Southwest Care Ltd

Vicarage House Nursing Home

Inspection report

The Old Vicarage
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Tel: 08458692976

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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

Vicarage House Nursing Home is registered to provide accommodation, nursing and personal care support for up to 32 older people. At the time of this inspection there were 30 people living there. This inspection was unannounced and took place on 29 November 2016.

The last comprehensive inspection of the home was carried out on 30 September and 05 October 2015. At that time there was a new manager in post who had not yet been registered. There had previously been breaches of regulation concerning record keeping relating to people's care, recruitment, and quality assurance. We found the new manager had implemented changes which had improved these and other aspects of the service, however they needed to prove these changes could be consistently maintained. Although we found no breaches of regulation at the inspection on 30 September and 05 October 2015, the home was rated 'Requires Improvement' because we identified further concerns about staff training and the involvement of people in the day to day running of the home.

We carried out an additional focussed inspection on 21 April 2016 to look at safeguarding concerns related to a lack of staff training and knowledge in the moving and handling of people, and the failure of staff to respond to people's changing needs. We found all staff had received training in moving and handling people and were using moving and handling equipment correctly. We also found staff were responsive to the changing needs of people in the home.

At this comprehensive inspection in November 2016 we checked whether improvements had been made since the last comprehensive inspection in September 2015. We found that while some improvements had been made, they were not always effective. We identified additional areas of concern.

There was a risk that people might not receive safe care, because risks to their health and welfare had not always been accurately assessed, recorded or reviewed. This meant staff did not have access to up to date written information about potential risks or the actions they must take to reduce those risks. Care plans did not provide the guidance staff needed to provide safe, effective, personalised care. This lack of information increased the risks for people, particularly if staff were less familiar with the person, for example if a person without the capacity to understand the risks, refused to be supported by care staff, or had communication difficulties due to sensory loss.

The systems in place for the administration of medicines were not safe, which put people at risk. The medicines policy did not cover all the required areas and failed to comply with current legislation and guidance for medicines administration. Medicine Administration Records (MAR) were handwritten, unclear and did not always contain the information needed to administer medicines accurately and safely.

Staff training related to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), needed to improve so that people's legal rights could be fully protected. Some people had restrictions in place, such as bed rails, but there had been no consideration of whether these restrictions were in their best

interests. In addition some 'blanket' capacity assessments had been made relating to people's ability to make decisions, rather than a specific decision, which indicates the MCA was not well understood. We also found people were potentially being deprived of their liberty, but had not been referred for assessment.

During the inspection we found that although some staff were kind and caring when supporting people, the 'person centred' values expressed by the registered manager were not consistently put into practice. Much of the care we observed in communal areas was 'task focussed', and people and relatives confirmed staff rarely spent time chatting with people in the lounges unless they were taking them to the toilet or giving them their meals. People and relatives told us staff didn't take people to the toilet frequently enough which they found undignified. One person told us, "You do have to wait a long time when you need to use the loo; you have to call out or bang your table. It can be annoying." Staff did not always promote people's independence, for example giving a person with poor sight access to a call bell, so they could ask for the support they needed to move around.

People were not fully protected from risks to their health and safety because the provider's quality assurance system had failed to identify some potential risks. Although audits were carried out related to the environment, accidents and incidents and pressure sores, the provider had not identified that risks to people's health and welfare had not always been accurately assessed, recorded or reviewed, or that care plans did not provide the guidance staff needed to support people effectively. They had not recognised that the systems in place for the administration of medicines were not safe, or that people's legal rights were not being protected.

Although the home was well staffed, they were not deployed effectively. People and relatives told us staff rarely spent time chatting with them in the lounges unless they were taking them to the toilet or giving them their meals. One person told us, "There are plenty of staff around, but it is hard to get their attention when needed".

Following the inspection in September 2015 the registered manager had introduced a 'friends of Vicarage House' group, a 'suggestion box' and customer feedback questionnaire, to better involve people in the day to day running of the home. However, despite this the people living at Vicarage House told us they did not remember being asked for their opinion about the day to day running of the home and had not attended any meetings there. Some people expressed dissatisfaction with some aspects of life at Vicarage House, which the registered manager had not been aware of. This indicates that the service needs to be more proactive in supporting people to make a meaningful contribution to the running of the home, and to express their views, particularly if they are living with dementia or sensory loss.

