Care UK Community Partnerships Ltd

St Vincents House

Inspection report

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Date of inspection visit:
07 March 2016
08 March 2016
15 March 2016

Date of publication:
27 May 2016

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

This inspection took place on 7, 8 and 15 March 2016. At our previous inspection on 2 and 3 March 2015 we found the provider was in breach of Regulation 18 in relation to the provider not ensuring that people who used the service were protected from the risks of not receiving care from sufficient numbers of suitably qualified and competent staff. The provider sent us a plan after the inspection setting out how they planned to address these issues. We conducted this inspection to check that improvements had been achieved and sustained in accordance with the provider's action plan. During this inspection we found that sufficient staff were deployed to safely meet people's needs, although there were now significantly fewer people using the service than at the time of our previous inspection.

St Vincents House is a 90 bedded care home with nursing for older people, and 69 people were using the service at the time of this inspection. It is divided into four separate units and provides care and accommodation for older people with general health care needs and older people living with dementia. The original premises was formerly a convent and residential home for older people. Accommodation is provided over three storeys and the building is served by a passenger lift.

During this inspection St Vincents House did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The service was being managed by a peripatetic manager. The provider had appointed a new permanent manager, who we met during the inspection as they were at the service attending their induction training.

Staff were safely recruited in order to ensure that they were suitable to work with people who used the service. Staff told us they were pleased with the quality of training that the provider supported them to undertake. The provider had introduced a new system for providing staff with regular supervision and an annual appraisal, so that staff had appropriate support to carry out their roles and responsibilities.

Although staff demonstrated that they understood how to identify the signs of abuse and report their concerns to their line manager, some staff did not fully understand the provider's whistleblowing policy, in relation to what is meant by whistleblowing and the legal protection afforded to employees who whistleblow.

Risks to people's safety and welfare were identified in the risk assessments, and guidance was in place to mitigate these risks. Appropriate systems were in place to make sure that people safely received their prescribed medicines, which included medicines training for nursing staff and regular medicines audits.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report upon our findings. DoLS are in place to protect

people where they do not have capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others. Staff had received training and we noted that there were DoLS authorisations in place. However, we found limited evidence to demonstrate that people's capacity was assessed and recorded in their care files. There was also a lack of documentation in relation to people giving their consent for their care and support.

People expressed some mixed views about the quality of the food service. We observed that they were offered a range of choices and provided with staff support for eating and drinking, where applicable. Discussions with people and their representatives, and notes within people's care files, indicated that they were able to access appropriate health care.

People told us that staff were kind and patient. We observed that interaction by staff with people tended to be in connection to the delivery of their personal care. People's dignity was promoted and their confidentiality was maintained.

Care plans showed that people's needs were assessed and these assessments were used to develop individual care plans. However, the record keeping was incomplete at times and did not satisfactorily demonstrate that people's needs were met in accordance with their care plans.

Satisfactory information was provided to people and their representatives about how to make a complaint. The complaints investigations showed that complaints were taken seriously by the provider.

People, relatives and staff spoke positively about how the service had been managed by the peripatetic manager. A new manager had been appointed and they confirmed they would be applying to CQC for registration.

The provider had plans to improve the quality of the service, for example in relation to the quality of activities for people living with dementia, which were being implemented at the time of this inspection. The provider's own quality assurance system did not wholly identify the range of issues detected at this inspection.

We found two breaches of regulation, in relation to ensuring that people's capacity was identified where necessary so that their human rights were upheld, and ensuring that record keeping was maintained to demonstrate that people received safe care and support that met their identified needs. We have made a recommendation in regards to staff training and support to ensure that all staff understand the provider's whistleblowing policy.

You can see what action we asked the provider to take at the end 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

The service was not always safe.

Staff understood how to recognise the signs of abuse and appropriately report their concerns. However, some staff did not fully understand the provider's whistleblowing policy.

Sufficient staff were provided to meet the needs of people who used the service at the time of this inspection, and effective systems were used to make sure that staff were safely recruited.

Risks to people's safety and welfare were identified, and guidance was in place to mitigate these risks. People's prescribed medicines were safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's care files lacked insufficient information to determine if they had capacity to make their own decisions and there was a lack of documentation in regards to whether people consented to their care and support.

