Southwest Care Ltd

Vicarage House Nursing Home

Inspection report

The Old Vicarage
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22 May 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 27 and 28 March 2018. Due to unforeseen circumstances the draft report had not been written when we received concerns in May 2018, therefore a further visit was carried out on 22 May 2018.

At the last inspection we found Vicarage House Nursing Home required improvement and breaches of the regulations resulted in four requirements. These identified that people were not always treated with dignity and their independence was not always promoted. The service did not always follow a best interest process when people were unable to consent to care and treatment. The service did not have effective systems in place to assess monitor and improve the quality of care provided.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the service provided.

At this inspection we found there had been an improvement in the quality of care provided however the systems in place were new, the new manager had only been in post for three weeks. Therefore Vicarage House Nursing Home continues to be rated requires improvement so that the improvements in place can be seen to be consistently effective.

Vicarage House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide personal care and accommodation to up to 32 people who are frail or living with dementia. Accommodation is provided in a converted residential dwelling over two floors. At the time of our inspection 27 people were using the service.

There was no registered manager in post however the new manager was in the process or applying to be registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were processes and practices in place to keep people safe. People told us they felt safe living in Vicarage House Nursing Home and with the staff who supported them. However some relatives said they were concerned about the number of new managers recently and were, "Keeping an eye on the changes to ensure their family member remained safe".

There were systems in place to ensure the management and administration of medicines was safe and protected people from harm. The provider's recruitment policy protected people from possible harm from the employment of inappropriate staff.

People received effective care and support because staff understood their personal needs and abilities. Staff had the skills and knowledge to meet people's needs. The provider had a programme of training which ensured staff had up-to-date guidance and information. The new manager explained they had also introduced other training which was specific to the needs of people living in the home.

People told us they were always consulted fully before any care and support was carried out. Staff were supported to develop their skills through training, staff meetings and one-to-one conversations. The new manager told us, and all staff spoken with confirmed, that they had carried out one-to-one meetings with all members of staff. This meant they had identified areas for training and development and areas of interest for staff to be involved in in the future.

Most of the people spoken with said they received care and support from staff who were polite and kind. One person said, "The staff are always very caring and very polite". However another person told us that about 10 months ago they did not feel a member of staff was very caring or polite towards them. They continued to add that things had improved and they were happy now.

Since the last inspection the activities organiser had been promoted to a full-time post. They were working with the new manager to introduce a full programme of meaningful activities for people to take part in. They were in the process of building up further relationships within the village. Children visited the home to read to people living there, and there were arrangements in place for people to visit the school once a month to have lunch with the children. The activities organiser confirmed that they were in the process of obtaining a minibus and improving the outside areas. A meet and greet tea party had been arranged for families to meet the new manager. When we returned in May people told us about the garden party they had had to celebrate the royal wedding.

The new manager had been in post for three weeks prior to the first day of the inspection. They had already identified areas for improvement and had introduced new working procedures and training for staff. Systems in place to monitor the quality the service had identified where there were shortfalls and they had implemented changes to drive improvement. It was evident that a lot of hard work had been carried out by the new manager, deputy manager and staff to ensure the experiences for people living in Vicarage House Nursing Home continued to improve.

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.

Improvements had been made, however we need to see this maintained consistently over time.

Records were maintained to show people's care needs had been carried out however they were not always recorded in the correct place.

People were supported by staff who had been well recruited to make sure they were safe to work with vulnerable people.

There was sufficient staff to maintain people safety and meet their needs.

People's medicines were safely administered by staff who had received appropriate training to carry out the task.

Is the service effective?

Good

The service was effective.

People's health and well-being was monitored by staff, advice and guidance was sought from healthcare professionals to meet specific needs.

People had access to a good diet and food was provided which met their specific needs and wishes.

People received care with their consent or in their best interests if they were unable to give full consent.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and patient.

People's privacy and dignity was respected and they received support in a way that respected their choices.

Is the service responsive?

Good

The service was responsive.

People were able to make choices about their day-to-day lives.

People were able to take part in organised activities which were being further developed.

People said they would be comfortable to speak with a member of staff if they had any complaints about their care and support.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements had been made in the quality monitoring systems in place. These improvements needed to be embedded in the culture of the home and implemented consistently to be effective.

