Dr Pepper's Care Corporation Limited

Vicarage Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on the 23 June 2016 and was unannounced. We carried out a focused inspection of the service on 12 September 2015 where we found concerns in relation to people being woken before 6am. Prior to this inspection we received further concerns about staffing levels, people being woken before they wished, the cleanliness of the home, staff conduct and concerns about the leadership within the service. During this inspection we looked to see if improvements had been made and we found that action had been taken. However, we found staffing levels were not always sufficient to meet people's needs and aspects of people's medicine management were not safe.

Vicarage Residential Home is registered to accommodate a maximum of 35 older persons. They provide residential care without nursing. Nursing is provided from the community nursing team as required. There were 31 people living at the service when we visited.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not sufficient staff on duty at all times to ensure people's needs were met. All staff we spoke with during the inspection expressed concerns about the staffing levels over recent months, particularly at night. Staff had been covering cooking, cleaning and laundry duties due to vacancies and sickness. However, five new staff were going through recruitment checks which would ease some of the staffing issues we found. We spoke to the registered manager about people's and staffs feedback and following the inspection were advised a meeting with the providers had been arranged to discuss safe staffing levels.

People's prescribed medicines were largely administered as prescribed. However, the service was piloting a new electronic medicine system which was causing some difficulties affecting people receiving their medicine safely. The registered manager was working to resolve issues and make improvements.

People told us activities were limited. Most people had little meaningful stimulation throughout the day. Staff told us they did not have time to do activities with people. The registered manger told us with budgetary cuts, providing individualised activities was not possible. This was an area he and the provider wanted to improve.

The home was clean and infection control procedures were followed. Some areas of the home had an odour but the registered manager was taking action to address this. Staff told us they were unable to keep up with the laundry duties. The registered manager was aware of staff concerns and was taking action to increase the laundry facilities to support staff.

Staff treated people with kindness and respect. We observed staff treating people with patience and

supporting people in their own time. People were complimentary about staff and how they treated them. They also confirmed staff always asked for their consent before commencing any care. Staff always protected people's dignity while delivering personal care. People unable to consent to their care were being assessed in line with the Mental Capacity Act 2005.

Staff were recruited safely and underwent training to ensure they could effectively meet people's needs. New staff underwent an induction and shadowed experienced staff. Staff were knowledgeable about identifying safeguarding concerns and understood how to raise concerns. All staff we spoke with stated they would raise these with the registered manager and felt they would be addressed. If not, they felt able to whistle blow and knew who to contact if this was required.

People and staff felt they could raise any concerns or issues about the standard of care or suggest changes about the service. The registered manager had systems in place to identify people's concerns or complaints.

The provider and registered manager regularly checked the quality of the service to ensure standards were being maintained to an appropriate level. A number of audits were completed to measure this. People and staff were asked for their views.

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 generally administered safely and as prescribed. However, we identified some concerns where stock had run out and people did not receive their medicine.

People and staff told us there had been a shortage of staff in recent months. We were advised new staff were going through the recruitment process.

Staff were recruited safely to ensure they were safe to work with vulnerable adults.

People were protected by staff who were trained in safeguarding people in their care.
There were risk assessments in place to support people to live at the service safely.

Is the service effective?

Good

The service was effective.

Staff told us they felt supported.

People were supported by staff who were trained to meet their needs effectively. Staff were updated to reflect current practice.

People were being assessed in line with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards as required.

People's health and nutritional needs were being met.

Is the service caring?

Good

The service was caring.

People were very positive about the staff and how they treated them. Staff were observed speaking to people with kindness and respect.

People felt in control of their care and were able to make suggestions on how their needs were to be met.

People were encouraged to remain as independent as possible for as long as they could. People advised their dignity was always maintained by staff.

People told us their visitors could come at any time and were always welcomed.

Is the service responsive?

Requires Improvement

People told us activities were limited and they would like more to do to pass the time. When activities occurred people enjoyed these.

The service was responsive to people's changing needs. People had care plans in place that reflected their needs and which they were involved in designing and agreeing to. Some care records were in the process of being updated.

People felt comfortable raising concerns and complaints. The registered manager ensured systems were in place to address complaints and check the person was agreeable with the outcome.

Is the service well-led?

Requires Improvement

The service was not always well-led. The registered manager and deputy manager told us they felt more l support was needed by the providers to address the areas of concern at this inspection.