Staff received training to carry out their roles and responsibilities, and the provider had commenced a programme of supervision and appraisals.

People were provided with a balanced diet that offered choices and different options to meet cultural preferences and nutritional needs. Variable comments were received about the quality of the food service. Gentle support was given to people who needed prompting and assistance with eating and drinking.

People were supported by nursing and care staff to access advice and treatment from a variety of external health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Most observations showed that staff spoke with people in a respectful manner, although interactions between people and the staff tended to only be about people's care and support needs rather than social engagement.

People were provided with personal care in a manner that promoted their dignity.

Confidential information was securely maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed in order to develop individual care plans, however the records for monitoring people's care and support needs were not consistently completed to a satisfactory standard by staff.

People and their representatives were provided with written information about how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some staff reported that they did not feel valued by the provider due to contractual issues.

There were systems in place to monitor the quality of the service and seek the views of people and their representatives. This system had picked up on some of the issues we identified about the quality of record keeping but had not effectively recognised concerns about pressure ulcer documentation.

People, relatives and staff were very pleased with how the service was managed by a peripatetic manager. At the time of the inspection a new permanent manager was being inducted.

St Vincents House

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.

This inspection took place on 7, 8 and 15 March 2016. The first day of the inspection was unannounced and we informed the registered manager we would be returning on the other two days.

The inspection team comprised four inspectors and a specialist professional advisor with experience in the nursing care of older people.

Prior to the inspection we looked at the information the Care Quality Commission (CQC) held about the service. This included notifications of incidents reported to CQC and the previous inspection report of 2 and 3 March 2015. We considered information which had been shared with us by the local authority safeguarding team and Healthwatch Central West London. This is an independent consumer champion that gathers and represents the views of the public in regards to health and social care services.

During the inspection we spoke with 21 people who used the service and seven relatives and friends, and observed care being delivered in communal areas. Some of the people who used the service were living with dementia and were not fully able to tell us their views and experiences. Therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

At the service we spoke with 20 staff, which included care workers, staff nurses, an activities co-ordinator, the newly appointed manager, the area manager and the peripatetic manager. A range of records were reviewed, which included eight care plans, medicine administration charts, and staff records in relation to recruitment, training, supervision and appraisal.

Following the inspection we contacted health and social care professionals to find out their views about the service and received comments from one professional.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in March 2015, we identified that there were insufficient staffing levels for nursing and care staff in order to ensure that people were safely cared for and supported to meet their needs. Following the inspection the provider wrote to us to state the actions they would take to meet legal requirements in relation to staffing levels. At this inspection we noted that improvements had been made and the provider was now meeting Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received varied remarks from people who used the service and their relatives about the staffing levels. Comments included, "They treat you well and they work hard, more staff would be good to give them extra help. There were three of them this morning instead of four, they were busy but they still managed" and "There is a difference when bank staff are on. They are not familiar with the environment so you can wait longer for them to find you when you ring the bell." One person told us they needed support from staff for getting in and out of bed. They remarked, "I get up when breakfast comes but I can get up when I choose and go to bed when I choose." We met a person who enjoyed reading every day and needed staff support to turn the pages of their book. They told us, "I use the call bell when I want the page turned, they usually respond quickly."

People frequently expressed that nursing and care staff did not have time to meet their social and emotional needs. For example one person said, "I never go out, there is no one to go out with. They said I might fall but I walk around here and don't fall." Another person told us, "There is not much to do in the day, I get bored. There's not many people to talk to." One relative said they were "happy with everything, very good home, couldn't ask for more, the staff are wonderful" and the visitor for another person told us they had concerns about the quality of the care but did not want to give details, as they were a friend and not a relative. The visitor confirmed that the person's relative had spoken with staff about the concerns.

