Dr Pepper's Care Corporation Limited

Vicarage Residential Home

Inspection report

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Date of inspection visit:
28 March 2017
29 March 2017

Date of publication:
07 June 2017

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 took place on the 28 and 29 March 2017 and was unannounced.

The Vicarage Residential Home is registered to accommodate a maximum of 35 older persons. They provide residential care without nursing. Nursing care if needed is provided from the community team. There were 33 people living at the service when we visited. The Vicarage also provided short term respite care for people.

The service had 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.

At the last inspection on the 23 June 2016 we found some concerns and areas where improvement was needed. We found medicines were not always managed safely, and people did not always receive their medicines at the time they needed them. The number of staff available were not sufficient to meet people's needs safely. People also told us there were limited opportunities or activities available to occupy their time, and we were told the service was not always well- led. The provider wrote to us and told us how they planned to address these concerns and by when. We found at this inspection that improvements had been made in relation to activities and the management of people's medicines. However, improvements were still needed in relation to staffing, and the leadership of the service.

Although the registered manager and provider told us action had been taken to address concerns relating to staffing, people and staff still said there were still times when staffing at night was not sufficient to meet people's needs and to keep them safe. The registered provider and registered manager told us staffing levels had been increased when the number of people in the home increased. However, we saw no evidence of an effective system to review staffing levels regularly based on people's needs.

People were supported by staff who had undergone sufficient checks before starting work in the home. However, people were not fully protected as systems were not sufficient to monitor and address risks, which had been identified in relation to staff supporting them.

The registered manager and provider undertook a range of audits to assess and monitor the quality of the service. They said they also met with people and staff regularly to discuss any issues and improvements required. However, these had not in all cases been effective in identifying shortfalls and gaps in staffing and records. Following the inspection the registered manager wrote to us and told us how they had improved the quality auditing process to include regular reviews and monitoring of staffing levels.

People told us about the different activities now available and an activities coordinator had been employed to improve the social opportunities available to people. However, information in people's support plans

about their backgrounds and interests had not always been completed, which could mean this information was not known to staff planning their care.

The admissions process required some improvement to help ensure people received consistent care as they moved between services. When people were admitted from hospital information had not always been gathered in relation to other aspects of their life, such as where they had previously lived. The absence of this information could mean important issues relating to people's life and lifestyle would not be known or form part of their on-going plan of care.

Healthcare professionals said the registered manager and staff had worked hard to improve links between the home and healthcare professionals. They said the registered manager and staff had listened to advice and had improved records, communication and staff training. This had resulted in people's health care needs being more appropriately met by the home and healthcare services.

People had their medicines managed safely. People received their medicines as prescribed and on time. People were supported to maintain good health through regular access to health and social care professionals such as GPs, social workers, district nurses and physiotherapists. Health professionals within the district nursing services spoke highly of the service. They said the staff team made appropriate and prompt referrals as well as working alongside them during visits to better understand and respond to people's healthcare needs.

On the day of the inspection staff within the service were relaxed, there was a calm and friendly atmosphere. Everybody had a clear role and information we requested was supplied promptly. Records relating to people's care and the service were well organised and easy to follow. Staff knew people well and were able to tell us about people's needs and how they chose and preferred to be supported. People were comfortable with staff and we observed positive interactions between people and staff supporting them. We met relatives visiting their loved ones and they told us they were always welcomed and able to visit at any time.

People said the food in the service was good and they were offered choice and plenty of snacks and drinks throughout the day. Staff were aware of risks associated with people's diet and clear guidelines were in place to minimise risks and to help ensure people had a good mealtime experience.

People we observed were safe. Checks were undertaken of the environment and equipment to help ensure it remains safe and fit for purpose. All staff had undertaken training on safeguarding adults from abuse and had the information and knowledge needed to report any concerns.

People's risks were managed well and monitored. Staff demonstrated a good understanding of the Mental Capacity Act (2005) and understood when people had the capacity to make decisions for themselves or if best interest meetings and the involvement of others were required. Families were involved in decision making where necessary.