A supervision programme had been introduced in September 2015 to provide an opportunity for staff to spend time with a more senior member of staff to discuss their work, and highlight any training or development needs. These supervision meetings were also a chance for any poor practice or concerns to be discussed. However, this programme was not in place when we inspected in November 2016. Immediately following the inspection the registered manager informed us that staff supervision was now in place.

Following the inspection in September 2015 the registered manager had implemented a staff training programme.

The staffing structure in the home provided clear lines of accountability and responsibility. There was now 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 was always a registered nurse on duty which made sure people and staff always had access to a more senior staff member to oversee people's health needs and respond to any concerns. Care staff demonstrated a good understanding of people's physical care needs. We observed staff caring for people in a safe way, for example they were using moving and handling equipment correctly, explaining to the person what they were doing, and providing assurances while they were moving them.

People were protected from the risk of abuse through the provision of policies, procedures, robust recruitment and staff training.

People's needs were assessed before moving into the home to determine whether the service was right for them and able to meet their needs. This included their individual nutritional requirements and preferences, and interests, to ensure they received a service appropriate to their needs and wishes.

The registered manager was working to expand the activities available through the recent recruitment of two activity co-ordinators and the development of community links.

People were supported to maintain ongoing relationships with their families and friends. Relatives told us they were kept informed about the well-being of their family member, and were fully involved in reviews of their care.

The service was able to provide effective care to people at the end of their lives. People's end of life wishes were discussed with the person and their family and documented. This meant staff and professionals would know what the person's wishes were and could ensure they were respected.

We recommend that the service seek advice and guidance from a reputable source about effective systems of staff deployment.

We have made a further recommendation that the service seek advice and guidance from a reputable source, about the meaningful involvement of people in decisions about the day to day running of the home.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Risks to people's safety were not always fully assessed, recorded and reviewed.

Ineffective systems meant there was a risk people may not receive their medicines safely.

People did not have the ability to call for assistance in communal areas.

The service had policies, procedures and staff training to protect people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

People's legal rights were not protected when they did not have the mental capacity to make decisions for themselves

Staff received an induction and training to enable them to meet people's needs effectively.

People received care and support from a stable staff team who had a good understanding of their individual needs.

People had access to healthcare services for ongoing healthcare support.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

The service did not always promote people's independence.

Relatives were kept informed about the well-being of their family member.

The service was able to provide effective care to people at the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not provide the up to date information and guidance staff needed to support people.

Feedback systems were not effective in allowing people living in the home to express their views.

The registered manager was taking steps to provide more social stimulation and activities for people.

Families were fully involved and consulted when care plans were reviewed.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The provider's quality assurance systems were not effective in monitoring and reviewing the quality of care to ensure the service continued to meet people's needs effectively.

The values and ethos of the registered manager were not consistently put into practice by staff, which meant people were not always treated with dignity and respect.

The registered manager was committed to developing and improving the service for the benefit of people and staff working there.

The registered manager was working to develop positive links between the people living at the home and the local community.

Vicarage House Nursing 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.

This inspection took place on 29 November 2016 and was unannounced. It was carried out by two inspectors and a specialist advisor with expertise in nursing care.

Before the inspection we reviewed the information we held about the service. We looked at the information we had received from the service including statutory notifications (issues providers are legally required to notify us about) or other enquiries from and about the provider.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

Throughout the inspection we observed care provision in communal areas and saw lunch being served. We looked at a range of records related to the running of the service. These included policies, staff records, staff rotas, training records, medicine records and quality monitoring audits. We looked at 13 care records and spoke with nine people, two visiting friends and nine relatives to help us understand their experiences. We also spoke with the clinical lead, one registered nurse, five care staff, one care supervisor, two activities coordinators, the cook and cook's assistant, and the registered manager.

