The Vineries Limited

The Vineries

Inspection report

Winterton Road
Hemsby
Great Yarmouth
Norfolk
NR29 4HH

Tel: 01493732171

Date of inspection visit:
09 August 2017
10 August 2017

Date of publication:
10 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Vineries residential home provides accommodation and personal care for up 24 people, some who may be living with dementia.

The service also provides short stays for people who require a period of reablement. The purpose of reablement is to help people who have experienced deterioration in their health and have increased support needs, to relearn the skills required to keep them safe and independent at home. Health and social care professionals from the reablement team visit the service and support the therapy, nursing, and social care needs of people admitted on a temporary basis.

When we inspected on 9 and 10 August 2017 there were 23 people using the service (two of which were receiving reablement for a short period). This was an unannounced inspection.

The registered manager had left the service in 2016. 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. In January 2017, the previous deputy manager began managing the service, and has made an application with the Care Quality Commission to be registered. This report will therefore refer to them as the 'manager'.

During this inspection, we found that the registered provider was in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to medicines, governance, staffing and consent. You can see what action we told the provider to take at the back of the full version of the report.

Quality assurance and auditing mechanisms had not been effective at identifying issues we found during the inspection.

Staffing levels were not sufficient in order to meet the needs of people in a timely manner and keep them safe at all times.

Best interests documentation was not always in place or reviewed regularly where decisions had been made on behalf of people who lacked capacity. The manager was reviewing people in the service to ensure they were meeting their duties and responsibilities in relation to Deprivation of Liberty Safeguards.

People's medicines were stored safely and in line with legal regulations. However, we found some controlled drugs had not been logged as having been received. There were missing signatures for some medicines which had not been identified to ensure that people received their prescribed medicines. We also found issues with the recording of external applications, such as creams.

People told us they had good relationships with staff who protected their privacy and dignity. We observed pleasant and patient interactions throughout out inspection. Staff had a good knowledge about the people they supported. However, staffing level arrangements did not always allow staff to spend time with people that was meaningful and unhurried.

Staff had access to training which gave them the skills and experience needed to be effective in their roles and people told us they had confidence in the staff's ability to care for them.

There was an activity co-ordinator working in the service who delivered activities to people. However, we saw their time in delivering activity was often interrupted to assist care staff with tasks.

Care plans contained detailed information reflecting people's individual needs and preferences. However, for people receiving reablement in the service on a temporary basis, we found more detail was required.

People's nutritional needs were monitored, and people received support to manage a healthy diet where required.

People were referred to other health care professionals in a timely manner to maintain their health and well-being.

There was a complaints procedure in place and people knew how to complain.

Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

Recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staffing levels were not sufficient to ensure that they were meeting people's needs in a timely manner.

The management and administration of medicines required improvement

Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Best interests documentation was not always in place or reviewed regularly where decisions had been made on behalf of people who lacked capacity. The manager was reviewing Deprivation of Liberty Safeguards to ensure they were meeting their duties and responsibilities.

Staff received training relevant to their role and were encouraged to continue their learning.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and caring. People were treated with respect and dignity by staff who knew them well. However, staff did not always have time to spend with people in a meaningful and unhurried way.

People were supported to see their relatives and friends.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The staffing level arrangements in the service did not always enable staff to respond to people in a timely manner.

Care plans contained detailed information which was person-centred.

More detail was required in the care plans for people receiving a period of reablement to ensure staff delivering their care had sufficient guidance.

Activities were provided within the service by the full time activity co-ordinator. However, their time in delivering activities was sometimes interrupted by having to assist care staff.

There was a complaints procedure in place. People and relatives knew how to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

Audits were completed to assess the quality of the service; however these had not been effective in identifying areas we found as requiring improvement.

There was an open and transparent culture in the service. People, staff, and relatives felt able to voice their opinions.

The Vineries

Detailed findings

Background to this inspection

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

The inspection took place on 9 and 10 August 2017, was unannounced and undertaken by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with community healthcare professionals and local safeguarding teams.

During the inspection we spoke with 10 people living at the service, and five relatives. We spoke with a visiting health professional, and staff from the reablement team, which included a nurse, physiotherapist, and an assistant practitioner. We spoke with the manager, deputy manager, administrator, activity co-ordinator, and five members of care and catering staff. We also observed the interactions between staff and people. Following the inspection we spoke with the registered provider.