Staff informed us they generally felt that staffing numbers allocated to each unit were sufficient, although they reported there were often staff shortages due to staff sickness and absences.
Staff also commented that the high dependency needs of people who used the service meant they did not have time to spend talking and socialising with people, because of the constant necessity to respond to people that required care and support. One staff member told us their unit was often short of care staff as they were required to escort people to hospital appointments and the temporary absence of a staff member particularly impacted at busy times, for example lunch time. Staff said that they were ordinarily allocated to a unit, which meant they got to know people's needs and wishes. However, staff felt they were not as efficient when they were allocated to other units that were short staffed. One staff member told us, "We constantly have to ask the regular staff on the unit what to do next, which makes it harder to respond to residents in a timely manner." Staff confirmed that they attended handover meetings if they were working on a different unit, which enabled them to receive a short verbal report about people's current needs, but did not usually have time to read people's care plans prior to providing care and support.

Our observations indicated that many people remained in their bedrooms all day. Staff were visible on the

floor to attend to people if they called for assistance and did not appear rushed when providing support; however, we did not ordinarily observe staff interact with people socially.
We noted that the number of people who lived at the service had reduced since the previous inspection. The service had a capacity to provide care and accommodation for up to 90 people and there were 69 people using the service at the time of this inspection. The provider had implemented their own restrictions on admissions in order to allow for a period where the requirements of people with specific complex needs could be re-assessed and alternative suitable placements found as necessary. At the time of the inspection admissions of one person each week were being undertaken. We noted that the provider used a dependency tool to calculate the number of nursing and care staff needed for each unit, and the staffing levels were reviewed on a daily basis in order to reflect how many people were living at the service and their dependency needs. Separate staff were employed to support people to participate in social activities, and undertake domestic, laundry, catering and maintenance duties. We observed that sufficient nursing and care staff were deployed at the time of the inspection to meet the care and support needs of people who used the service. However, staff expressed their concerns that the staffing levels would not remain adequate if and when the service approached full capacity again, unless appropriate staffing increases were made by the provider. Therefore, we were not able to determine if people's needs would continue to be safely met over a period of time by sustained appropriate staffing levels, as the number of people living at the service continued to increase. The peripatetic manager informed us that the provider was in the process of recruiting more registered nurses.

The information within the staff recruitment folders demonstrated that the provider followed rigorous procedures in order to ensure that staff were safely recruited. Each file held applicable checks to ensure that staff were suitable to work with people who used the service. These checks included evidence of identity and official address, proof of eligibility to work in the UK, at least two verified references and a Disclosure and Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

Staff informed us they had been trained in safeguarding and most were able to provide definitions of different forms of abuse when asked, although not all care staff were clear about the provider's safeguarding procedures. They said there was a staff handbook that they could refer to and would inform their line manager if they had a concern that a person was at risk of abuse or neglect or they had witnessed any abuse. There was a copy of the safeguarding policy in the staff office on each unit for reference and a flowchart in the reception area, which outlined contact details for reporting safeguarding concerns.

Although most of the staff we spoke with were aware that there was a whistleblowing policy, they demonstrated a low level of understanding about the meaning of whistleblowing or any protections that would be offered if they raised concerns about the service. Two staff members stated that they would refer to the staff handbook for guidance about the whistleblowing policy. The lack of staff understanding in regards to the provider's whistleblowing policy was identified in the previous inspection report.

Staff wore different uniforms according to their designation, so that they could be identified easily by people who used the service and visitors. Most, but not all staff were observed to be wearing name badges, which could impact on people's ability to accurately report any concerns about the conduct of individual staff.

A relative told us they thought their family member was at risk of a trip or fall, as they had been supported by staff to wear an unsuitable item of clothing. We looked at this item and recognised the potential risk it posed. This concern was raised with staff who took appropriate action. Care plans contained a range of risk assessments for different aspects of people's care. This included risk assessments for tissue viability and prevention of pressure ulcers, moving and handling, falls prevention and nutrition. The scores on each

assessment identified the level of risk and the assessments were noted to have been updated on a monthly basis. This information was used in order to plan individual care and support for people that endeavoured to enable people to safely retain their independence as much as possible, and minimise the impact of identified risks. However, we found a few instances of where the risk scores were contradictory. For example, one care plan contained a Waterlow risk assessment for the prevention of pressure ulcers with a score of 19; however, the 'care needs summary' document within the care plan stated that the Waterlow score was 23. This type of discrepancy could result in people not receiving appropriate care to meet their needs. (The Waterlow scale is a clinical tool that was developed to give an estimated risk for the development of a pressure ulcer in a given patient).