The manager promoted inclusion and encouraged an open working environment.

The manager and staff were continuously working to learn, improve and measure the delivery of care to people.

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 27 and 28 March 2018. The first day of the inspection was carried out by one adult social care inspector and an expert by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was carried out by one adult social care inspector and was announced. Following concerns raised we returned to the home on 22 May 2018 this part of the inspection was carried out by one adult social care inspector and was unannounced.

Following the last inspection the provider sent us an action plan on how they would improve the service and by when. We reviewed this document as well as the 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.

During this inspection we spoke with 12 people living at the home, seven members of staff and six visiting relatives. We also spoke with the new manager. We spent time observing care practices in communal areas of the home.

We looked at a number of records relating to individual care and the running of the home. These included ten care and support plans, five staff personnel files, training and supervision records and minutes of meetings held at the home.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found that systems did not always ensure people were safe. At this inspection we found there had been improvements in the way the service ensured people remained safe. However there was still some work needed to maintain this improvement, therefore this domain remains requires improvement.

We asked people if they felt safe, they told us, "Yes, I don't really know why. I just feel safe. I've felt safe ever since I've been here". Another person said, "Feel safe? Oh yes, perfectly happy, very nice home". Whilst another person told us "Yes I feel safe, very much so. I have a call button, en-suite toilet and sink and a view across the valley." However some family members did not feel reassured that people living in the home felt safe. One relative said, "The home hasn't got that safe, comfortable feel that it had". They went on to say, "I worry about staff shortages and lack of continuity of staff and management." Another relative said they felt the transition time for a new manager had been too long and they worried about the new manager being able to make the required changes.

At the last inspection we found the systems in place to ensure people received medicines safely were not effective. We found Medicine Administration Record charts (MAR's) did not clearly record when medicines were given, peoples allergies and directions for the application of creams/ointments. This inconsistency in recording medicines administered meant people were placed at risk of harm through either an overdose or omission of medicines.

At this inspection we found the recording and management of medicines had been improved. One qualified nurse was responsible for overseeing the management, storage and ordering of all medicines. They also carried out regular audits of the way medicines were recorded and administered to ensure people were safe and medicines were managed within current legislation.

One visiting relative told us that they did not feel the administration of medicines was safe as they had witnessed staff putting medicines into a pot and taking to the person. They felt it would be safer if the member of staff took the whole trolley. We observed the member of staff placing medicines for one person in a pot and taking them to the person. They only potted up medicines for one person at a time; they observed the person take the medicines before recording in the MAR that the medicine had been taken. We spoke with the nurse about taking the trolley to the person's room. They told us they felt the placing of a trolley in a person's bedroom or in the dining room during lunch did not reflect the fact that it is their home. We noted that the nurse checked thoroughly that they were administering the right dose, to the right person at the right time and we did not feel this practice placed people at risk.

We saw systems were in place to ensure people's medicines were managed consistently and safely by staff. Medicines, including controlled drugs were obtained, stored, administered and disposed of appropriately. Controlled drugs are medicines which have special requirements about storage and recording.

Where people had been prescribed medicines on an 'as required' basis, such as pain killers, plans were in

place for pain management, including the use of pain scales to identify the severity of pain. Staff used a computerised system for administering medicines which meant they could not administer before the time they were due. If they administered later than the time due an audit trail would show where they had failed to administer medicines on time. People told us they received their medicines on time and when they requested them if in pain. One person said, "Medicines? Yes, on time, the staff help me to take them. I have Paracetamol when I need it. No problems". Another person said, "Yes, they bring my tablets to me. Yes, regular and timed. They stand and watch you take them".

Following concerns received in May 2018 we revisited the home. We had been informed a person's medicines had been left for the person to take later. We discussed this with the new manager who told us they had already identified with one registered nurse the need to ensure people took their medicines when they administered them. This had been dealt with through a one to one discussion with the nurse involved and a re-evaluation of their competency to administer medicines safely.

At the last inspection we found 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. At this inspection we found systems were in place to identify and reduce the risks to people living in the home. People's care plans included risk assessments however some care plans lacked clear guidelines. The new manager had identified areas in care plans which lacked suitable information for staff to work to. They were in the process of dealing with this through staff meetings and reviewing people's care plans. All care plans were stored electronically.