Requires Improvement

Is the service safe?

Our findings

Although there were systems in place to ensure people received their medicines safely, they were not effective, which meant there was a potential for unsafe practices. Medicine Administration Records (MAR) were sometimes handwritten, unclear and did not always contain the information needed to administer medicines accurately and safely. For example, some people had their pain relief administered through a medicated adhesive patch placed on their skin. There was no guidance in MAR charts about when and how they should be administered. Another person had emergency medication prescribed for seizures. There were no instructions for administration on the MAR chart or in the care plan. One person had an allergy to penicillin, but this information was recorded on only one of several MAR charts.

The MAR charts did not include creams and topical medication and there were no records of the application of these medicines in people's rooms. This meant that it was not possible to tell whether the person had received this medication, and they were at risk of not receiving the treatment they needed. Several care plans referred to people requiring 'thickened fluids' to minimise the risk of choking, but none were prescribed on their MAR chart and there was no guidance in care plans. This meant staff were unclear about the amount of thickening agent required. During the inspection one person went to have a drink of a 'thickened fluid', and found the liquid had turned into a thick gel which they could not drink.

Medicines were administered by registered nurses and a senior care assistant who had completed their medicines administration training prior to working at Vicarage House, some years ago. There had been no review of the senior care assistant's knowledge and skills, to ensure they remained competent and able to safely administer the medicines required by people at the home.

The medicines policy did not cover all the required areas and failed to comply with current legislation and guidance for medicines administration. For example there was no guidance related to people administering their own medicines, which should ensure an assessment of the person's ability to manage this task safely, the recording of the amounts given to each person and that they would have a secure area to lock the medicines away. There was no guidance about the safe management and storage of oxygen. Two people had oxygen in their rooms. We saw there were no hazard notices, risk assessments or care plan instructions regarding the use of oxygen.

These issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

There was a risk that people may not receive safe care, because risks to their health and welfare had not always been accurately assessed, recorded or reviewed. This meant staff did not have access to up to date written information about potential risks or the actions they must take to reduce those risks. Risk assessments were not always dated and signed, which meant it was not possible to tell if the information was current or who had completed them. Risks to people's physical health were not being monitored and reviewed. For example one person was at risk of malnutrition. They had a soft diet and nutritional supplements, with the stated goal to, "maintain a stable weight". The care plan said the person should be

weighed weekly, however at the time of the inspection it had been eight weeks since their weight had been recorded. This meant their risk of malnutrition was not being monitored or reviewed in line with their care plan.

The care plan of a person with a catheter contained no information about how and when to change the bag and position it to ensure the urine drained downwards. We found the catheter bag was in the person's bed with them, which meant it could not drain downwards and there was a risk of urine backflow and other complications. There was no record of when the bag had been changed.

The blood sugar levels of a person with diabetes were consistently outside the desired range identified in their care plan, but there was no evidence in their care plan that any action had been taken in response to this. Some people had been assessed as being at high risk of developing pressure ulcers. They were nursed in bed on mattresses designed to relieve pressure and minimise the risk of skin breakdown. However, care plans did not advise what the mattress setting should be for the person's weight, and there was no record that this had been checked.

There were no turning charts in people's rooms to show whether they had been moved in bed. One person's care plan stated they should be turned every four hours, but there was no turning chart to show if this had been done. This put them at risk of skin breakdown because there was a risk they would not be turned in line with their care plan. During the inspection we identified three people being cared for in bed who were very thirsty. However their fluid intake was not being recorded which meant it was not possible to tell if they were receiving sufficient fluids.

These issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

Although the risks to people's welfare had not always been accurately assessed, recorded or reviewed, we found that staff had some understanding of the risks and how to minimise them, although this would not be the case for new staff or agency staff who did not know people well. For example, a staff member described the frailty of a person and talked about how they cared for them. The described the actions they took to ensure the risk of pressure ulcers were reduced, such as the mattress being at the correct setting and checking areas of risk during personal care. They also understood the importance of good hydration. The registered manager told us, "It's a good team out there. They know what they are doing". This was confirmed by a person who had recently moved from another home. They said, "It was hard moving from somewhere else. I had to get used to everything but the staff seem very nice and they seem to understand my needs and risks". Following the inspection the registered manager advised that action would be taken to address the concerns raised about the risk assessments and medicine administration to ensure people's safety.