People were supported by staff who had undergone a comprehensive induction programme and on-going training relevant to the needs of people being supported. Staff said they felt well supported by the registered manager and deputy manager and had opportunities for discussion and to reflect on practice.

The registered provider and registered manager were visible in the home throughout the inspection. When the registered manager was not working in the home they were on call and available to be contacted by staff. The registered provider spent time in the home talking to people, and listening to their views about

the service. People said they felt the some aspects of the service had improved, such as décor and availability of management. The registered manager undertook spot checks of the environment as well as a range of audits such as medicines, records, equipment and people's personal finances. Systems were in place to record and analyse incidents and these processes had allowed prompt action to be taken when concerns and changes in people's needs had been identified.

We found breaches in the regulations. 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 always safe.

People were supported by staff who had undergone sufficient checks before starting work in the home. However, people were not fully protected as systems were not sufficient to monitor and address risks identified as part of the recruitment process.

Staffing levels had been put in place to meet people's needs and to keep them safe.

People were protected by safe and appropriate systems for handling and administering medicines.

People were protected by staff who understood how to recognise and report signs of abuse or poor practice.

Staff managed risk appropriately and recognised people's rights to make choices about their lifestyle.

Is the service effective?

Good

The service was effective.

People received support from staff who knew them well and had the knowledge and skills to meet their needs.

Staff felt well supported and had opportunities to discuss their role and reflect on practice.

People's rights were promoted and their best interests considered in line with the Mental Capacity Act 2005.

People were supported to have their health and dietary need met.

Is the service caring?

Good

The service was caring.

People were supported by staff who had taken time to get to know them and understood their needs.

People were treated with respect by staff who were kind and caring.

People's privacy and dignity was promoted and respected.

People's friends and visitors were able to visit and welcomed into the home at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The admissions process was not always sufficient to ensure people received consistent and appropriate care as they moved between services.

People had the opportunity to partake in social activities and to maintain important relationships with family and friends.

People's support arrangements were reviewed regularly to ensure they remained appropriate and met their needs.

People had access to a complaints policy if they wished to raise any concerns about the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider and registered manager had not ensured effective systems were in place for reviewing and monitoring staffing levels in the service.

Quality assurance systems had not picked up gaps in people's support arrangements relating to their backgrounds and personal interests.

Staff were clear about their role, and demonstrated a good understanding of people's needs.

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 checked 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 28 and 29 March 2017 and was unannounced. The inspection was undertaken by two inspectors and a Pharmacist inspector who specifically looked at the management of medicines.

Prior to the inspection we gathered information about the service from other agencies including the local authority and local safeguarding team. We also reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events, which the service is required to tell us by law.

During the inspection we spoke with twelve members of the staff team. This included management and care staff as well as other members of the team including kitchen staff. The registered manager was present throughout the inspection and was supported by a deputy manager. We spoke with the registered provider who was also the owner of the service and they were present at the end of the inspection when we provided some headline feedback.

We looked at the care records of eight people and spoke with these people where we could about their care. As part of the review of medicines we looked 12 electronic medicines administration records and observed twelve people as their medicines were being administered. We also spoke with 15 other people either in their rooms or the communal parts of the home. We observed how staff interacted with and delivered care to people. This included observations at mealtimes and, whilst people were partaking in planned activities. We spoke with four relatives and a district nurse who were visiting at the time of the inspection.

Other records we reviewed included, policies and practices, records of how the registered persons ensured the quality of the service such as quality assurance processes and audits. We also looked at four staff files, which included recruitment records and training certificates.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on the 23 June 2016 we found the service was not always safe. We found some concerns relating to medicines. Stock of medicines had on occasions run out and people did not always receive the medicines they were prescribed and needed. We also found concerns in relation to staffing levels. Staff said they felt staffing levels at night were not safe and they were not able to sufficiently meet people's needs at this time. The provider sent us an action plan telling us how they would address these concerns and by when. We found at this inspection improvements had been made in relation to the management of people's medicines and activities. However, concerns continued to be raised about the number of staff on duty at night.