People told us they weren't always asked their view of the service wanted to be more involved.

There was evidence of governance and leadership in place, the registered manager and deputy were clear regarding their role and responsibilities and worked hard to create a quality service. However the staffing issues affected their ability to carry out their role as well as they wanted to.

Staff felt they could suggest changes to how the service was run and these would be listened to and adopted where possible.

People and staff identified the registered manager as being in charge and felt they were approachable.

The registered manager ensured they monitored the quality of the service and used a number audits to do this. Learning from events was taken forward to ensure everyone's care was improved.

Vicarage Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 the 23 June 2016 and was unannounced.

The inspection team was made up of three inspectors. Prior to the inspection we reviewed all the information held by the Care Quality Commission (CQC) on the service including previous inspection reports and notifications we require registered persons to send us about significant events that have happened.

We requested a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. At the inspection we asked the provider to tell us anything they thought they did well and any improvements they planned to make.

During the inspection we spoke with eight people living at the service. We observed how staff interacted with and delivered care to people. We read three care plans and spoke to these people where we could about their care. We reviewed four staff personnel files and staff training records. We spoke with eight staff and we were supported through the inspection by the registered manager and deputy manager. One of the providers was at the home while we were there. We spoke with the local authority prior to the inspection and following the inspection we spoke with a social worker.

Other records we reviewed included, policies and practices, records of how the registered persons ensured the quality of the service such as, staff meeting minutes and quality assurance processes and audits.

Requires Improvement

Is the service safe?

Our findings

We previously carried out a focused inspection of the service on 12 September 2015 where we found concerns in relation to people being woken before 6am. The provider sent us an action plan advising the improvements they would make. Prior to this inspection we received further concerns about people being woken before they wished, staffing levels and the cleanliness of the home. We reviewed these concerns on the 23 June 2016. We found our concerns regarding people being woken early, from the previous inspection, had been addressed. However, there were not sufficient staff to keep people safe.

There were not always sufficient staff on duty to meet people's needs. On the day of the inspection there were 31 people living at the home and we were informed by staff nine of these people were considered "high" dependency. This meant they needed two staff to care for them or they may have additional care needs such as requiring end of life care or advanced dementia. During the day the service aimed for five staff in the mornings, four in the evenings and there were two staff on at night. Staff told us the staffing levels frequently included new staff who were shadowing and unable to do certain tasks and two at night was not enough. Staff sickness and staff leaving had impacted on the staffing levels in the months prior to the inspection. Staff told us they had been covering cleaning, laundry and cooking duties due to vacancies.

Staff told us they were too busy to do the additional cleaning, cooking, laundry and activity tasks being requested. Care staff had been cooking whilst there had been staff sickness in the kitchen. The registered manager told us he was managing the kitchen at present with support from the provider who did the food ordering. During the inspection one of the providers was helping in the kitchen and cooking lunch as the kitchen supervisor had recently changed their role.

All staff told us of their concerns, that two staff at night was not sufficient to meet people's needs safely. People told us although call bells were responded to in a timely way; they were often told they would need to wait for help. One person told us this had meant she had been incontinent at night. People also told us they had people walking into their rooms which sometimes frightened them, with one person telling us someone had tried to climb into their bed. The registered manager told us people were able to shut and lock their bedroom doors to prevent this occurring.

Staff comments included, "People's needs are greater now, people and staff are at risk of getting verbally and physically abused"; "We are understaffed all the time, we have had times when it is just two of us on in the day and I go home and explode"; "I'm shattered, it's taken its toll mentally and physically" and "I'm always in a rush, I'd love to sit down and speak to residents but I don't have time"; "Staffing is a humongous issue" and "It's alright sometimes, other times hectic, there are not enough staff on and staff bickering when they shouldn't" and "We are short staffed but we pull together as much as we can." People told us "Unless I press my alarm for toileting, I don't see any staff"; "There are two staff at night, they come and say they are sorry they cannot see to me at the moment, switch the call alarm off, I understand they are short at night, but it has meant on occasions I have wet myself." Another person told us "They were short staffed last week and I had to wait until 1.45 pm to be washed and dressed, I was told there were only two staff on that day." The registered manager told us the home there were never only two staff on during the day.