On the day of the inspection there were 17 staff on duty at the home, including the clinical lead, a registered general nurse, seven care staff, two activities co-ordinators, the registered manager, and cleaning, laundry and administration staff. The registered manager told us, "We always use the same level of staff whether the home is half empty or full. If we are fully staffed we can cover every eventuality". Staff told us they felt the number of staff on shift meant they had time to chat with people most afternoons. However people and relatives told us staff rarely spent time chatting with them in the lounges unless they were taking them to the toilet or giving them their meals. We observed people banging their cups on their tables to call for help, and on one occasion it took 10 minutes for staff to respond. One person told us, "There are plenty of staff around, but it is hard to get their attention when needed". Only one person in the lounge had the ability to call for assistance as they had a portable call bell. This person said they often had to use it to call for staff for

other people. The registered manager told us there was usually a bigger staff presence in the lounge, but on the day of the inspection they had been deployed elsewhere due to a medical emergency. They told us they would ensure people kept their call bell with them at all times so they could call for help wherever they were.

People told us they felt safe. One person said, "Yes I feel safe as the staff know me so well, so it makes it easier". Another person said, "They take care of me really well, I am comfortable and feel safe". A third person said, "I would rather be in my own home but I feel safer here because I don't worry about anything".

We observed staff caring for people in a safe way, for example they were using moving and handling equipment correctly, safely and respectfully, explaining to the person what they were doing, providing assurances while they were moving them and doing this in a happy and cheerful manner.

Risks of abuse to people were minimised because the registered manager ensured all new staff were checked to make sure they were suitable to work at the home. Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. The DBS checks people's criminal history and their suitability to work with vulnerable people. The registered manager told us any new staff awaiting their DBS worked with another member of staff under supervision, and did not support people with personal care.

Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. They had recently had safeguarding training, which would be updated annually. This would allow them to maintain their knowledge and awareness.

There were formal disciplinary procedures in place to manage concerns about poor staff practice; however the registered manager said they had not needed to use them. They told us that they had a 'very open relationship' with staff, and if there were concerns about a member of staff, they would speak to them. They said they were "approachable and will listen….That's why our [staff] retention is good... At the same time as being approachable and fair, if a talk is needed a talk is given".

A comprehensive fire risk assessment had been completed. People had individual personal emergency evacuation plans (PEEP's), which took account of their mobility and communication needs. This meant, in the event of a fire, staff and emergency services staff would be aware of the safest way to move people quickly and evacuate them safely.

We recommend that the service seek advice and guidance from a reputable source about effective systems of staff deployment.

Requires Improvement

Is the service effective?

Our findings

People's human rights were not being protected under the Mental Capacity Act 2005 (MCA). 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. Some people had restrictions in place, such as bed rails, to keep them safe, but the service had not fulfilled its legal responsibilities under the MCA to ensure these restrictions were in their best interests. For example, there was no best interest process for the use of bed rails documented in one care plan, although the risk assessment noted their use should not be discussed because the person had 'minimal understanding.' In addition 'blanket' capacity assessments were made and determined whether; there was an 'assumption of capacity'; whether the person had 'capacity to make informed decisions'; 'capacity to make unwise decisions'; or 'does not have capacity'. This indicates the MCA was not well understood, because the process for assessing a person's capacity under the MCA had not been followed, and assessments of capacity under the MCA are made in relation to a specific decision.

People's rights were not being protected under the Deprivation of Liberty Safeguards (DoLS). 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). During the inspection we found people were potentially being deprived of their liberty, but had not been referred for assessment.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

We discussed these issues with the registered manager, who provided assurances that immediate action would be taken to ensure people's legal rights were protected.