The registered provider told us since the last inspection they had undertaken a review of staffing levels. They said they had increased the number of night staff from two to three when there were over thirty three people in the home. However, staff said due to the changing and increasing needs of people in the service staffing levels at night remained insufficient.despite the numbers of people living in the home. Comments included, " It can be really difficult at night when only two staff are on, with the amount of people needing double up support it does mean people's call bells are not answered". Staff we spoke with about staffing levels said they felt three staff were needed at night as people's needs were increasing and at-least 12 people needed two staff to support them with personal care and re-positioning. Therefore, people could be placed at risk as no staff were then visible or able to observe people during the time spent in people's bedrooms.

The registered manager said they felt staffing levels at night were at times insufficient to meet people's needs and to keep them safe. They said twelve people needed two staff to support them with personal care and re-positioning during the night, which would often mean other people were left unsupported when only two staff were on duty.

People said they felt there were usually enough staff around to meet their needs during the day. However, some people said they felt staffing levels were still on occasions low at night, which meant they had to wait to be supported by staff. Comments included, "There seems to be more people who need lots of support living here, I know two staff have to help some people, so that means we have to wait" and "It is usually ok, but sometimes I have had to wait too long for the toilet, which can be embarrassing and upsetting".

Staff said people's needs had increased and changed regularly due to the number of people coming into the home for respite care and following discharge from hospital. We saw no evidence of regular reviews of staffing arrangements to reflect these changes. The registered manager did show us an assessment of people's needs they had completed prior to the inspection.They said this had been passed to the registered provider as evidence that additional staff were needed at night. The registered provider told us at the time of the inspection that due to this new information they would increase the number of staff available at night.

Following the inspection the provider wrote to us and said staffing levels at night had increased. They said formal arrangements were now in place to review staffing levels on a regular basis to help ensure they

remained appropriate and safe.

All recruitment files contained relevant information including DBS and references. It was noted that at the point of selection of some new staff some issues had been found, which prompted the registered manager to raise further questions and to ensure their appropriateness to work in the home. We saw this information had been documented at the point of recruitment but not as part of an on-going risk management plan. The absence of a clear process for monitoring and addressing risks associated with staff could mean people were not fully protected by a safe and appropriate staff team. The registered manager told us they would add this information to staff supervision records.

When risks relating to staff had been identified as part of the recruitment process, systems were not sufficient to ensure ongoing monitoring of their practice and safety in the home. This is a breach of Reg 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place for managing medicines. We spoke to staff involved in the governance and administration of medicines, observed medicine administration for 12 people and looked at 12 electronic medicines administration records.

The service used an electronic computerised medicines system. At the last inspection we saw that this system was not working effectively to keep people safe. Many of the concerns raised at the previous inspection had been addressed. Staff recorded medicines administration directly on to a laptop computer; this meant that medicines records were always accurate and up to date. Staff used a bar-code scanner to identify medicines for people before administration. We saw that some bar-codes either did not scan or were not recognised by the system. Staff told us that this was due to the input of information by the system supplier. Where items did not scan, staff checked the dispensing label and the electronic record to ensure that medicines were given correctly. Staff contacted the system supplier regularly to inform them when medicines bar-codes would not scan.

Some people were prescribed medicines to be taken when required. There was no facility on the computerised medicines system to record additional information that could guide staff about when and how often these medicines should be given. However, we saw that staff knew people well and were able to identify non-verbal cues to indicate that they may require a medicine. For example, one person who was living with dementia was given a pain-killer as staff had noticed stiffness in movement whilst helping the person get up from bed. The computerised medicines system allowed staff to set a follow up time to check whether the person had been helped by the when required medicine and to record the outcome. This ensured that people were receiving medicines that were effective. Additional written information was available to care staff about where and how often to apply creams. Care staff recorded the application of creams or other external items on the electronic care record.

