sheet as having been administered but was not recorded as administered on their MAR chart. This meant that it was not possible to see from the person's MAR chart what medicines have been given and meant that there was an increased risk of a medicines error occurring.

People who lacked capacity and did not wish to take their medicines had these given covertly (without their knowledge). There was no record of a Mental Capacity Act assessment or best interest meeting documenting how this decision was made or who was involved in the decision. Medicines that were mixed with food or drink had not been assessed by a pharmacist to ensure they were suitable to be administered

in this way. This meant that medicines could be mixed with food that made them less effective.

Homely remedies (medicines which can be administered without being prescribed) were used in accordance with a signed and dated Homely Remedies list. Medicines administered without being prescribed were recorded in a homely remedies book but the reason for giving the medicine was not recorded. This meant that it may not be possible to check if the medicine had worked and people could be given prescribed medicine for the same symptoms.

Staff recorded in people's daily notes that skin creams had been applied. There were no body maps in place to show which area of the body the cream should be applied to, the frequency or the amount of application. This meant that prescribed creams might not be effective if they were applied to the wrong area of the body or in the wrong amount.

Fridge temperatures were not recorded every day. This meant staff could not be sure that medicines were stored at the correct temperature. The fridge record for February 2016 showed temperatures were not recorded on 11 out of 29 days and had been recorded down to -3 degrees Centigrade, meaning that some medicines may have been frozen and so no longer be suitable for use. One medicine had been found to be out of date and may not have been effective.

People's medicines were not properly managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff carrying out a medicine round. Staff completing the medicines round were observed to have a caring relationship with individuals.

During this inspection staff continued to raise concerns about the staffing levels and the increasing needs of people staying for respite care or living in the service. Staff felt this was placing a higher demand on their time to meet people's needs beyond basic tasks. For example, they told us they were washing, dressing and making sure people ate, but no more. Staff comments included; "Not sufficient staff. We need three at night" and, "Not enough staff. People staying on respite have higher needs and dementia."

We saw that staff were meeting people's physical care needs and were seen to be busy around the home. They did not have the time to spend chatting to people. Also, if someone required two staff to meet their needs, staff were not available to respond to the needs of people in the communal areas. One person required staff to be vigilant about their needs due to their wishing to leave the service. This person was living with dementia and was unable to identify risks for themselves. Records showed this person had left the premises more than once and had been found walking down the road.

Not ensuring there were sufficient staff to meet people's care needs at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us there was a high use of agency staff which they felt placed people at risk of receiving inconsistent care due to lack of continuity and knowledge about the service. We spoke with the nominated individual (NI) who is the person registered with us to account for the service at the provider level. We asked them what systems they had in place to ensure there were sufficient staff to meet people's needs. For example, the staff were clear people's needs and dependency had increased. They told us they had changed the rota and relied on staff to tell them if this had not resolved their concerns. We confirmed there was no system in place to ensure there were sufficient staff to meet people's needs safely.

People had risk assessments in place in relation to their risk of falling, manual handling, skin care (Waterlow assessments), nutritional needs (Malnutrition Universal Screening Tool; 'MUST' assessments) and choking. However, these were not regularly updated or always an accurate reflection of people's needs. One person had several falls from bed. Records stated that this person did not wish to use bed rails for their protection. However no risk assessment had been completed to help keep this person safe or advise staff how they could protect this person. For example, the type of bed and other means used to protect the person had not been looked at. Another person had a risk assessment in place to monitor their diabetes and blood sugar levels. However, other records held conflicting information on how this should be managed. For example one record said the person required insulin to control their diabetes, a second record said tablets were required and a third record said the person's diabetes was controlled by diet. One staff member stated that this person was not on insulin tablets nor was diet controlled due to their current health needs. The GP had advised palliative care allowing the person to eat what they wanted. Another person's records said they displayed "inappropriate behaviour" and "gets depressed." There were no associated risk assessments or care records explaining what this meant for people and how staff should support their needs in these areas. This meant staff did not have the details available to meet these people's needs consistently.