Part of the concern raised in May stated that there were no records maintained in people's rooms to show how often they had been repositioned or the amounts of food and fluid people had had. We discussed this with the new manager who explained they had gone completely electronic and did not keep paper records in people's rooms. We looked at the electronic records regarding repositioning for people identified as being at risk of developing pressure ulcers. We saw these records were being inconsistently recorded; some were recorded in daily progress notes whilst others were recorded in the correct monitoring record. The new manager said they had already identified this as a training issue for staff and had discussed record-keeping at a recent staff meeting and had arranged for further training in record-keeping using the electronic system to be carried out.

The concern received in May also stated that a person who experienced epileptic type seizures did not have a record to show the seizures were monitored. We discussed this with the new manager who confirmed the person had only had one seizure since they moved into the home and this had been recorded in the progress report. The manager immediately implemented a monitoring form in the person's electronic care plan system for staff to use in the future.

Following discussions with the new manager it was evident they had carried out audits and monitoring of records maintained to reduce the risk of harm to people. They had learned from mistakes found and had put systems in place to prevent these mistakes from occurring again. The manager was open to discussion around how they could improve outcomes for people living in the home.

The provider had systems and processes which helped to minimise risks of abuse to people. These included a robust recruitment process and ensuring staff understood how to recognise and report concerns. The staff we spoke with had completed training about how to recognise and report abuse and all were confident that anything reported within the home would be dealt with to make sure people were safe. The new manager had already developed links with the local authority safeguarding team and had worked with them in ensuring people were protected from harm. During the inspection the new manager agreed to seek advice

from the safeguarding team about a situation that may have been considered abusive. This was followed up with the safeguarding team and appropriate actions taken.

We saw the new manager had carried out an audit of recruitment records maintained by the home. They had identified that some application forms being used did not provide sufficient guidance for prospective staff on declaring a full work history. The new manager had already implemented a new application form which was very clear and asked for a full work history to be included.

We spoke with the new manager about the staffing levels in the home. Opinions from people living in the home, relatives and staff varied. Relatives said they would prefer a staff presence in the lounge as they had often needed to go and find a member of staff if needed. People said they often had to wait to use the toilet. However other people said there was plenty of staff. Staffing levels were also raised as part of the concern received in May. We discussed this with new manager who showed us how they had already identified issues around the deployment of staff. They felt there was sufficient staff in the home to meet the needs of people, however they were not being used efficiently. We saw a new system was being trialled which ensured there was always a member of staff in the lounge and that staff were deployed more effectively. This meant people's personal care was carried out within a reasonable time and meals were taken to people whilst still hot.

The new manager explained how they used a dependency tool to assess how many staff were required on each shift to ensure people's needs were met. At the time of our visit in May staff did not appear rushed and there was a relaxed atmosphere in the lounge. We observed that a member of staff was always available in the lounge and people requesting drinks or the toilet did not have to wait. We also observed that bells were answered promptly and one person who was calling out was responded to promptly and their position changed as they requested.

People were protected against the risks of the spread of infection because all areas of the home were kept clean. There were handwashing facilities throughout the home and alcohol gel was available for staff and visitors to use. There was clear guidance in toilets on hand washing and staff had received infection control training. Staff had access to personal protective equipment such as disposable gloves and aprons which also helped to minimise risks to people.

To ensure the environment for people was kept safe specialist contractors were commissioned to carry out fire, gas, water and electrical safety checks. There were risk assessments in place relating to health and safety and fire safety.

Risks to people in emergency situations were reduced because, a fire risk assessment was in place and arrangements had been made for this to be reviewed annually. Personal emergency evacuation plans (PEEP's) had been prepared: these detailed what room the person lived in and the support the person would require in the event of a fire.

Good

Is the service effective?

Our findings

At the last inspection we found people did not receive care and support that was effective. At this inspection we found there had been improvements in the way the service ensured people received care and support that was effective and met people's need.

People said they felt all the staff were well trained and knew their needs well and supported them to make choices and be independent. One person said, "They [staff] know me well and know my routine and try to accommodate me. I am up at 7am. They respect my decision not to have a hoist to shower" Another person said, "Choices? Yes I can choose when to get up and go to bed and when I shower or bath". When we visited in May one person told us, "I love it here, they know me and understand what I want and what I like to do. I don't want to leave here."