Medicines were stored securely. Medicines requiring cold storage were monitored to check that temperatures were suitable for storing medicines, so that they would be safe and effective. There were suitable storage arrangements and records for some medicines that required additional secure storage. Regular checks were made of these medicines, and there were suitable arrangements for destruction and disposal of medicines.

Medicines policies and procedures were available to guide staff. There was a reporting system in place for any medicines errors or incidents and the computerised medicines system alerted staff whenever an action was required. Staff had received appropriate training and were assessed as competent to administer medicines. A medicines audit had been completed by the community pharmacy and we saw that the

manager had completed internal audits of medicines processes as part of a drive for quality improvement.

People were protected from discrimination, abuse and avoidable harm by staff that had the knowledge and skills to keep people safe. Policies and procedures were available for staff to advise them of what to do if they witnessed or suspected any incident of abuse or discriminatory practice. Records evidenced management and staff had undertaken safeguarding training. Staff were aware of the reporting procedures and said they trusted any incidents would be dealt with promptly by the registered manager and provider.

People were supported by staff who managed risk effectively. Support plans described potential risks to people and how these could be minimised. For example, risk assessments were in place for people in relation to risks associated with skin, nutrition and mobility. One person had a plan in place due to known risks associated with their skin. The plan described how staff needed to attend to the person's personal care and hygiene promptly to help reduce any breakdown in their skin tissue. A pressure care, repositioning and nutrition plan was also in place for this person detailing the care and monitoring needed for this person. Another person had known risks associated with falling. Their plan detailed the need for staff to ensure their bedroom was uncluttered, that they had their glasses on each day and any mobility equipment was available to them. Staff undertook regular well-being checks of each person in the home. This required staff to check each person at-least every two hours to ensure they were comfortable and safe. These checks were carried out in addition to everyday care and support and were increased if people's needs changed. Staff spoke in a way, which demonstrated they understood the importance of a person's choice, regardless of their age or disability. Staff actively supported people to make choices and to have as much control and independence as possible.

Assessments had been carried out in relation to risks associated with the environment. People had personal evacuation plans in place, which helped ensure their individual need were known to staff and emergency services in the event of a fire. A fire risk assessment and fire equipment audit was in place. It was noted that the log book was not in all cases up to date to confirm equipment had been checked as required. The registered manager said these checks had been completed. They said a staff member had recently completed fire safety training and as part of their new role would be responsible for ensuring all records are kept updated.

People were kept safe by living in a clean and hygienic environment. The home was visibly clean and sanitising gel, gloves and aprons were available, which we saw staff using throughout the inspection. The registered manager was aware of parts of the home, which required additional cleaning due to people's particular conditions and care needs and cleaning plans were in place. It was noted that some commodes had not been emptied and had been left open in people's bedrooms. This was pointed out to senior staff at the time of the inspection.

Good

Is the service effective?

Our findings

People were supported by staff who understood their needs and had the skills to support them effectively. One person said, "The staff are very good, they know how to look after me". Relatives said, "[…] is seen regularly by the District Nurse and the manager always keeps us updated".

Staff undertook a thorough induction programme when they first started working in the home. This included shadowing experienced staff and familiarising themselves with policies and procedures relating to people and the services provided. New staff said they felt the induction programme was good and prepared them for their role in the service.

A training programme was in place for all staff, which included a range of mandatory training such as fire safety, food hygiene and safeguarding as well as more specific training relevant to the people being supported. The local district nursing team provided staff with support and training in relation to particular health needs such as pressure care, ulcers and diabetes. Staff said they felt the training opportunities were relevant to their role and the needs of people they supported.

A training matrix was in place, which detailed the training staff had completed and when it required updating. It was noted some staff had not attended dementia training. A number of people were living with dementia and needs associated with this condition. The registered manager said this training was planned and would be covered as part of the Mental Capacity Act 2005 training. We saw a list of training planned for March 2017, which included Fire safety, safeguarding, medicines assessments and first aid response.