We discussed the staffing issues with the registered manger and deputy manager. Both had been trying to support the care staff but felt this had affected aspects of their managerial roles such as holding regular resident meetings, regular staff meetings and staff supervisions and appraisals. The registered manager and deputy also felt additional staff were required at night as people's needs had changed. Night staff were also responsible for undertaking cleaning duties. We were told increasing day and night staffing had been previously discussed with the registered provider and not agreed. We were advised by the registered manager a further meeting had been arranged with the providers to discuss safe staffing levels. Five new staff had been appointed and were undergoing recruitment checks. We were also advised a new post for 16 hours administrative support had been appointed too. Following the inspection the provider informed us that an additional staff member would be recruited for the night shift so there would be three staff on duty at night.

There were not sufficient staff on duty at all times to safely meet people's needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People's medicines were not always managed safely. The service had introduced a new computerised medicine system. However this had caused issues with the ordering, administration and recording of the medicines. For example, one person's medicine was recorded twice on the EMAR (Electronic Medication Administration Record). Medicines, when given by staff, were scanned from the original boxes and this was meant to show up on the computer as administered. However not all medicines could be scanned including liquids.

The medicine system had a computer tablet for staff to carry around and use with the scan when they administered medicines. However when the tablet required charging the staff member used the laptop that linked in with the tablet. However it did not always synchronize quickly enough. Therefore when the laptop was used, it did not show that all previous medicines administered that morning had been given and signed for. Therefore staff could not be sure if this medicine had been given as prescribed.

The registered manager was fully aware of the poor quality of the computerised medicine system and had a meeting arranged with the supplier the following week. During our inspection the registered manager made immediate contact with the supplier to update them on the system and errors taken place. Staff confirmed they had received training in how to administer medicines.

People had not always been given their medicines as prescribed. For example, one person told us they had not had their sleeping tablets the previous night and "Had a terrible night's sleep." We also saw that one person had not had their regular medicine for six days due to the service running out of their medicine. The medicine had been ordered, however staff had not followed this up to ensure the person had received their medicine as prescribed. Following the inspection the registered manager put in processes to reduce the likelihood of this occurring in the future.

People did not always receive their medicines as prescribed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found the home looked clean but there were areas that smelled odorous. The registered manager advised they were aware that new flooring was required in areas of the home, particularly where people had continence needs.

The laundry assistant had reduced their hours, staff also carried out laundry duties alongside their caring duties. Staff told us they were unable to keep up with the laundry as people's needs had increased. On the

day of the inspection we observed two soiled laundry bags remaining. The registered manager told us he was looking into larger machines which would help staff manage people's laundry more efficiently.

Staff had undertaken infection control training and there were policies and procedures within the home for staff to refer to when required. Staff understood their roles and responsibilities to minimise the risk of infection and the environment was clean and hygienic. There was ample hand gel, hand washing facilities and protective equipment for staff to wear. We observed staff wearing aprons and gloves to carry out people's personal care needs.

Staff recruitment files showed appropriate checks had been undertaken before staff began work. New staff in post confirmed all recruitment checks had been conducted prior to them commencing work. Disclosure and Barring (DBS) checks had been requested and were present in all records. These are checks which help ensure staff are of a good character, have no previous convictions and are safe to work with vulnerable adults. The registered manager assessed the competency of staff in areas of their care work and any concerning issues were promptly followed up and action taken where necessary.

People were supported to take everyday risks. We observed people move freely around the home. Where people were able, they made their own choices about how and where they spent their time. For example we spoke with one person who liked to spend all of their time in their room and this was respected. Risk assessments were in place to maintain people's independence and respected their right to take risks, promoted their freedom and helped keep them safe. Where people were less independent and there were risks relating to their health for example falls, diet or pressure ulcers, risk assessments were in place to minimise risks and clearly linked to people's care plans. For example, one person had a health condition which made them more at risk of skin damage. They had a special mattress in place, staff regularly moved them, their food and fluid intake was monitored and body maps illustrated where skin creams should be applied. Other people at risk of falls had been assessed for bed safety rails and where required had crash mats on the floor.

We saw that each person had an individual evacuation plan in the event of a fire and equipment had been checked. As people's needs changed these were updated. Routine maintenance within the home and environment was undertaken to ensure the environment remained safe. For example, smoke alarms were tested and fire drills carried out. The environment had safety precautions such as corridor rails to help people move around safely and radiator covers to prevent people being burned. A new key pad entry system was being installed to improve the security of the building and reduce the likelihood of people walking away from the home unnoticed.