To help us assess how people's care needs were being met we reviewed five people's care records and other information, including risk assessments and medicines records. We reviewed five staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with raised some concerns about staffing levels. One person said, "They're [staff] always rushing, hectic. I get anxious waiting." Another said, "Sometimes they [staff] are busy but they are communicating and tell me they'll be with me shortly." A third said, "So many people here need a lot of help. They're [staff] always rushing around from one [person] to another." A relative said, "The staff will be in and out, they're [residents] not neglected but staff aren't sitting chatting to them."

Staff we spoke with told us that they needed more staff to meet people's needs in a timely manner. One staff member said, "With the amount [of staff] we have at present, no there is not enough staff. We have a lot of people who need two staff to assist them, and they have to wait until there are two of us available." Another said, "All shifts need more staff on. This [home] is great, people's needs are met and people are happy, but there is not enough staff, people have to wait." A third told us, "Care is task focussed and we have no time to talk to people. Sometimes I feel rude not having given people the time they need to chat, so I stay after my shift to sit and chat to people."

We observed that current staffing levels at times had a negative impact on the care people received as staff were unable to meet their needs as quickly as they would like. For example, at 10.30am, one person had still not had their breakfast. A staff member said, "[Person] has not had their breakfast yet, as they need to be sitting up to eat and staff are busy."

The manager told us that they were aware that staff were raising concerns about the staffing levels, they and the provider had identified the need for a fourth member of staff on the late shift and had implemented a 5:00pm- 9:00pm shift. Staff we spoke with and the manager told us that a fourth member of staff was needed for the full shift (2:00pm-10:00pm) due to nine people requiring two staff to attend to their needs.

We also observed that staff members completing medicine rounds were constantly interrupted, delaying and increasing the time it took them to administer people's medication. Interruptions included phone calls, answering the front door, and finding another staff member to assist them to sit people up. During lunch time, we saw that one person had to wait 20 minutes before they received their meal, as their medicine had been given later than planned (needed to be taken 30 minutes before food). This meant that the person could not eat with other people at their table until 20 minutes had passed. Staff told us that administering people's medicines could take up to two hours.

The manager told us they and the provider had considered different options to reduce the length of time the administering of medicines was taking. For example, having two medicine trolleys, and having an extra staff member between the hours of 07.00am -11.00am. Given that this shortfall had been identified, the provider had not taken timely action in response and as a consequence sufficient staff were not always available.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff had received training in medicines administration and received competency checks. We reviewed the

processes in place for the administration of people's medicines. We noted that for medicines prescribed for external application such as topical creams, there were gaps in the records of administration. For example, one person had an external cream prescribed to be applied three times daily, but the record had several gaps where staff had not signed. Therefore the records did not confirm these medicines had been applied as intended by the person who had prescribed them.

We checked the recording within people's MAR (medicine administration records) charts, and found there were unexplained gaps in some MAR's. For example, one person was prescribed a medicine for depression, and we found that this had not been signed to confirm it had been given for a period of nine days. We checked the stock and found it to be correct, indicating that the medicine had been given. However, staff were unable to explain why this had not been signed for and why they hadn't identified this sooner.

Where people were prescribed medicines that were to be taken as and when required (PRN) these were not consistently supported by a protocol. This is important information to ensure staff who did not regularly work in the service gave people their right medicines as prescribed.

We saw that medicines were stored securely, with appropriate facilities available for controlled drugs and temperature sensitive medicines. However, some controlled drugs which had been received had not been logged as being received. This was important due to the possible misuse of these types of medicines. We also found that daily temperatures had not been taken where the medicine trolley was stored, which we noted was very warm due to its close proximity to the kitchen. This meant the effectiveness of medicines could have been compromised to treat people's health conditions as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us they received their medicines safely. One person said, "I get them [medicines] regularly, they [staff] always stay". I notice whenever they give people tablets they [staff] stay with the person. They don't leave until they've taken them." Another said, "They [staff] sit here until I've taken the tablets." We also observed that staff took their time to ensure people were taking their medicines safely.