Staff said they felt well supported by their colleagues and management. They said there were plenty of formal and informal opportunities for discussion such as daily handovers and staff meetings. The registered manager said formal supervision discussions were held and documented when required, however there were no planned times for these meetings to occur. It was noted that the provider was in the process of undertaking a number of disciplinary hearings with staff and had also agreed some actions with new staff as part of the recruitment process. It was discussed with the registered manager that the absence of formalised supervision sessions and documentation could mean these discussions and agreements would not be monitored and reviewed as required.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions or authorisations to deprive a person of their liberty were being met. 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 as far as possible people make their own decisions and are helped to do so when needed. When a person lacks the mental capacity to make particular decisions, any made on their behalf must be in their best interest and least restrictive.

People's support plans included information about capacity and when people could make their own choice or required support. Discussion with the registered manager confirmed best interest discussions and meetings had taken place when people lacked the capacity to make a decision. The registered manager had

liaised closely with health and social care professionals to consider the best interests of one person who due to their health needs may lack the capacity to make decisions in relation to their medicines.

People can only be deprived of their liberty in order to receive care and treatment, which is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care home is called the Deprivation of Liberty Safeguards (DoLS) The registered manager was aware of this process and had made applications under DoLS when required.

People's consent was obtained by staff prior to them undertaking a task. We observed staff asking for people's consent and checking people understood what was happening before providing care.
One staff member brought a person back into the lounge after lunch. They told them what they were doing as they brought them into the room and provided them with a call bell, which they said they could use while they went to get equipment to move them into a more comfortable seat. The person was clearly happy with this information and nodded to confirm they understood what was happening.

People had their nutritional and dietary needs met. Comments included, "There is always plenty of food and drink available at any time", and "The food is very good, I can't complain". We observed people as they had their lunchtime meal. We saw people were offered a choice, and the food was well presented. Staff interacted with people, talking about their meal and checking people were comfortable and happy. Two people arrived a little later and after the first course had been served. Staff reassured them it was fine and said their meal had been saved or they could choose something else.

When people had known health needs or risks associated with their diet, plans were in place to support them and keep them safe. For example, one person had been assessed as being at risk of not eating a sufficient diet due to their cognitive impairment. Guidelines were in place for staff to support the person to eat and drink. Assessments identified when people needed food, fluids and weight to be monitored and daily charts were in place and completed.

People were supported to maintain good health and when required had access to a range of healthcare professionals. District nursing services provided positive feedback about the service and said management and staff made prompt and appropriate referrals as well as being good at following advice and guidance provided. We were told the provider and district nurse services had worked closely to improve communication and develop the skills and knowledge of the staff team. When new staff started working in the home they had the opportunity to work alongside district nurses during their visits to help them develop a better understanding of people's needs and the treatment being provided.

Staff responded promptly to changes in people's health or well-being. Throughout the day and night two hourly well- being checks were undertaken of each person to check if they were comfortable or if there were any concerns needing to be addressed. The registered manager said these checks increased when needed. We saw staff respond promptly and sensitively when a person became distressed. Staff were very aware of the person's deteriorating health and action had been taken to involve relevant healthcare professionals.

Good

Is the service caring?

Our findings

People felt well cared for by the staff team. Comments included, "The staff are always lovely, friendly, polite and caring". Relatives we met said their loved ones were well cared for and told us, "The staff are excellent. We visit regularly each week, […] is always well cared for. There room is always clean and tidy, and we are kept well informed about [….] well-being".

We spoke with a group of people in the communal lounge. They all said they were happy living in the home. Two people said they had recently moved in and had settled well. We saw staff greeted people as they walked through the sitting room, and even if they were in the middle of a task acknowledged people as they walked by. We heard staff say, "Morning everyone ", "Are you ok, comfortable?", "Is there anything I can get you". When one staff member left the sitting room, people commented, "He is a very nice young man". We spoke with a person who was staying in the home for a few weeks before moving into a different service. They said the staff had been kind and they had been made to feel welcome.