At the last inspection we found 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. At this inspection we saw care plans contained assessments of people's capacity to make certain decisions and, where necessary, a best interest meeting had been held with appropriate people involved in their care and decision making. Staff spoken with were aware of the need to assess people's capacity to make specific decisions. One relative told us how they had been involved with their relatives care plan and decision making.

At the last inspection we found 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). At this inspection we found applications had been made for people who it was felt were being deprived of their liberty. We saw the new manager had reviewed all applications and had a record to show what decisions had been made and when applications had been followed up with the local authority.

At the last inspection we found people were not offered a choice of menu for lunch. The provider had said they would provide a menu with a choice. At this inspection we saw there was one main meal and the choices available for alternatives were clearly displayed. On both days of the initial inspection we saw people making choices. One person said, "They always come and ask me and if it is not what I fancy there is always something else I can have."

Part of the concern raised in May said that staffing levels meant people eating in their rooms were not served promptly and their food could have been cold. The new manager explained that they had carried an

observation of staff deployment. We saw they had introduced a new routine which was being trialled by staff. This appeared to remedy the issues raised in the concern as staff deployment meant everybody received their meal on time and still hot.

Everybody spoken to said the meals were good, One person said, "The food is really very good. Yes, you are supposed to drink. Never without a drink. If you don't like something they will do something else. Very good like that". Another person said, "Food, yes. I'm not a big eater. I don't like meat at all, and they cater to my likes and dislikes, very nice people." One relative told us, "I cannot fault the food. [Person's name] is not eating much. I am a bit concerned. Once a week I have lunch with [the person]. I praise the standard of the food".

We observed the lunchtime experience for people. Lunch for those who wanted company was served at the table in the communal area. The table was nicely laid. Where appropriate people wore protective clothing, people were asked before protective clothing was put on. Food was served quickly and it looked appetising and was eaten. Portion sizes appeared to be appropriate to people's individual needs. Some people ate at small tables in front of their easy chairs. They were supported with the same attention to care as those who ate at the table. The environment was calm and relaxed. One visitor had brought sandwiches and ate their lunch alongside their family member.

People told us there was plenty to drink. One person said, "Drinks are always available. There is a cool box with orange juice and a choice of squash. You can help yourself." During our return visit in May we observed people being offered drinks. One person told us how they had already had a cup of coffee and had wanted a second cup, this was provided immediately. Another person with swallowing difficulties required their fluids to be thickened. We saw they were enjoying a cup of tea, when we asked if it was 'ok' they gave the thumbs up sign and nodded their head. The staff had clear guidance of how thick the fluid should be and understood the importance of getting it right.

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 stars. 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.

People only received care and support with their consent or in their best interests if they were unable to give consent. During the inspection we observed people being asked for their consent. Procedures were explained clearly and people told us their choices were taken into consideration. For example we observed one person being mobilised with the aid of a hoist. Time was taken to explain each step. Engagement with the person was caring and kind. The staff appeared to be aware of the person's needs and took care to maintain their dignity.

New staff received an induction including information relating to the Care Certificate and shadowing more experienced staff. The Care Certificate was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. Staff confirmed they had spent time in induction training and shadowing other staff before working unsupervised. We also observed training information displayed within the staff room and on other locations around the home.

Staff received the training they required to safely fulfil their roles and effectively support people. The provider had a training matrix which showed when staff had completed training and when up dates were required. This helped to make sure people received care and support from staff who had up to date skills and knowledge to meet their needs. The provider also supported registered nurses to maintain their registration through continued professional development. The new manager explained they had already identified some areas for training. We saw training advertised for staff and staff meeting minutes showed specific areas had been discussed. The new manager had arranged for specialist nurses to provide training on specific conditions such as Huntingdon's Chorea and Parkinson's. They had also arranged advanced training in Percutaneous Endoscopic Gastroscopy (PEG) feeds. This is a means of enabling people who cannot swallow to have nutritious fluids direct to their stomach.

Staff told us they had received enough support from the new manager to meet people's care needs. The new manager had completed one to one supervision meetings for all staff and planned to meet on a more regular basis as well as hold regular team meetings when wider issues could be discussed. For example we saw evidence of discussions around how people consented to care, and how staff correctly completed daily records in the electronic care planning system.