Checks on new care workers had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

Personal Emergency Evacuation Plans (PEEP's) were available in people's records. These showed the support people required to evacuate the building in an emergency situation. We found that some records needed to be more detailed particularly for people who may be living with dementia. On the second day of our inspection we saw that these had been updated. The fire service had visited recently and assessed that the service was of a 'good standard' in relation to fire safety, but had made three recommendations, one of which was to have an evacuation chair on the first floor. The manager informed us that the provider was in the process of arranging this.

People's care records included risk assessments and guidance for staff on the actions that they should take to minimise risk. These had been reviewed to ensure any needs which had changed were updated. These included, falls, nutrition, skin integrity, moving and handling and continence. Where appropriate, actions to mitigate risks were put in place. For example, the provision of pressure relieving equipment. Outcomes of risk monitoring informed the care planning arrangements, for example we saw that weight loss had prompted onward referrals to dietetic services.

Risks to people injuring themselves or others were reduced because equipment, such as hoists had been serviced and checked so they were fit for purpose and safe to use. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria.

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One care worker said, "I'd go straight to the manager if I felt there were any issues or something wasn't right. I think we know people well here, so any changes in their character, or if they were quieter than usual, we [staff] would notice." Another said, "There are different types of abuse; emotional, physical, financial. I would report anything like that to the safeguarding team; I know how to contact them."

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 decision made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

The manager told us that one application had been authorised for DoLS and we saw that this was in place on the person's records. However, we discussed two other people who were living in the service under constant supervision and unable to leave where DoLS applications should be considered. The manager told us they would review this promptly to ensure they were meeting their duties and responsibilities under the deprivation of liberty safeguards.

We checked whether the service was working within the principles of the MCA, and we found some areas which needed improvement. For example, one person had bed rails in place to keep them safe from falling out of bed. There was no information to demonstrate this was the least restrictive option to keep the person safe when they were in bed.

Where people were taking their medicines covertly (crushed and given to them in food or drink without their knowledge) documentation was in place to show that relevant people (such as a GP, family members and staff) had been involved in the best interests decision. However, we found that one had not been reviewed since 2014, and another had no review date noted. We also found there were no formal mental capacity assessments where people were unable to make a decision about their medicines. The continued need for covert administration must be regularly reviewed within specified timescales as should the person's capacity to consent. We found this was not in place.

The above constitutes a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

We found some areas which did support good practice in relation to MCA. People's care plans contained information which related to their cognition and mental capacity. These plans supported staff to understand which decisions people were still able to make for themselves, for example, what to wear, where to sit, and what to eat. They also detailed what decisions people may require support with and who should be involved. This was further supported by a communication care plan, outlining how the person expressed their views, and how staff should support them to do so. For example, one plan described how the person struggled to find the right words, and how staff should support the person to express their views by making

direct eye contact with them and using a calm manner to help the person find the right words. It also reminded staff that every decision should be assessed on each occasion that it needed to be made. This supported the principles of the MCA, which maximised people's ability to make decisions and express their views.

We observed staff asking people for consent prior to assisting them with tasks such as administering medicines, assisting people to eat, and deciding where to spend their time. One staff member said, "People have a choice, we know if they say no we come back later. You learn about each individual and how they respond to accepting our help." A relative said, "[Person] likes to lay in bed in the mornings and they [staff] let them stay. It's they [person] who decides. They have their breakfast in their room, but [person] enjoys having lunch in the dining room".

Systems were in place to ensure that staff were provided with training and support, and the opportunity to achieve qualifications relevant to their role. This included moving and handling, safeguarding adults, medicines, nutrition, dementia, DoLS and health and safety. People and relatives told us that staff were well trained in meeting their needs. One person said, "They [staff] definitely understand my needs". A relative said, "They [staff] seem to be natural, as a human thing. The staff are not mechanical in their training." Another told us, They've [staff] tried very much to learn about [relative's] needs."

Staff new to the service completed an induction, which consisted of mandatory training and shadowing of more experienced staff. The manager told us that new staff would shadow more experienced staff first depending on their level of experience. If new staff did not hold relevant qualifications in care, they were expected to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their work, and we saw that currently two members of staff were studying for this award.