Staff were able to tell us about the people they supported and said they had the opportunity to get to know people by spending time with them and reading their records. A staff member commented, "Yes, there are lots of jobs and tasks to do but we try and sit with people and have a little chat. This is also seen as an important part of our job". We spoke with a staff member about one person who due to their high care needs had most of their care provided in their bedroom. The staff member was able to tell us about this person and about how they chose and preferred to be supported. They said, " […] needs to be cared for in their room, but loves to see staff and for people to talk to them. They like having their nails painted and the television on during the day". We saw this person was nicely dressed and looked comfortable in their bed. They had their nails painted and the room was clean, tidy and bright with the television well positioned for them to watch.

We found staff were compassionate and caring. Throughout both days we observed people being supported in their bedrooms as well as the communal areas, including the lounge area and dining room. We saw people were respected by staff and treated with kindness. We saw and heard staff speaking at all times in a kind and friendly manner.

Staff were skilled and responded in a caring and compassionate way when people showed signs of anxiety or distress. For example, one person had become distressed when they had slipped down in their bedroom chair. They had called out indicating they were confused and distressed about what was happening to them. We saw the staff responded promptly and appropriately to minimise their distress and to help them feel comfortable and safe. Staff closed the person's bedroom door to help ensure their privacy and provided gentle words of reassurance, whilst staff helped them re-position safely in their chair. Staff were very aware of this person's needs and were monitoring them closely as their needs had changed and increased. Another person who was in bed during the day shouted out regularly for staff to help them. They spoke in a way that suggested they were confused and did not understand about where they were living. We saw staff responded to this person providing reassurance about where they lived. Staff had a good knowledge of this person's needs and said they respected their wish to stay in bed but gently encouraged them to get up and

dressed in their own time.

People were treated with dignity and respect. People said staff were respectful when supporting them. Comments included, "Yes, they always speak to me and support me in a way I would expect", and "I choose not to have male staff supporting me with my personal care needs and this is respected". We observed staff knocking on people's doors before entering and closing doors when personal care and support was being provided.

Visitors told us they were welcomed into the home at any time. We saw people enjoying visits from family and friends. Staff provided cups of tea and chatted with relatives about events in the home, which helped create a welcoming and homely atmosphere.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on the 23 June 2016 we found the service was not always responsive to people's needs. People told us activities were limited and they would like more available to occupy their time. The provider sent us an action plan telling us how they would address these concerns and by when. At this inspection we found improvements had been made in the number of activities available to people However, improvements were needed in their admissions procedure and their records relating to people's interests.

Some people were staying in the home for a period of respite or following a stay in hospital. Other people had lived in the home for a number of years on a more permanent basis. We were told the provider undertook an assessment of need prior to people moving in. We saw the records of one person who had moved into the home following an admission to hospital, and whilst long term plans were being considered. We saw information had been passed to the home by the hospital about this person and this had been used to plan the person's care during their stay in the home. However, this information was limited and based mainly on their health and stay in hospital. The assessment had not taken into account the person's experiences prior to being in hospital and contact had not been made with the person's previous placement. This could mean people's care was not always consistent as they moved between services and did not always take into account their past experiences and needs when planning care. This issue was discussed with the registered manager and provider at the time of the inspection. They told us they would would review their admissions procedure.

An activities coordinator had been employed and was working in the home four days each week. We met this member of staff and they told us about their role and plan to improve people's opportunities and experiences in the home. They said group activities were organised such as bingo and arts and crafts as well as individual activities for people who needed or chose to spend time in their room. The activities coordinator also supported people when possible to go out shopping or to have lunch or a drink in local cafes. We saw activities were listed for the week on the main notice board and included arts and crafts, bingo, music and movement, reminiscence and a quiz. One person who was staying for respite said they did not know about the activities and wasn't familiar with the use of the notice board. We pointed this out to the activities coordinator at the time of the inspection, who said they would consider ways of further ensuring everyone received this information.