Good

Is the service caring?

Our findings

At the last inspection we observed staff were caring however they did not engage in conversation with people unless it was task driven. At this inspection we observed very caring and relaxed approaches with staff engaging with people naturally and involving them in decisions and the day to day activities in the home. One person told us how they liked to help out with household chores in the home. They told us they were supported to do these chores by staff and enjoyed being involved in the day-to-day running of the home. When we visited in May they told us how they had enjoyed the royal wedding weekend party and they were now helping to tidy up all the bunting and decorations from the weekend. They told us the staff were, "Lovely and very caring," and they, "Want to stay here for ever".

People were cared for by kind and caring staff. Throughout the three days we were in the home we saw staff spoke to people respectfully and showed kindness and patience when supporting them. Staff supported people to move around the home, they did not rush people and offered encouragement and reassurance where appropriate.

During the inspection many positive comments were made regarding the attitude of the care staff from both people using the service and their relatives. However one person did say they had experienced poor attitudes towards them about ten months ago. They said things had improved since then. Comments made included, "Oh yes, they are very nice, kind caring and friendly". "Yes, they are very nice" and "Yes, they are kind and caring". One relative said, "From my observations they are kind and caring. They work hard to understand people's needs".

Since the last inspection the activities person had taken on a full-time role, this meant they were in the home as an activities organiser Monday to Friday 9-to-5. Part of their role was to be a constant presence in the lounge ensuring people were comfortable, provided with fluids and took part in an activity if they wanted to. We observed that this person had a very close relationship with the people they spoke with. People were all cheerful when they were with them and there was a very happy and relaxed atmosphere in the lounge area.

When we visited in May we observed a member of staff assisting a person to change their position in bed in a very caring responsive and kind way. They spoke clearly to the person explaining what they were doing and asked them if they were comfortable before they left. This person would request frequent changes of position throughout the day and all the staff supported them in a patient and caring way.

One relative told us how they were concerned about the changes in staff. They said people needed a stable staff team. The new manager explained how they had been working on ensuring the staff in the home were all, "familiar faces" so people could be reassured that staff knew them well and understood their likes, dislikes and preferences. During the three days of our inspection all staff spoken to were able to tell us about people's preferences and their care needs. They spoke fondly about people and passionately about the changes the new manager was introducing.

The new manager had been in post for three weeks prior to the start of the inspection they had already introduced further resident/family meetings. These had happened before however people told us not very often. People told us that they were able to make their own decisions and staff respected them. One person said, "Yes, my decisions are respected and listened to. I get up and go to bed when I want to, and if I don't want to do anything during the day they are ok with that too." Another person told us, "I don't want to do much. Can't do much really, only sit in the chair". On the first day of our inspection one person told us about a tea party the new manager had organised to meet family and friends. "We had a meet and greet on Saturday. A tea party. We were asked about activities. Nothing prior to this". When we returned in May several people told us how they had enjoyed the garden party to celebrate the royal wedding.

Some people told us they felt involved in decisions about the care they received. One person told us, "I know about my care plan through the Social Worker. It was discussed last Thursday. The family know about it too and were all helpful and supportive". Another person said, "Yes, I have a care plan. My daughter has seen it recently". Whilst another told us, "Yes, I have a care plan They review it with me when the family call in". However one person told us, "Care plan? I've heard of it but not aware of mine". The minutes from a quality improvement meeting (QIM) held in February stated, "Care plans have been discussed with residents and they have been asked to look through them and add/amend information as necessary". The QIM is a multidisciplinary meeting held with home managers to support them in ensuring improvements are made in the provision of care. The new manager explained how they were reviewing all care plans as they increased the use of the electronic care planning system. When we returned in May the new manager had put every care plan onto the electronic system. We saw people had been involved in some of the content of their care plan. One care plan for a person receiving respite care included their input on how they wanted to be cared for and what support they required.