People were protected by staff trained in safeguarding vulnerable adults and who demonstrated they understood the importance of reporting any concerns. There were flow charts and easy read safeguarding guidance in place for people and staff. All staff we spoke with felt any concerns would be listened to by the registered manager and deputy manager and action would be taken. Where this was not the case all staff understood the importance of blowing the whistle and understood the role the local authority and CQC played in relation to this. Staff told us "I know what to do and who to contact and I wouldn't hesitate."

We saw that incidents, concerns and safeguarding concerns were recorded; action was taken promptly and reviewed regularly by the registered manager. Any themes were noted and learning from incidents was shared with the staff team or individuals as appropriate. This helped to minimise the possibility of repeated incidents.

Good

Is the service effective?

Our findings

People felt supported by knowledgeable, skilled staff who effectively met their needs. One person stated; "Yes – staff are well trained, all very good."

Staff undertook an induction programme. Staff told us they had a general introduction to the home which introduced them to policies and procedures. Staff also had the opportunity to shadow other staff when they started at the Vicarage. Staff had completed a range of training including first aid, dementia awareness, fire safety and medicine management. Staff told us "I cannot fault the training you get." Ongoing training was planned to support staffs continued learning and was updated when required. All staff told us there was ample training and further development opportunities.

Staff supervision, appraisals and competency checks were conducted by the registered manager although these were not as frequent as they would have liked. Most staff told us they felt supported by the registered manager and deputy. We saw some observational checks had been undertaken to ensure staff were caring for people well. Staff meetings were held to provide the staff the opportunity to highlight areas where support was needed and encourage ideas on how the service could improve. The registered manager said these had not been as frequent as he wished due to the recent staffing vacancies and hoped to make these more regular as new staff joined the team.

The majority of people living at the service were independent and able to consent to their own care and treatment. Other people who could consent but required staff support told us staff always sought their consent before commencing any care or support. They confirmed staff always respected their choice and would come back later if they requested this. We observed staff also sought people's consent before supporting people in communal areas and gave people time to respond to the offer of support.

People when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS is for people who lack the capacity to make decisions for themselves and provides protection to make sure their safety is protected. The MCA is a law about making decisions and what to do when people cannot make decisions for themselves. The registered manager was aware of the recent changes to the law regarding DoLS and had a good knowledge of their responsibilities under the legislation. Care records showed where DoLS applications had been made or considered and evidenced the correct processes had been followed. Health and social care professionals, family or advocates had appropriately been involved in the decision. This enabled staff to adhere to the person's legal status and helped protect their rights.

Staff showed a good understanding of the main principles of the MCA. Staff were aware of when people who lacked capacity could be supported to make everyday decisions. Staff knew when to involve others who had the legal responsibility to make decisions on people's behalf. A staff member told us how they gave people time and encouraged people to make simple day to day decisions. For example, what a person would like to wear or drink. However, when it came to more complex decisions such as a do not resuscitate order, they explained a health care professional or if applicable, a person's lasting power of attorney in health and

welfare, would be consulted. This helped to ensure actions were carried out in line with legislation and in the person's best interests. The MCA states, if a person lacks the mental capacity to make a particular decision, then whoever is making that decision or taking any action on that person's behalf, must do this in the person's best interests.

People told us they used to be involved in decisions about what they would like to eat and drink but this no longer occurred. We fed this back to the registered manager who told us people were asked at the morning tea round and he would check this was still happening. Following the inspection we were informed this had been stopped briefly due to staffing but had now been recommenced. People told us they were not involved in the menu planning either but told us they liked the food and if they did not like what was on offer, they could have an alternative made. Following the inspection we were informed by the management team that the residents survey and preferences for food contributed to the menu plan. Care records identified what food people disliked or enjoyed, and listed what the service could do to help each person maintain a healthy balanced diet. People were encouraged to say what foods they wished to have made available to them. There was a visible menu in the communal area but not all people due to their health or mobility could see this. The registered manager was going to consider giving people a copy of the menu for their rooms.

We observed practice during the lunch time period. People were relaxed in the newly decorated dining room and told us the meals were good, at the right temperature, and of sufficient quantity. There was a relaxed atmosphere with music playing and people chatting. People who needed assistance were given support and nobody appeared rushed. Comments included "Very nice meal"; "Nice meal, I really enjoyed it" and "Everything is fine, I'm not a big eater, you have what you are given." One person said "I have to ask what is for tea and tell them if I like it or not. Some staff just put it in front of you without even asking."