We spoke with some people about their particular interests' and things they enjoyed. One person said the activities did not always interest them. It was noted that people's records had a section for staff to complete about people's background, history and particular interests. This information had not in all cases been completed as part of people's plan of care. We spoke with the activities coordinator and provider about how they find out about people and what they enjoy. The activities coordinator said they spent time talking to people and used this information to plan and explore new activities. They said this information had been documented in the past, but this had more recently not been completed by staff. The absence of this information could mean people's interests' hobbies and background would not be known to staff supporting them and providing care The activities coordinator expressed an enthusiasm and interest in developing this information in the future.

We saw activities being organised in the main lounge on the first day and five people enjoying a bingo session during the morning of the second day. We heard lots of friendly conversation and laughter when the hairdresser visited, and it was evident this was a long established and important arrangement. One person said, "I am waiting to get my hair cut, it makes me feel so much better".

Each person had a plan of care, which was documented using a computerised recording system. Care plans included information about people's health and social care needs and were separated into key areas, such as health, personal care, mobility and communication. Each area of the plan described what people were able to do for themselves as well the support they needed and wanted from the home and others such as health services and relatives. For example, one plan described a person's needs in relation to personal care and the risks associated with skin breakdown. The plan described how staff needed to attend to the person's personal care needs promptly to avoid skin breakdown as well as describing the use of pressure care equipment and monitoring to further ensure their needs were met. Another plan detailed how staff needed to support a person living with Dementia. The plan stated the person could often appear anxious, confused and disorientated and described how staff needed to approach them and talk to them to reduce their anxiety. Staff were able to tell us how they supported these people, which reflected the information we had read.

Care plans were regularly reviewed and amendments were made to people's care arrangements to reflect any changes in need. For example, one person was being monitored by staff every two hours to check their well-being and to ensure they were comfortable and safe. However, following an incident these monitoring checks were increased for a period of time and until the staff were satisfied the person's well-being had emotional state had improved. Where possible and appropriate people and their relatives were kept informed and involved in discussions and reviews of support arrangements.

The provider had a policy and procedure in place for dealing with any complaints or concerns about the service. This was made available to people, their relatives and visitors. The registered manager told us about the most recent complaint in relation to a staff member. The action taken confirmed procedures had been followed and the complainant had said they were happy with the outcome

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on the 23 June 2016 we found the service was not always well-led. People told us they weren't always asked their views of the service and wanted to be more involved. The provider sent us an action plan telling us how they would address these concerns and by when. At this inspection we found improvements had been made. People said they felt more involved in issues relating to their care and the day to day running of the service. However, we found improvements were still needed in quality monitoring systems to ensure the on-going quality and safety of the service.

The registered provider did not have an effective system for regularly reviewing people's needs and therefore assessing and monitoring staffing levels. Although staffing levels had been raised as a concern by people and staff in three previous inspections it was not evident that these concerns had been listened to and fully addressed. For example, during inspections in May and September 2015 people had raised concerns about their needs not being met sufficiently due to only two staff being available at night. Following these inspections the provider told us they would take action to improve. At the last inspection on the 23 June 2016 concerns were raised again by people that staffing levels were not sufficient to meet their needs. The registered provider told us they would take action to address this concern and to ensure appropriate staffing levels were in place. At this inspection staff and people still said there were times when two staff were on duty at night and this was not sufficient to meet people's needs and to keep them safe. The registered manager told us they had raised this concern with the registered provider on a number of occasions. They said although staffing levels had at times increased when numbers of people in the home were higher this had not been based on an-going assessment of people's needs and risks.