For another person, there was no risk assessment or care plan information to enable staff to support the person safely who had been identified at risk of malnutrition. The care plan noted that the person was at risk of malnutrition and stated staff were to monitor them closely and encourage healthy food intake. No risk assessment was in place to manage this risk and no MUST tool was available. The records on the food and fluid intake monitoring form were incomplete so it could not be used to reflect if additional assistance was required. This placed this person at risk of not receiving sufficient nutrition to maintain their health.

People who were on respite (short stay) at the service did not have risk assessments completed to ensure staff knew how to manage and reduce the likelihood of any risks people may face. Staff confirmed people staying on respite care did not have updated risk assessments in place that clearly reflected their needs. Staff added they struggled to meet some people's needs as they only found out about risks as they got to know them.

Not assessing the risks to the health and safety of people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control procedures did not always ensure people were protected from the possibility of cross infection. An infection control audit had last been completed in October 2015. The NI stated this should be completed every month in line with the provider's guidance. The service had had an outbreak of sickness and diarrhoea in March 2016 that had not been reviewed to ensure any further risk of infection was detected and controlled. Also, the records of staff training showed not all staff had undertaken training in infection control appropriate to their role. Some staff spoken with confirmed they had not completed this updated training. This meant some staff may not have the knowledge and skills in place to maintain safe infection control practices.

Not assessing the risk of, and preventing, detecting and controlling the spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who delivered care were following safe infection control practices. People said staff always wore aprons and gloves when delivering personal care. Staff were provided with disposable gloves and aprons at various points around the service. The service was mainly odour free and people said their rooms were kept clean. One room was found to have an odour related to a person's specific continence needs which staff were addressing.

People told us they felt safe living in the home and there were enough staff to meet their needs. One person said; "Yes I feel really safe here because there are always staff around." Another said; "I like to stay in my room but the staff are always looking in all the time day and night." A visitor said; "The staff have got a jolly difficult job to do, but there is always somebody on hand."

Staff spoke confidently about how they would recognise signs of possible abuse and understood how to identify abuse and would always report concerns to the manager or provider. Staff had regular training in safeguarding vulnerable adults. Staff knew they could raise their concerns outside the organisation if they felt their concerns were not being addressed internally.

Requires Improvement

Is the service effective?

Our findings

We inspected Patricia Venton House on 25 June and 2 July 2015 and found records were not completed consistently which meant people's health needs were not met. This included people's food and fluid charts not being completed consistently placing people at risk of not receiving sufficient food and fluid to maintain their health. The provider sent us an action plan detailing how they would make improvements. We found these actions had not been completed.

At this inspection we found records did not demonstrate people's health needs were being met. Records did not consistently identify people's health needs and the support required. For example, some people had urine and faeces samples taken and sent to the GP surgery for analysis following the infection outbreak in March 2016. Actions required in this outbreak had not been followed up. No results from these tests were documented. This placed people at risk of any medical follow up needs being missed.

One person was required to have their blood sugar levels monitored twice a week. Records showed this had only been completed six times in January, not at all in February and for two weeks prior to the start of this inspection. This meant the person's needs in relation to their diabetes management were not being met. Records showed the action staff needed to take if these blood sugar levels went below or above a set level. The manager stated they would ensure this person was assessed by the district nurse as a matter of urgency so their blood sugar levels were known. They would then address staff recording of this information and the care being provided.

The care and treatment of people was not always appropriate and did not meet their needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A lack of recording meant there was insufficient information for staff to ensure people's needs were met. For example people receiving respite care, who were only staying at the home for short periods of time, were not having their health needs assessed prior to or immediately on admission to ensure staff had this information. Where health professionals were involved in a person's care, the recording of any advice they gave or actions they asked staff to complete, was inconsistent and lacked detail. For example, records showed one person's GP had been contacted due to weight loss but there was no further detail of what the GP said or advised. We spoke to staff who located a letter which showed this person had been referred on to other services but this was not recorded in the daily notes, professional visit section or care plan.

People said their GP was called on their request. Records showed people could access a range of professionals including an optician and chiropodist. Most records detailed medical advice and guidance, however we found staff were recording GP or other health professional advice in different places. Some staff wrote in the record for professional visits whereas others wrote the details in the daily records which meant it might not be acted on.