On the day of the inspection the menu, displayed in the dining room, was chicken and mushroom pie and crème caramel for dessert; however there were no alternative choices. The cook and their assistant told us they asked people if they were happy with the menu that day and offered an alternative if necessary. This was confirmed by most of the people we spoke to. However one person said they would enjoy more food choices, such as fish, but they did not know they could ask for alternatives to the menu. No one was taken to the dining room to have their lunch, everyone in the lounge stayed in their chairs with a table placed in front of them. One person said they did not mind but would enjoy sitting with people because, "It would mean we could chat". Other people had their meals in their rooms because they chose this or because they were too frail to get up.

Following the inspection the registered manager sent us a revised menu plan, from which people could choose an alternative meal and where to eat. We will follow this up at the next inspection to see if this has been implemented effectively.

People's individual nutritional requirements and preferences were assessed and documented to ensure they received a diet appropriate to their needs and wishes. This information was on a whiteboard in the kitchen to remind the cook. All food was cooked from fresh including cakes for afternoon tea. The home had a food hygiene rating of 5. The service was able to cater for any special dietary needs, for example diabetes or a soft diet. The speech and language therapy team (SALT) were involved if people had swallowing issues.

At the last comprehensive inspection in September 2015, the registered manager identified staff training as an area requiring improvement. The training had been planned and was due to start, but it was too soon to judge whether the improvements would be maintained. At this inspection the registered manager told us, "Time has passed and things are moving on. Training is extremely important". They told us they had consulted with staff to identify their training needs, and set up a training programme consisting of two training sessions a month. This had been running for 10 months. It was delivered at the home by an external trainer, and was practical and 'hands on'. Topics included, moving and handling, infection control, nutrition and hydration, MCA and DoLS, safeguarding adults, and dementia. When asked how dementia training had improved their practice, one member of staff told us it had helped them understand what it was like to be in people's shoes. They said they were more understanding, and took more time to explain things to people, even if it meant having to explain more than once. They also said it was important to remember that people could still experience things like grieving even though they were living with dementia. Another member of staff described how dementia training helped them communicate better with people, by sitting at their level, ensuring they had eye contact and were speaking clearly and simply. Regular updates were planned to ensure staff maintained their knowledge and skills.

'Bespoke' training was arranged as required to enable staff to meet people's individual needs. For example one person required a feeding pump to help them maintain their nutrition, and a nutritionist had come in to train staff on how to use it. The registered manager told us, "If there's something we don't have we will look for it, find them and bring them in".

New staff had an induction which gave them the basic skills they needed to care for people safely. This covered a range of essential topics like understanding dignity, first aid, and fire safety. During this period they spent 13 weeks working alongside more experienced staff to get to know people and about their care and support needs.

Staff told us they felt supported by the registered manager. None had had individual documented supervision sessions; however they all told us the registered manager was easy to talk to and was supportive. Following the inspection the registered manager told us supervision had now been arranged for staff, and meetings with staff would become 'more formal', with records kept.

The registered manager told us, "We are well staffed. The retention level is fantastic. Some come back after years away. We use an agency very rarely, and agency staff will be teamed up with a care supervisor, team leader or a long term carer. We try and get the same agency staff". The consistency in the staff team meant staff knew people well, and had a good understanding of their support needs. For example, one staff member talked about a person at risk of choking and described what measures were needed to keep them safe. Their descriptions matched what was recorded in the person's care plan and risk assessment.

People had access to healthcare services for ongoing healthcare support. There was a weekly GP clinic at the home, and care records showed people were referred appropriately to other professionals, such as the dentist, optician, and chiropodist. A relative confirmed, "They will organise visits from health professionals. There has always been the understanding (that they would do that)".

Requires Improvement

Is the service caring?

Our findings

Although we observed staff in the lounge were responsive, kind and patient when assisting people, we also observed that they only interacted with people when carrying out a task, for example supporting people to move in and out of the lounge or assisting them to eat. There was very little conversation. One person when being assisted to eat had no conversation other than, "Alright?"