Staff received supervision sessions which provided staff with a forum to discuss the way they worked, identify training needs, and receive feedback on their practice. One staff member said, "I get regular supervision, but I can always speak to [manager] at any time."

People were supported to eat sufficient amounts and maintain a balanced diet. Where people required assistance, they were supported to eat and drink. This included keeping records of their food and fluid intake when there were risks. Staff monitored the amount of food people ate during the lunchtime period via a nutritional chart. The manager told us, "We do record how much every person eats in case this information is ever requested. It also helps us build a picture where there may be issues in the future."

Where people had needed the specialist advice of dietician's or speech and language therapy, referrals had been made to the appropriate professionals. A relative told us, "[Relative] was taking medication for type two diabetes. Since [relative's] been here they've managed to control their diet. Subsequently this has enabled the medication to be taken away". Another relative told us about a positive outcome for their relative. They said, "Since [relative's] been here they've put on weight."

We observed the lunchtime meal. 12 people sat in the dining areas across five tables. The atmosphere was relaxed, and we observed people chatting amongst themselves. Food was served relatively quickly, and attention was given to people's individual needs. For example, some people preferred to have their meat cut up, and staff assisted with this. Others had a pureed meal, or soft diet. Where people needed assistance to eat in the dining area, staff attended discreetly, and sat down with the person. We saw people enjoying alcoholic beverages of sherry, wine and vodka. One person said, "I love my sherry at lunchtime, why not?." Another said as they sat down, "Oh lovely, they've [staff] poured my wine."

People told us they enjoyed the food. One person said, "There's always two hot options, and if you don't like them you can have a salad." Another said, "I like the food, they [staff] come and help you", and, "They [staff] wait on us in the dining room, it's very good". A relative said, They [staff] do give them [people] options, preferences. They do have soft diet options, they're very accommodating". They've [staff] offered [person] options outside the menu. [Person] had no interest in eating whatsoever, now they're eating much better, the dietician has prescribed fortified drinks."

For people who needed assistance to eat in their rooms, a staff member told us that they have to sometimes stagger the time lunch was served, as there were not always enough staff available at the same time. We saw that all people were being assisted to eat, but the staff member told us this was because relatives had visited and they were helping. They said at other times food is kept warm in the oven until staff are available to assist people.

People had access to health care services and received on-going health care support where required. We saw that referrals to relevant professionals were done so in a timely manner. This included dieticians, GP's and other health professionals. One person said, "The chiropodist comes every six weeks, I'm ok with that. I've had oil in my ears for the last week, one of the carers came with me to the surgery which was lovely". Another said, "If we don't feel well we tell them [staff] and they will look out for us". A relative said, "It was the carers who noticed [relative] was restless and a bit breathless, the paramedics were called promptly." A health professional told us, "I've worked for years with The Vineries, and I always find it to be one of the better homes. Good leadership."

Requires Improvement

Is the service caring?

Our findings

We observed staff to be kind and caring in their interactions with people, however, the staffing level arrangements in the service did not always enable staff to spend meaningful time with people that was outside of the caring tasks being delivered. Staff told us that often care tasks were hurried, so they could support the next person as quickly as possible. One staff member said, "We can't spend the time we need to with people as there is not enough staff. Yes people's needs get met, but not as quickly as they should. They [people] are human, not tickets, they have a beating heart like you and I."

All of the people and relatives we spoke with told us that the staff were kind and caring. One person said, "The care is absolutely marvellous, everything, the company, they look after us well. I get on well with all of them [staff], they're all lovely people." Another said, "The friendliness, absolutely wonderful. I really couldn't believe how lovely the staff are." A relative told us, "[Relative] is a lot brighter and happier since they came here, bright eyed."

Staff understood people's needs well and were able to tell us about the individual needs of people, including their preferences in relation to how they liked to spend their time, what time they liked to get up, and how they liked their care delivered. Many of the staff working in the service had done so for a number of years. This had enabled trusting relationships to develop, and we observed that people were relaxed in the presence of staff.

People readily asked for assistance when they needed it, and there were friendly interactions between people and staff. We observed two members of staff explaining the use of a hoist to one person. The person was reluctant to be moved and resisted, becoming more anxious and agitated. Both members of staff comforted the person, explained the benefits and reassured the person of their safety. Rather than persisting they offered the person the choice to remain in their lounge chair to eat their lunch, therefore reducing the person's anxiety.