People who required them had eating and drinking plans in place to monitor their intake. However these were not always completed as required for the staff to be able to ensure that people had enough to eat and

drink. One person was described in their care plan as at risk of malnutrition requiring staff to monitor and encourage a healthy food intake and encourage a set amount of fluids. No information was found to confirm this had been carried out or any information provided to staff regarding how to address any concerns.

Not maintaining accurate, complete and contemporaneous records in respect of people who use the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff confirmed they had not received regular ongoing training, support or supervision. Staff also confirmed no staff meeting had been held for some time. Staff stated they had asked for support and guidance from senior managers, but had not been provided with the necessary support and guidance they felt they needed to meet people's needs.

The staff training records showed, and staff confirmed, not all had completed regular updated training. The staff training matrix confirmed not all staff had completed training in safeguarding, dementia awareness and infection control. Some staff had not completed fire safety training within the home or been shown the evacuation exits to use in the event of a fire.

Staff not receiving appropriate support, training and supervision as is necessary to enable them to carry out the duties they are employed to perform is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the home currently had no usable baths within the residential service and one person was unhappy the staff were using their en-suite bathroom for storing items including continence items. Staff told us people were unhappy they were unable to have a bath. One person spoken with said they would enjoy a bath but were unable to as none where working. This was brought to the attention of the manager who told us they would look at both these issues.

The service had a range of equipment available to meet people's specific needs. For example, there were a number of mechanical lifts and stand aids to support people to move safely. People were provided with their own slings which had been assessed for them. Also, people were provided with pressure relieving equipment, such as air mattresses and seating, to prevent skin breakdown as required.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. Many staff had not been trained in the MCA and Deprivation of Liberty Safeguarding's (DoLS). Therefore some staff spoken with had little or no knowledge of how the MCA and DoLS affected people. The 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.

Whereas at the last inspection we had found the service was meeting the requirements of the MCA, on this inspection we found the recording of this to be inconsistent and the records held inconsistent and incomplete information. People on respite care had not been assessed in respect of their mental capacity to make particular decisions. This was despite people being noted as having conditions, such as living with dementia, which may mean they are less able to make decisions about their care and treatment. The manager understood their responsibilities in regards of the MCA and had identified that this area of people's records was incomplete. They planned to address this during the weeks following the inspection.

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 DoLS. We asked the manager if there were people who required a DoLS assessment staying at Patricia Venton House. That is, the person was subject to continuous supervision and control and was not free to leave. We were told by the manager at the start of the inspection that one person had a DoLS in place. Staff also told us this person was subject to an authorised DoLS.

People were provided with a balanced diet. One person commented; "There is always plenty to drink throughout the day." Another said; "They ask me if I want my main meal at lunch or tea. I can have a sandwich for lunch and a meal for my tea." The catering staff were knowledgeable about people's food likes, dislikes and needs. They always asked people what they would like to eat each day. Creative ways were looked at to support people to eat. For example high sided plates assisted people to eat independently. Special diets, including diabetic meals, were catered for and people had their food prepared in line with their care plan or specialist assessment. People were content with the quality of the food. They said; "The food is excellent, you can really have what you want, it's no trouble. A relative said, "I can come and have a meal with my relative and the food is top notch." People confirmed the catering staff visited them daily to ascertain their choice from the two main items for the following day, and alternatives were made available if they did not want the choices offered.

The service had a range of equipment available to meet people's specific needs. For example, there were a number of mechanical lifts and stand aids to support people to move safely. People were provided with their own slings which had been assessed for them. Also, people were provided with pressure relieving equipment, such as air mattresses and seating, to prevent skin breakdown as required.

We received feedback from two healthcare professionals who were positive about the service and its ability to meet people's health needs.

Requires Improvement

Is the service caring?

Our findings

People's end of life care had been discussed with them and their relatives and so their wishes, should their health deteriorate, were known to staff. Each person had a treatment escalation plan (TEP) in place detailing their wishes on resuscitation, though it took the manager some time to locate them. Therefore they were not at hand if staff needed them in an emergency. Some staff had completed training, provided by the local hospice to improve the end of life care planning with people. However, staff raised concerns that a person who recently passed away did not have one to one care with them during the day when they were at the end of their life and they felt this was due to staff shortages. Staff said the training they received on end of life care emphasised the importance of one to one support.