Care records highlighted where risks with eating and drinking had been identified. For example those who required their food pureed. Care and kitchen staff were aware of these people's particular needs. Care plans recorded people's dietary needs, monitored their weights and where required recorded people's food and fluid intake.

Research was used to promote best practice. For example, Staff used the Malnutrition Universal Screening Tool (MUST) to identify if a person was malnourished or at risk of malnutrition, and the 'waterlow' pressure sore assessment. The registered manager told us when time allowed they attended the local forums where good practice was discussed.

Care records detailed where health care professional's advice had been obtained regarding specific guidance about delivery of specialised care.

Good

Is the service caring?

Our findings

Everyone we spoke with was positive about the staff and the atmosphere in the home. There was a calm atmosphere and people appeared comfortable in the company of staff. Lots of appropriate humour, supportive conversations and kind, gentle interactions were observed throughout the day.

People told us "It's lovely"; " I get plenty of kindness"; "If I want anything, staff would go out of my way to get it for me"; "Yes, staff are kind and caring, it's all the little things they do for me"; "They all deserve a medal"; "I am happy here, I can't see where else would suit me better"; "It's all just how I like it, everything is very nice"; "They remembered my birthday, I got chocolates and a card".

"Comments from staff included: "I love my job and I love working in care"; "I love working here, you develop a bond with people and I'm loving it"; "All the girls are lovely".

Staff were observed treating people with kindness and respect. Staff supported people who had become confused with gentleness. For example, one person walking down a corridor was met by a member of staff who asked if they could help them. The person had mislaid their walking stick so staff found it for them. Another person was anxious about the medicine they had missed the previous night, staff were reassuring and told them of the action they had taken to ensure it was in stock for them that evening.

Staff demonstrated in conversation with us that they understood and cared for the people they were looking after. Staff were patient with people; one person told us "I haven't met a bad one yet!"

People told us their dignity was always respected and staff would ensure their privacy at times of delivering personal care. Staff told us "I shut curtains, cover people up and encourage them to do as much as they can for themselves." Staff were observed offering discreet support to people in the lounge when suggesting it may be time to go to the toilet. Some people had their room doors open but those we spoke with said they liked this and could close it, or ask staff to close the door if required. People who stayed in their rooms told us staff would always come when they used their call bells but often did not have time to spend sitting and chatting with them which they would have liked.

People who were able to be involved in care decisions told us they felt in control of their care. Not all people were aware of their care plans but we saw they had been written by staff, with people and with family involvement. A new electronic care planning system was in place and care plans were being updated so they included people's personal histories and preferences.

Visitors were welcome at any time. People told us their relatives were always welcomed and they were kept informed if their family had called. One person told us, "Yes, my family are always made to feel welcome and they even bring them lunch sometimes.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found people were woken prior to the time the might have wanted. The provider sent us an action plan advising the measures they would take to ensure this did not occur. Prior to this inspection we received more concerns people were woken early, before they wished. To help establish if this was occurring we visited the service at 5.45am and found the only people who were awake were the ones who had wanted to get up. We checked people's records and queried the time some people had received personal care in the mornings but the interventions had been due to people needing to be changed for their comfort.

People told us there was not always enough to do to keep them active during the day; comments included, "Activities have lapsed since we've had staffing issues". One person told us "I would like there to be more activities, it would help pass the time away…I don't mind what it is, I'll let them decide." We observed many people had their television switched on for long periods even if they were asleep or unable to hear the sound because they were hard of hearing. People told us there used to be more going on but activities were rare now. Relatives, family and friends could take people out but visiting the local community or area was not a frequent event for people unless this occurred. Staff told us activities were limited. We spoke to the registered manager who told us this was an area they wanted to improve. An activity person regularly came weekly for two hours and there was occasional monthly music entertainment. When activities were held, people told us they very much enjoyed these, particularly the animals which visited. Following the inspection, the provider shared their future plans with us for improving this area which included a designated activity person.

People told us they felt they had their needs met and staff were responsive to them when these changed. One person stated, "I am being well looked after; definitely". People who were able to talk to us said they woke and went to bed when they wanted to. Most people felt staff responded to their calls for support in a timely way stating that at busier times they may have to wait longer, but this did not affect them unduly. People also told us they could have their care delivered how they wanted and when they wanted. For example, one person stated "I can go to bed when I choose and get up when I want" and another, said they didn't want any more or different support than they currently received.