Most people's privacy and dignity were respected and their independence was promoted where possible. One person said, "Dignity, oh yes. I certainly wouldn't have them do otherwise. They knock the door if they want to come into my bedroom; they keep me covered as much as they can when they are helping me wash". Another person said, "I get respect and my dignity respected when I am washing and dressing". Another person told us, "They're very good with dignity. Really kind with my memory going". However a relative told us, "On Sunday [the person] had to be hoisted. There were visitors in the day room. I had to ask for a blanket because all her underwear was showing". On the first day of the inspection we observed staff use a hoist to help mobilise a person in the communal area. Care was taken to cover the person at the back to prevent exposure of their underwear and a blanket was put in place at the front to protect modesty. This showed the new manager and staff had learnt from concerns raised by the family member.

People's cultural and religious beliefs were respected. One person told us they enjoyed the monthly communion service however another person told us it was a shame there wasn't a service in the home. The new manager told us they were developing links with the local village church and would be looking at ways of enabling people to visit the church if they wanted to rather than wait for the service provided in the home. The new manager was also aware of how they could access information regarding other religions and beliefs if necessary.

Good

Is the service responsive?

Our findings

At the last inspection we found the service was not always responsive. Care plans did not provide the guidance staff needed to provide safe effective and personalised care. At this inspection we found there had been improvements in the way care plans were written and the guidance available to staff.

We found the information in people's care plans had improved and provided sufficient guidance for staff to meet people's needs. There was very clear guidance on one person's repositioning needs. Another person's care plan was very clear about the consistency their fluids needed to be to prevent them from choking. People's preferences were clearly recorded which showed that people had been consulted, when able, on the way they preferred their care to be provided.

Following concerns raised in May we looked at how care plans recorded the specific needs around pressure relief and the recording of seizures. The new manager had already identified training needs for staff in the recording of records in the electronic system. It was evident that a lot of work had been put into revising care plans and ensuring sufficient guidance was available for staff. All staff spoken to had a very clear understanding of people's needs. The care plan for one person requiring respite care was very clear about their specific needs. Information had been obtained from the person, from websites and the new manager had arranged for training for staff from a nurse who specialised in the condition the person was living with. We spoke with this person when we visited in May, although they could not communicate with us verbally they were able to indicate by smiling and nodding their head and giving the thumbs up, that they were happy with their care and the way they had been involved in setting up their care plan.

People told us they knew how to complain if they needed to, one person told us how the new manager was very approachable and that they felt they would be able to talk to her. Another person said, "Yes I know how to complain but have no complaints". One relative told us, "I will be keeping an eye on things. It would be good if the new manager works out. This transition to a new permanent manager has been too long". They did feel they could complain to the provider and said They had voiced their concerns in the past. The new manager told us on our return visit, that she had met with one relative who had expressed concerns with the frequent management changes. They felt they had, "Built bridges and overcome some obstacles." Working practices showed us that the new manager and staff learnt from concerns when they were raised. For example, working practices around dignity when assisting a person with a hoist had been improved.

People's feelings about activities in the home were mixed. Some said there was not enough to do whilst others said there was plenty they enjoyed. One person said, "Activities, no, very lacking in that". However we observed this person to be very animated and smiling when the Pets for Therapy dog visited and later joining in with the sing-a-long. Another person said, "I don't go downstairs much I like to watch my sport and they make sure I can do that."

The activities organiser was passionate about the role they had taken on full time. They had plans for activities relevant to people's life histories and what they wanted to do. They had already, with the new manager, organised a "meet and greet" tea party so people could meet the new manager and discuss plans

for the future. One relative said they had attended and felt it was good to be asked their opinion. When we visited in May people told us about the garden party they had had for the Royal wedding. Everybody said they had enjoyed themselves. One person said it was a shame more people from the village didn't come. The new manager told us they were building relationships with the village community and trying to involve them and the people living in the home in more activities together.

The activities organiser explained how they planned to develop the space outside the home further. They said they now had an activities budget so were looking at the purchase of a minibus and a greenhouse this would enable people to get out more and for a gardening club to be started. They told us how they planned to be more involved with the local school and village clubs/organisations. Children already visited the home to read to people and the head teacher was hoping to invite a few people to the school once a month to have lunch. The activities organiser said, "I really enjoy coming to work every single day now. I am looking forward to doing some training in providing meaningful activities, especially for people with dementia."