People felt they received their care at times they wanted it. Everyone was happy that they woke, rose and retired (with or without assistance) at a time of their own choosing. People felt staff cared about their emotional welfare. People we spoke with said they could; "get up when we want and go to bed when we choose."

People were looked after by staff who treated them with kindness and spoke with people with respect. People said staff always ensured their dignity was respected. The interactions we observed between people and staff were positive. Staff ensured doors and curtains were closed at times of personal care. Staff were seen and heard to knock on bedroom doors before entering, and each room had door bells for staff and visitors to use. We observed staff offering care discreetly to people in the lounge.

People who lived in Patricia Venton House were supported by staff who were both caring and kind. Interactions observed between people and staff were positive.
People who were able to, agreed they were well cared for and spoke well of the staff and about the quality of the care they received. Comments included; "The staff are very, very caring. Respect and dignity, absolutely!" Another said; "They always close my door and curtains when washing me" and "They are so kind and patient when they take me to the toilet."

Visitors said they were kept up to date with their relative's care and wellbeing when visiting. A relative said; "My relative was really poorly with a urine infection. They were brilliant and let me sleep overnight in the chair in their room."

Staff spoke about the people they were caring for in terms that showed they cared about them. Comments included, "Even though we are always short of staff we always make sure people are well cared for." Another said; "Staff always go the extra mile."

Requires Improvement

Is the service responsive?

Our findings

We inspected Patricia Venton House on 25 June and 2 July 2015 and found that people's records were not completed consistently which meant their health needs were not met. This included people's turning charts, the lack of communication between staff, and not recording when personal care had been carried out. The provider sent us an action plan detailing how they would make improvements. We found these actions had not been completed.

People's pre-admission forms, particularly for people staying for respite care, were often incomplete and lacked information about people's likes and dislikes as well as details staff required to ensure care delivered met the person's needs. Initial assessments of people's health and welfare were not always completed which meant staff did not have the details available to identify changes to their health or care needs. Staff told us this meant it was only when a person had been staying for a while that they became aware of this information. For example when people were not sleeping well at night or needed additional support, such as one to one staffing.

Records of people's care were often incomplete with gaps in recordings and monitoring of people's needs not being completed. People did not have plans in place that addressed their specific diagnosis. For example, there were no care plans in place to address the needs of people living with dementia to ensure staff understood how to meet these people's individual needs.

People's records held forms to be completed on medical visits, for example GP visits. We found these had not always been completed. For example one person who had significant weight loss and had seen a GP did not have this information recorded on this form. Also district nurses visits were not always documented on these forms. This mean staff did not have complete information to meet people's needs.

Records of people staying for respite care held inconsistent and incomplete information and was disorganised. Care plans, particularly for people staying for respite care also held loose sheets of paper which risked being lost. For example records did not record if people had any allergies, their date of birth and no photos to identify the person. This meant staff did not have the full details about a person.

Another person's initial information recorded that they were able to manage their continence needs independently. Staff told us the person needed assistance with their continence needs. However records had not been updated or showed if the person had been referred for assessment with the continence team. In the meantime, staff who delivered care were working together to try and resolve this person's needs.

Daily handover notes and records of how staff met people's needs were not always completed as directed or they held information which conflicted with other records. For example, information recorded about prescribed medicines conflicted with information in the care plans. We found that not all changes in people's needs were recorded, followed up, or written into the care plans.

Records did not detail accurately people's personal preferences. People had a, "This is me" record in their

care plans which was intended to detail people's preferences and staff could access easily. These were found to be inconsistently completed with some conflicting information. For example, this record for one person stated what they liked for breakfast but this information contradicted other records about the person's breakfast preferences.

Not maintaining accurate, complete and contemporaneous records in respect of people who use the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged and supported to maintain links with the local community. Patricia Venton House had a day centre attached to the service. This was used by people living in the service and people living in the community. Activities were displayed and showed planned trips out. Staff said there was a designated staff member who arranged trips. Staff stated they tried to vary the activities daily and keep people active. People who attended told us how much they enjoyed the activities offered. People commented; "I go and join in at the day centre and I love my knitting." Another said; "They take me down town and I went on a trip out to Plymouth Museum" and, "I love my music, so me and a couple of my friends sit in the quiet room after lunch and just listen to country music, you can't beat it."