Following the inspection the registered manager sent us written information about how they had started to address the staffing concerns raised during the inspection. They said staffing levels at night had been increased and systems were in place to review staffing levels on a regular basis based on people's needs and changing circumstances. The registered manager said since the inspection they had spoken weekly with the registered provider and met fortnightly to discuss staffing levels as part of their qualiy monitoring process. They said the registered provider visits would also include discussions with the staff team and senior on duty to help ensure any concerns could be raised and considered. The registered manager said they had also undertaken a needs assessment for each person to ensure staffing levels were sufficient and the outcome of the assessment had been documented as part of the person's support plan. The registered manager said these changes would now form part of their on-going quality monitoring process.

We saw a number of audits were carried out in relation to the quality of the service.The registered manager said audits were completed of people's records. We found in most cases records were up to date and included detailed information about people's needs. However, the audits had failed to pick up and address gaps in people's records relating to people's backgrounds and personal interests.

Although we were told improvements had and would be made the provider and registered manager had failed to ensure effective systems were in place to regularly review and monitor staffing arrangements in the home. Systems had not always been effective in identifying and addressing gaps in people's care

records.This is a breach of Reg 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we did receive some mixed feedback from other agencies regarding the registered manager's response to any issues or concerns raised. Healthcare professionals said the registered manager and staff had worked closely with them to consider areas for improvement. They said they had listened and taken advice about ways to improve communication and links between the home and healthcare professionals. They said this response and joint working had resulted in improvements to people's healthcare. However, we also received some feedback from other agencies involved with people in the service that the registered manager and provider had at times been defensive when people and relatives had raised issues about their care. They said this had at times resulted in people and relatives losing trust in the service and the care provided.

The service had a registered manager who was responsible for the day to day running of the service. The registered manager was supported by a deputy manager. The registered provider was also regulary in the home and and worked alongside the registered manager undertaking a range of tasks including quality audits and small maintenance tasks, such as gardening. The registered manager was in the home during the inspection and spent time speaking with staff and people using the service. We observed the provider sat with people following their lunchtime meal and asking them if they were happy and if they had enjoyed their meal.

People said they felt staff and management listened to them and valued their views. The registered manager said they had introduced resident's meetings, however, people had not attended so they had gathered people's views on a more individual basis and via questionnaires. We saw some examples of these audits and records to show how the information had been used to improve the service.

People and staff said there had been some improvements in the management of the service. People said the registered manager and deputy were both approachable and understanding. Comments included, "We can go to them at any time" and "The management here go above and beyond to help". Relatives said, "I have no complaints, any issues I talk to the manager or deputy and it's dealt with straight away". The registered manager was supported by a deputy and both were present within the home throughout the week with an on-call system in place at weekends. The registered manager said they would frequently support staff at weekends when staffing levels were low due to sickness or other unforeseen circumstances.

We found the staff team were all very cooperative during the inspection. Staff were clear about their role, and demonstrated a good understanding of people's needs. Regular discussions and handover meetings took place to help ensure staff had the information they needed and the opportunity to talk and reflect on practice. Staff were very skilled at using the electronic recording system and a range of electronic hand sets were available to help ensure records were updated in a timely manner.

The registered manager said they had attended local provider meetings to discuss and consider ways of improving the quality of services. Improvements had been made to the environment, which included, decoration of the lounge area and some bedrooms, renovation of two bathrooms and painting and maintenance to the exterior of the property. We saw information regarding the planned use of CCTV. The registered manager said this had not been installed at the time of the inspection, but was due to be fitted in some communal areas, as a means of further protect and safeguard people in the home. Information had been provided to people about this plan and the registered manager said this would be re-visited when the system was in place.

The registered manager and provider undertook a range of audits relating to the service and people's support arrangements. We saw recent audits had been completed in relation to infection control, people's medicines and personal finances. Incidents had been documented and a system was in place to analyse and act on any trends or patterns. For example, one person had suffered a number of falls in a short period of time. The documentation and analyse highlighted this change, which prompted the registered manager to make a referral to the occupational therapy department as well as purchasing additional equipment for the person's bedroom.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always operate effective systems and processes to make sure they regularly monitored and reviewed the quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not fully protected as systems were not sufficient to monitor and address risks associated with staff supporting them.