We observed three small well-trained dogs lying in beds in a quiet seating area. We were told that the dogs belonged to members of staff and that they brought them in as the majority of people enjoyed their presence. One person said, "Love the dogs, love them." There was suitable music playing throughout the day in one seating area and several people were heard to comment positively about this. The atmosphere was calm and without any loud or disruptive noise.

People's care plans reflected what was important to them, and their preferences as to how their care was delivered. This included people's individual hopes and concerns which demonstrated that people had been involved with planning their care. The importance of maintaining a level of independence was also reflected in people's care plans. This included guidance for staff on the areas of personal care people were still able to manage, and how they should encourage people to have control over their lives. One person said, "They [staff] say, 'would you like to do it yourself'?."

People's privacy and dignity was also respected, and we saw staff speaking quietly with people when they

were assisting a person with personal care tasks. One person said "They [staff] always knock before they come in. If they have to tell you something [personal] they're always very discreet, always in private." A relative told us, "They [staff] are very aware of [person's] personal dignity. They were just about to be put on the commode and staff said would you just give us ten minutes? Everything was all cleared up and tidy when we were invited back in, and we've experienced that many times."

We also saw that four people held keys to their own rooms so they could lock them when they were in other areas of the service. We saw people locking their rooms as they left them, which ensured their privacy was respected, and their belongings kept secure. The manager told us that people were welcome to have a key to their rooms if they chose to, and encouraged people to ask if they wanted this.

Visitors were welcome at any time, and we saw that people received a good number of visitors during the course of the day. The five visitors we spoke with all told us they were always made to feel welcome and involved. One relative said, "I'm always made to feel welcome and I can come at any time."

Requires Improvement

Is the service responsive?

Our findings

All of the staff we spoke with told us they felt frustrated by the lack of time they had available to spend with people in a meaningful way, such as just chatting. Though staff were kind and caring, we did not see casual or spontaneous interactions between staff and people. The majority of conversations were task related. Staff were unable to spend time with people in a meaningful way, in an attempt to progress and develop relationships. A staff member told us that one person needed time to chat with them before they would agree to being assisted to drink. The staff member said, "[Person] doesn't always drink enough fluids, and I've found that they will if I spend time chatting with them first, but of course I haven't always got the luxury of time." This meant that the person may not be provided with the time they needed from staff to ensure adequate hydration.

People's records included care plans which guided staff in the care that people required and preferred to meet their needs. This included personal care, falls, continence, nutrition, tissue viability, life history, social interests, hobbies and spirituality. Respectful and thoughtful language had been used to describe people's needs. The records we reviewed were very detailed, and demonstrated that thought and attention had been given to making them individual and person centred.

Care plans for people receiving reablement required more detail in terms of their aims whilst they were in the service. We also found there were no risk assessments in place for care staff to follow. Ensuring this information was available would guide staff on how best to support people, taking into account any behavioural or physical limitations. The manager told us that the care plans were completed by health and social care professionals from the reablement team, but they would discuss adding additional information with them. This will help to ensure that information is adequate to guide care staff working in the service as they were delivering people's day to day care needs, such as their personal care. Staff told us that people's care needs were handed over verbally and they also read the information collated by the reablement team which was available to them, however they also felt that more information was required. One staff member said, "People having reablement are only here for a week or two, but yes more information would be good."

The service benefited from a full-time activities coordinator covering alternate weekends. However, due to the staffing level arrangements we observed that this person undertook many other roles throughout their working day, which included assisting staff with care tasks and being available during the lunchtime period in case people needed support to eat.

The manager showed us a list of upcoming activities which the activity co-ordinator had planned. This included reminiscence, board games, baking and one to one time. There was not a designated activities room, and we saw in the afternoon that eleven people were playing musical bingo in the dining area. The provider told us that activities were organised in other areas of the service at the request of people. We spoke with the activity co-ordinator who clearly was committed to providing a range of activities, however, they told us this was often interrupted by having to support their colleagues with care tasks. We observed that this impacted on the activity co-ordinators time in delivering activity.