Staff were observed respecting people's privacy with the use of screens, knocking on people's doors and speaking discreetly. Staff also told us about "putting people at ease by ensuring people were covered as much as possible when giving personal care". However the service was not always committed to promoting people's dignity. One person was unable to walk safely without being assisted by staff. A relative told us, "Staff don't take [person's name] to the toilet enough, plus they can't call for help as no bell is provided". Another person said, "You do have to wait a long time when you need to use the loo, you have to call out or bang your table, and it can be annoying."

The service did not always promote people's independence. One person's care plan said the person was independently mobile, however, due to their poor sight required two carers beside them, and a call bell if they needed help. During the inspection we noted the person had no call bell beside them, and they were in the lounge all day.

These issues constitute a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect.

Staff told us how they supported people to make choices. For example, one member of staff described people's right to make decisions, explaining how they always involved them in decision making and checked what they were doing was ok and in their best interests. During the inspection we heard staff in the lounge explaining what they were doing and obtaining people's consent before supporting them with a task.

Most relatives had extremely positive comments about the home. One set of relatives said "[Person's name] is very settled and happy here, we couldn't ask for better care. They can choose to get up or stay in bed, they respect their wishes. We are kept informed of everything which makes us feel they care…We visit regularly and always find staff numbers are good and they are very kind". Another relative told us, "Staff are lovely, very approachable, excellent". They also told us staff always phoned them to keep them up to date with any changes with their relative's condition. Another relative told us how their family member was much more relaxed having returned to the home after a hospital admission. The relative lived abroad and described the registered manager's communication with them as "excellent".

The registered manager told us the service was able to provide effective care to people at the end of their lives. People's end of life wishes were discussed with the person and their family and documented. This meant staff and professionals would know what the person's wishes were and could ensure they were respected. Training in end of life care had been arranged for all staff.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive. Care plans did not provide the guidance staff needed to provide safe, effective, personalised care. For example, the care plan of a person with dual sensory loss stated their hearing was good and they could communicate their needs well. The registered manager confirmed this was inaccurate. The newly appointed activities co-ordinator told us they had not been able to do any activities with the person due to difficulties with communication. Without accurate and clear guidance for staff about how best to communicate with this person there was a risk they would not be able to make their needs known and they would become socially isolated.

Care plans did not support staff to provide personalised care. For example there were no instructions about how people should be supported with personal care, such as how and when the support should be given and the persons' preferences. The guidance in one person's care plan did not reflect that the person was visually impaired and deaf. Care plans did not contain detailed guidance about how staff should support people living with dementia. For example the care plan of a person who "was unable to maintain personal hygiene due to dementia and a lack of understanding "and "could get irritated at times and quite aggressive", contained no guidance for staff about how to safely support the person during personal care if they were to become aggressive, and what action they could take to ensure the person still received the support they needed in this situation.

These issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The registered manager advised that the 'clinical lead', who had been working one day a week, would now be working full time, and would focus on improving the care plans.

At the last comprehensive inspection in September 2015 we found people were not involved in making decisions about the day to day running of the home. At this inspection we found some improvements had been made, such as the 'friends of Vicarage House group', which raised funds for activities and organised community activities for people; the introduction of a 'suggestion box' and a customer feedback questionnaire. People were informed about the questionnaire in the monthly newsletter, and advised to talk to the registered manager if they wished to complete one. We saw there had been four positive responses from relatives. However, the people living at Vicarage House told us they did not remember being asked for their opinion of the home, the food, activities or staffing. They said they were not aware of, and had not attended any meetings in the home. Whilst most people gave positive feedback on their experience in the home, some were dissatisfied with the types and level of activities, and told us they would happily use the dining room if they were given the opportunity to have meals there but had never been asked.

One person told us they felt the social stimulation was "lacking and unimaginative at the moment", although they enjoyed "the man with the guitar who came in monthly". Another person told us, "We have sing songs, bingo, films and children read to us. It's ok but nothing exciting really, I really enjoy the [visiting] children and I enjoyed a film the other day but that's about it. I will join in bingo but only because there is

nothing else". The registered manager was taking steps to provide more social stimulation and activities for people. They had recently recruited two activity co-ordinators who had been employed for a week at the time of the inspection, so had not yet had training relating to their role. They had been sitting with people chatting, doing puzzles, painting nails and watching films. They were less sure of how to work with people who had more complex needs, but said they were getting to know people and hoped with training they would be able to expand the range of activities they could provide. The registered manager had recently arranged for a vicar to give monthly communion, which people told us they were looking forward to. There had been greater involvement with the local community, with people attending a cream tea in the village hall, and going to the local school for lunch.