People were assessed prior to coming to live at the service. This detailed the person's initial condition, likes and dislikes and care needs so staff were informed. Staff confirmed this would then be discussed at the next shift handover. Assessments helped inform staff of people's capabilities and risks. These included assessments on people's skin, their cognition and memory and their nutrition.

People were supported by staff who knew how to meet people's needs. New, comprehensive, electronic person centred care plans were in progress. The care described in the care records detailed information about the person's condition and how they liked their care to be delivered. When a review of their care was need they or their representative were involved in this, and this was recorded.

We noticed that some of the care plans had not been reviewed as regularly as the monthly expected

timetable. The registered manager advised this was due to the recent staffing issues which had meant the deputy manager and they had been required to ensure the care was delivered as required. With the staffing issues more in hand, this had now started to be put right. A new administrative post would be supporting the ongoing improvement of care planning.

People told us they felt comfortable speaking to staff about any concerns they may have. For example, one person said "I'm quite happy here. If there's anything I'm not happy with I tell them, and they sort it out." People felt they would raise concerns for themselves or ask a family member to do this on their behalf. Everyone we spoke with felt they could also ask to speak to the registered manager and any issues they raised would be addressed. One person told us "The staff are so very good; I can't fault them" and another said, "I can speak up for myself if I am not pleased". The registered manager had systems in place to address people's complaints and concerns.

Requires Improvement

Is the service well-led?

Our findings

Vicarage Residential Home is owned by Dr Pepper's Care Corporation Ltd. There was a management structure in place led by the registered manager. There was also a nominated individual in place, who is someone who takes responsibility a higher level. There was evidence of communication and involvement by the nominated individual in measuring the quality assurance of the home and service. For example, there were weekly meetings with the registered manager and an audit of the building, upkeep and maintenance.

Prior to the inspection concerns had been raised with us regarding the leadership within the home. We did not find any evidence to substantiate the concerns raised with us. However, the registered manager and deputy told us that they had both felt under great pressure with the staffing vacancies and needed support from the providers to address the concerns found during the inspection. We were told the inspection findings and areas which required improvement came as no surprise to the registered manager and deputy, we were told they would discuss the areas again with the provider.

People told us they were happy living at the home however, not all felt involved in the day to day running of their home. People were unable to recall when they had last been asked for their views on the service. Residents' meetings were rare, the registered manager told us people were encouraged to make suggestions and comments but admitted with the staffing difficulties he had not been as visible to people and the walk arounds previously undertaken had lapsed. However, he was hopeful that as new staff started, these would recommence. The registered manager was considering a regular newsletter to keep people up to date.

Staff meetings were held to enable open and transparent discussions about the service and people's individual needs. These meetings updated staff on any new issues and gave them the opportunity to discuss any areas of concern or comments they had, about the way the service was run. Staff told us they were encouraged and supported to raise issues but formal support processes were ad hoc. The registered manager was aware these were areas of future development.

We found the registered manager and deputy manager knew people and their staff well but the recent staffing issues had made them feel overwhelmed with work. They were hopeful as new staff came into post their roles would become more manageable. Staff found the registered manager and deputy manager supportive and most staff told us they felt valued and listened too.

Staff told us they were mostly happy in their work, and the management team motivated them to provide a quality service and they understood what was expected of them. The home had a whistle blowers policy to support staff. Staff said they felt able to raise issues.

There was an effective quality assurance system in place to make improvements within the service. For example there were regular audits including audits on medicines and falls. Falls audits recorded the place, date and time of each fall. This enabled falls to be evaluated and extra protection put in place for people if needed.

The registered manager had undertaken training in the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The service had notified the CQC of all significant events which had occurred in line with their legal obligations. All incidences and accidents were recorded and analysed to identify what had happened and actions the service could take in the future to reduce the risk of reoccurrences. This showed us that learning from such incidents took place and appropriate changes were made.

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 12 HSCA RA Regulations 2014 Safe care and treatment Safe Care and Treatment Medicines were not always managed safely. People did not always receive their medicines at the time they needed them. This is a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing There were not sufficient staff on duty at all times to safely meet people's needs. This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.