People and their visitors told us about events and entertainment taking place from time to time and how much they enjoyed these when they had taken place. One relative told us, "They do provide quite a lot of activities here; it's their personal choice when [person] doesn't choose to join in. They have regular events that involve the family." A person said, "I enjoy when they play the music, I enjoy joining in." A weekly chair based exercise programme was also undertaken by an external person, and we saw that there was also a weekly entertainer. At the residents meeting held in January 2017, people requested that more outings were arranged. The activity co-ordinator confirmed that nothing had been arranged since this was raised, but were aware of the need for this.

There was a complaints procedure in place which was displayed within the service. One complaint had been received recently, and we saw that information relating to the complaint had been compiled and provided to the local authority as they had requested this. People felt comfortable to complain if something needed to be raised. One person said, "Yes I would [complain] if I thought something was wrong, I would probably go to the manager and I feel sure they would resolve the matter." Another said, "[Manager] comes to see me. If I have any worries I will let them know." A relative said, "Everything that's not been right [initially] they've [manager] put right."

Requires Improvement

Is the service well-led?

Our findings

The registered manager had left the service in 2016. There was a new manager in post from January 2017, who was waiting to be registered with the Care Quality Commission. They told us they were supported in their role by a deputy manager and that the registered provider regularly visited the service to offer support. Throughout the inspection the management team demonstrated an open and transparent manner, actively seeking feedback to improve the service.

The routines of the service did not always promote opportunities for staff to ensure that the time and interactions with people was of good quality. During the 'residents meeting' held in January 2017, people had commented on the lack of staff. The minutes of the meeting noted that, "Clients [people] feel more staff are needed on shift. All staff are nice, but no time to sit and chat." We observed at this inspection that this was still an issue. Staffing levels had been identified as needing to be increased by the registered provider and manager, and although recruitment was in process, immediate cover had not been found to ensure there were sufficient staff to keep people safe and meet their needs. Therefore timely action had not been taken to improve the quality of the service.

Audits to monitor the quality and safety of the service were in place. These included medicines, accidents and incidents, care plans, environmental and infection control. However, these had not been effective at identifying where improvement was needed. For example, we found shortfalls with medicines procedures, the completion of medicine administration records (MAR) charts and the administering of topical applications. Audits had also not identified that improvement was required in relation to people's ability to consent and decisions made in their best interests.

The above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff meetings were held in the service so that information was shared and known across the staff team. Minutes form the staff meeting in March 2017 showed that relevant items were discussed such as medicines errors, infection control, and that the manager had offered to work alongside staff when needed. Staff told us they felt able to speak up and raise concerns with the manager and registered provider, however, they sometimes lacked confidence that action would be taken to address certain issues promptly. For example, staff felt the issue of staffing levels was one that had been on-going for a long period of time.

People living in the service commented on the leadership in the service. One told us "It's only the second time I've seen [manager] but I know they're there." Another said, "We [people] don't see [manager] much, we don't really know what's going on, sometimes they put little notices up."
Relatives we spoke with told us they thought the home was well managed and described the manager as approachable and fair. One relative said, "[Manager] is very 'hands on', they're happy when they're on the floor. Doors always open. I think [manager] sets the tone and all the staff follow that." Another said, "I feel comfortable with the staff [manager] has been very open and lovely."

We saw that satisfaction surveys and questionnaires were issued every three months, and had last been issued to people and relatives for their feedback in May 2017. We saw that feedback was mostly positive, and where needed action had been taken. For example, one person wanted a bigger bed and this was arranged. Another person wanted to move to a downstairs room, and this was also actioned.

The registered provider had plans to improve the outdoor facilities for people to enjoy, by developing the outdoor space to include a summer house and sensory garden. They also planned to make this space secure so people could freely access this when they chose to.

We also saw that meal time observation audits were being implemented to highlight any potential areas for improvement. The manager also informed us that the quality assurance manager from another of the providers' locations was working between services to share good practice and improve the auditing processes.

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 11 HSCA RA Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines records were not accurately completed to ensure people received their medicines as intended. This included oral and topical medicines. 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Auditing processes did not enable the provider to identify where quality and safety was being compromised. 17 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to ensure that people's needs were met in a timely manner.

18 (1)