Before moving into the home, people's needs were assessed to determine whether the service was right for them and able to meet their needs. The registered manager told us that families often visited the home prior to admission to see if it would suit their family member. Where possible the registered manager visited the person and their family which gave them the opportunity to find out about their personal history, and what was important to them as a person. They told us, "Social history is very important. For example, if they like listening to Radio 4, when they come in the radio in their room is tuned to Radio 4".

In the Provider Information Return (PIR), the registered manager stated, "We ensure our service is responsive by actively involving the families who are known personally to us by holding regular review meetings with relevant professionals and families together. This ensures everyone is involved in the decision making of ongoing care requirements and all are up to date with what happens next" .This was confirmed by relatives who told us they were involved in reviewing care plans, every 12 months, and that the community nurses were also invited.

The registered manager told us people and their families were made fully aware of the home's complaints policy and process. They told us, "They know where to come and what to do. There isn't a log of complaints because we don't get them". A relative confirmed, ""If I've ever had a problem I've gone to see the registered manager. They've sorted it out straight away." One person told us they would always tell staff if they were unhappy with anything. They told us they were confident the manager would deal with concerns very quickly but said they had never had a reason to raise anything.

We recommend that the service seek advice and guidance from a reputable source, about the meaningful involvement of people in decisions about the day to day running of the home.

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were not well led. The registered manager told us the service had been "in transition" when inspected in September 2015, with "lots to improve upon". They believed they had "moved things forward quite a bit" and told us, "Everything that was raised has been addressed. There are systems in place to maintain that". They showed us an action plan that they had developed following the last comprehensive inspection in September 2015. We found that while some actions had been achieved, for example related to staff training, the development of the 'friends of Vicarage House' group, and privacy screens erected around toilets in people's bedrooms, others had not.

The action plan identified a need for "care plans to be more person centred indicating how a person would like the care provided, also need to give clear guidance for staff on specific issues for example challenging behaviour" . We found this had not been achieved and that care plans did not provide the guidance staff needed to provide safe, effective, personalised care.

The action plan stated, "Many audits to be added over the next two years and will be monitored with action required and corrective action reports". The registered manager advised that the providers visited once a month and carried out audits of the service. The PIR stated, "Management meetings are held monthly to ensure consistency of service provided and will highlight any areas for improvement", and that "key staff will also partake in internal auditing and quality management systems training to improve our auditing and recording techniques." We found however that although audits were in place relating to the environment, fire safety, accidents and incidents, and pressure ulcers, the provider's quality assurance systems had not been effective in monitoring and reviewing the quality of care to ensure the service continued to meet people's needs effectively. For example, audits had not identified that some risk assessments were inaccurate, poorly recorded and had not been reviewed regularly. Care plans did not provide the guidance staff needed to support people effectively. We found risks in the medicines administration policies and procedures that had not been picked up and addressed. Audits had also failed to recognise that people's human rights were not being protected under the Mental Capacity Act 2005 (MCA).

The registered manager told us, "We are very much person centred. It's all about respect and dignity. Before people had to be up by a certain time, toileted at a certain time. Residents aren't numbers anymore. If someone wants to stay in bed, let them stay in bed. They've got choices and this is portrayed to every member of staff and their families". However, during the inspection we found these values were not consistently put into practice by staff. People were not always aware they had choices, for example that they could ask for alternatives to the menu. Although the home was well staffed, some people and their relatives told us they had to wait a long time to be taken to the toilet which they found undignified.

These issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

When we inspected in September 2015 the manager had recently introduced a supervision programme to provide an opportunity for staff to spend time with a more senior member of staff to discuss their work, and

highlight any training or development needs. These meetings were also a chance for any poor practice or concerns to be addressed in a confidential manner. At this inspection we found staff were not receiving individual support and supervision in this way, although they told us they felt well supported. Immediately following the inspection the registered manager informed us that staff supervision was now in place and that staff meetings would be documented. We will follow this up at the next inspection to see if this has been implemented effectively.

At the last inspection in September 2015 the manager, although in post, was not registered with the Care Quality Commission. Since March 2016 they had been registered with the Care Quality Commission as the registered manager for the service. They had a detailed knowledge of the individual needs of people at the service and were 'hands on', working alongside care staff where necessary. People, relatives and staff were complimentary about them. A relative told us, "[Manager's name] is easy to talk to. They are very responsive to whatever you have to say". A member of staff commented, "The manager is brilliant. They are so supportive… fantastic... constantly there. They will let you work in the way you want to work. They won't leave something; they will make sure it's done straight away". Another member of staff told us the manager "walks the floor regularly", so understood what was going on and "sorts things out quickly". The registered manager told us, "We don't have staff meetings per se. Every morning we have a meeting where people's conditions are discussed, birthdays, who's going out. I'm there. If there is an issue in the home it's reported to me. We have an open door policy and we are speaking and communicating all the time".

The registered manager told us their ethos was; "To ensure the involvement of all". They told us, "We don't want to be a closed unit any more. We want to use the resources out there that are available to us to better ourselves. We are transparent; we want to be as transparent as we can be. There is an open door management policy, where anyone at any time can feel welcomed for their views. We have a culture now of training to improve". The registered manager had focussed on staff training since the last comprehensive inspection in September 2015. In the PIR they stated, "All staff have a choice to input into the training available. I have adopted a "you ask, we do" policy on training with two sessions a month covering a variety of areas. This has given staff a sense of involvement in their development and they feel their input and suggestions are taken into account and followed through".

There was a staffing structure in place, including a clinical lead in post for nine months, which the registered manager was confident provided clear lines of monitoring and accountability. Staff were clear about their roles and responsibilities. For example the care supervisor described how they allocated work, checked on work completed and talked about how they "sorted out issues during the day and passed on information to the nurse if necessary".

The registered manager told us they felt well supported by the providers, who "communicate every other day by phone and visit at least once a month". They "took care of maintenance and finance" and were "very committed to the home". There had been a lot of investment in improving the environment, including new carpeting and the creation of a large shower room with an overhead hoist. There were plans to build an extension with 24 additional rooms which would house a specialist dementia unit. Works were due to begin in Spring 2017.

The registered manager told us they kept up to date with best practice through attending every training session at the home as well as sessions provided by external organisations including 'The Mental Capacity Act for Managers'. They also attended 'engagement days' run by the Somerset Clinical Commissioning Group where they were updated about developments in local health care services.

The registered manager worked to foster links with the local community. For example the home had been

part of a local project linking schools, care homes and businesses to raise awareness of dementia. They had hosted an afternoon tea and other events were planned. A thank you letter stated, "Many thanks to yourself and all the staff at the Vicarage for the excellent village cream tea yesterday…For many this was their first visit to the Vicarage and there were very many positive comments about the décor, the staff, the surroundings and the warm reception. "

As far as we are aware, the home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. 10(1) People's independence was not always promoted. 10(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where a person lacked mental capacity to consent to care and treatment, the service did not always follow a best interests process in accordance with the Mental Capacity Act 2005.11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and welfare had not always been accurately assessed, recorded or reviewed.12(2)(a) Risks to people's welfare were not always effectively managed.12(2)(b) The service did not ensure staff competency for administering medicines. 12(2)(c). Systems for managing medicines were unsafe which put people at risk. 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Safeguarding service users from abuse and improper treatment People's rights were not being protected under the Deprivation of Liberty Safeguards (DoLS). 13(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have effective systems in place to assess, monitor and improve the quality and safety of the service. 17(2)a The service did not assess, monitor and mitigate the risks related to the health, safety and welfare of service users. 17(2)b The service did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided and decisions taken in relation to this.17(2)c