We observed people going out on a trip during one day of our visits and other activities taking place. Some people said they wanted more trips out and others were happy with what was offered. A relative said they would like to see more trips arranged.

People, their relatives and healthcare professionals knew who to contact if they needed to raise a concern or make a complaint. The provider had a policy and procedure in place for dealing with any concerns or complaints. The policy was displayed in the home and was available in a format everyone was able to understand. People felt the service would take action to address any issues or concerns raised. A complaints audit showed complaints which had been made, the actions taken and the outcome of the complaint. Any complaint received was shared with staff to help reduce any recurrence.

Requires Improvement

Is the service well-led?

Our findings

We inspected Patricia Venton House on 25 June and 2 July 2015 and found the registered person did not have effective quality assurance and auditing systems to assess monitor and improve the quality of the service. The provider sent us an action plan detailing how they would make improvements. We found these actions had not been completed.

Patricia Venton House is run by Plymouth Age Concern. There was a nominated individual (NI) in place who is a person appointed to be responsible for supervising the management of the service. The registered manager had left in May 2015. Another manager was appointed who subsequently left in December 2015. A newly appointed manager started at the service two weeks before our inspection started and is planning to register with us. During the absence of a manager a senior manager of the organisation was overseeing the service with the support of the Nominated Individual (NI).

At this inspection we found a lack of quality monitoring of the service as systems and processes were not always in place to ensure good governance. For example, there were no audits of records to ensure people's needs were accurately identified and recorded when they stayed for respite care; and ongoing records of people's care were not completed and lacked essential information about people's individual needs including risk assessments. However systems were in placed to ensure the building and equipment were safely maintained.

Where audits were used these did not identify concerns. For example, an audit in respect of medicines had been introduced, but had not identified concerns in respect of the administration of medicines found during the inspection. Information about people's accidents and falls was not being effectively used to identify themes, to help keep people safe and prevent further incidents. An infection control audit had not been reviewed to ensure any further risk of infection was detected and controlled. This meant lessons learnt from the outbreak had not been taken forward.

We spoke with the management team about the action plan which had been provided after the inspection in June and July 2015. We were advised improvements had initially been made however this had not been sustained. Some areas we had been told were in place had not been progressed as reported.

The systems in place to monitor the quality of service people received were not effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission had not received all required notifications as required. We had not been notified of all safeguarding concerns or when people had sustained serious injuries.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff said the service was unsettled, not well-led and morale was low within the staff team. Staff told us the communication with senior management was not good and no staff meetings or similar had been held for

some time. A visitor also said; "I think the communication could be better."

We discussed what staff had raised with us with the NI and new manager and they said they would meet with the staff.

People who had met the new manager were very positive about them. One person said; "I'm very impressed with the new manager." A visitor said; "The new manager seems very good. They seem to have time for everybody." The new manager understood the basic principles of the Duty of Candour (DoC) regarding the requirement to apologise when things go wrong. They were seeking to address this more fully as they settled into working at the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18(1) and (2)(e)(g) The Commission had not been notified without delay of allegations of abuse and an event which prevented the provider to continue to safely meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9(1) and (3)(a)(b)(c)(f)(h) The care and treatment of people was not always appropriate, met their needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1)and (2)(a) Sufficient staff were not employed at all times to ensure people had their needs met. Staff did not receive appropriate support, professional development, supervision and appraisal to enable them to carry out their duties.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) and (2)(a)(b)(g)(h) The registered person had not assessed the risk to the health and safety of people in relation to their care and treatment in order to mitigate those risks; medicines were not being managed properly and the risk of infection was not being effectively controlled.

The enforcement action we took:

We issued a warning notice.We have told the provider they are required to become compliant with the Regulation by 1 August 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) and (2)(a)(b)(c) Systems and processes had not been established to effectively: Assess, monitor the quality and safety of the service; assess, monitor and mitigate the risks relating to the safety and welfare of people and others in the event of an emergency; records were not kept which were always accurate, complete and contemporaneous.

The enforcement action we took:

We issued a warning notice.We have told the provider they are required to become compliant with the Regulation by 1 August 2016.