People could be confident that at the end of their lives they would be treated with compassion and any discomfort would be effectively managed. The new manager explained that their previous role had been in palliative and end-of-life care. They had already discussed the possibility of developing end-of-life care as a specialist area for the home. The new manager was qualified as a trainer in palliative care and had introduced monthly training for staff. They were also forming links with the local GP and community nurse team. The new manager explained two people living in the home had become extremely frail and they had arranged just in case medicines for them and had carried out end-of-life care training with staff so that they received appropriate care that met their needs and expectations. The home was not accredited with the gold standard framework (GSF) however the new manager said they hoped to apply for accreditation and work towards the standards. The GSF is a comprehensive quality assurance system which enables care homes to provide quality care to people nearing the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found the service was not always well led. We also found systems in place did not always drive improvement. At this inspection we found that although the new manager had only been in post for three weeks before our first visit they had already made some notable changes to drive improvement. However there was still some work needed to maintain this improvement consistently, therefore this domain remains requires improvement.

There was not a registered manager in post; however at the time of the inspection the new manager had already started the process to register with the Care Quality Commission. 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.

We found that significant improvements had been made since the last inspection. Although there was an improvement in identifying and dealing with issues it was clear the governance systems put in place needed to be embedded in the culture of the home and used consistently to drive improvement. For example, the systems in place had failed to identify that one person's care plan did not contain a record for staff to record seizures, however the one seizure they'd had, had been recorded in the progress notes. This meant patterns and triggers could be missed. Although the new manager had identified that important records such as repositioning and nutrition charts had not been recorded in the correct place this was still happening. Evidence of sustained effective governance systems will be reviewed at the next inspection.

There were audits and checks in place to monitor safety and quality of care. The deputy manager continued to carry out medicines audits to ensure the management and administration of medicines was safe. Both the new manager and deputy manager worked shifts alongside staff during the day and night to monitor the continuity of care and observe working practices.

The new manager explained how, when they first took the post some information/documentation required to effectively run the service was not available. They had carried out audits of all areas to identify where changes were needed and how they prioritised the changes they wished to put into place. It was evident from the changes seen during the inspection a lot of hard work had been done by the new manager and deputy manager to ensure the service continued to improve and comply with regulations. For example they had identified issues with record keeping and had discussed this at a staff meeting and introduced further training.

It was evident throughout the inspection that the manager was open to learning from concerns and issues identified as failing to provide the type of service people would expect to receive. They had listened to concerns and carried out their own audits. These meant changes had been made as soon as they were identified and additional training was provided for staff when considered necessary. Most staff told us they were pleased with the changes the new manager had put in place. Whilst others had found adapting to the changes difficult. However most staff spoken to were positive about the future of the home.

The new manager explained they were passionate about improving the service provided and had already started introducing new working practices such as the deployment of staff, reviewing care plans and a fulltime activities organiser. Relatives spoken with said they found the new manager approachable but were going to, "Keep an eye on it for now." One relative said, "The transition has been too long with too many changes. The elderly in care need stability and continuity so I will be watching and hoping it continues to improve." One person told us, "I see the manager nearly every day, she's new but she makes her presence known. I think it is very well run." Another person said they did not see the new manager, however when they came into the lounge the person smiled, looked up and said, "That's the new manager she's good."

The registered manager and provider promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. For example they were very open with us about where the service was failing and what they were doing to address this. They had already held a meet and greet tea party to talk with families and ask their views on the service. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

There were systems in place to share information and seek people's views about the running of the home; however these had lapsed in the absence of a permanent manager. The new manager was planning to send surveys to people using the service, families and professionals involved with the home. We will look at the outcome of this at the next inspection.

Staff confirmed that a system of one to one supervision meant they could discuss training needs and any issues regarding the care and support they provided or the running of the home. This also gave the new manager the opportunity to share best practice training and guidelines with staff either on a personal basis or in group supervision. The new manager confirmed they had met formally with all staff on a one to one basis and held staff meetings to introduce herself and address some issues such as record management and staff deployment.

At the time of the inspection the new manager was building up working relationships with the local healthcare professionals. They had already met with the safeguarding team and had plans in place to discuss the future running of the home with other healthcare agencies. We will look at the progress made with working with other agencies at the next inspection.

The registered provider ensured the home was run in line with current legislation and good practice guidelines. There were up to date policies that were available to all staff to make sure they had the information they required to provide safe and effective care.

The provider had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.