We observed that medicines were safely administered and managed. Medicines were securely held in hygienically maintained cupboards and trolleys, and the records for room and fridge temperatures were recorded daily and noted to be within the required ranges. Nursing staff demonstrated a clear understanding of the provider's medicines policy and procedure. We observed people receiving support with their medicine needs during the inspection. Staff nurses ensured that people took their prescribed medicines before signing their medicine administration record (MAR) charts and spoke in a sensitive and supportive manner with people who were reluctant to take their medicines. We noted that the MAR charts were properly written and contained the necessary information to promote the safe administration of medicines, for example any known allergies were recorded and each MAR chart had a photograph of the person who used the service. Records of medicines consigned for destruction were seen and controlled drugs had been destroyed through the use of controlled drug destruction kits, which was appropriately documented. We noted that if it was necessary for nursing staff to administer any medicines covertly, this decision had been subject to a best interests decision which included the professional views of the person's GP and the pharmacist.

One person told us, "My room is kept clean. The cleaners keep everything nice and clean." Arrangements were in place to ensure that the premises were clean, and equipment was serviced and maintained. Records related to the safety of the premises were clearly presented with up to date information. Staff told us they received regular training on infection control and hand washing techniques. We spoke to a member of the domestic team who correctly outlined the colour coded system for cleaning equipment. Sluice rooms were clean, uncluttered and kept locked, as were the cupboards used for storing cleaning equipment and hazardous materials, in accordance with Control of Substances Hazardous to Health legislation. We observed that catering, nursing and care staff wore protective aprons and gloves when delivering food at meal times. The provider appropriately informed statutory bodies including the Care Quality Commission of the outbreak of an infectious disease in 2015, which was resolved by the provider following medical guidance.

We saw records of safety checks for the internal and external areas of the building, and the regular testing of individual items, for example wheelchairs. We looked at records that demonstrated the provider conducted a range of checks to ensure the safety of people, staff and visitors, which included window restrictor checks, emergency lighting testing, water temperature checks, and checks of the fridge and freezer daily temperatures. We found Personal Emergency Evacuation Plans (PEEP's) in all of the care plans we looked at. This is a bespoke 'escape plan' for people who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency.

We recommend that the provider seeks advice from a reputable source to support staff to comprehensively understand the provider's whistleblowing policy.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf 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. We saw assessments of capacity had taken place and best interest meetings had taken place for specific people. There was some understanding of the principles of MCA and best interests meetings among nursing and care staff, who informed us they had received training. We did not find evidence of mental capacity assessments in the care plans we viewed, apart from documentation to show that a best interests' decision had been made for a person in relation to the use of bedrails. We noted that some Do Not Attempt Resuscitation (DNAR) forms stated that people did not have mental capacity but we could not always find documented evidence of how this had been assessed.

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 provider was aware of their responsibilities in making an application to the supervisory body (local authority) if s person assessed as lacking mental capacity was potentially being deprived of their liberty. We noted that applications for DoLS were being made; however, the needs of people who used the service as indicated in their care files, suggested to us that there were potentially more people living at the service who could meet the criteria for DoLS.

We observed that people were asked for their consent, for example staff asked people in communal lounges if they could support them back to their bedrooms for personal care and checked with people if they wished to be brought to the dining room for mealtimes. However, there was limited written evidence to demonstrate that people, or a representative with appropriate lasting power of attorney status, had been consulted and given their consent to their care and treatment in the care files we reviewed.

The provider had not demonstrated that they ensured care and treatment was provided with the consent of the person and had not acted in accordance with the Mental Capacity Act 2005. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had regular training so that their skills and competencies were kept up to date. All of the staff that we spoke with expressed that they received an acceptable amount of training which took place either in a classroom setting or via electronic learning. They were able to provide examples of recent training, which included health and safety, safeguarding and food hygiene. Staff told us that they were familiar with the care plans for people living on the units that they regularly worked on. Our observations showed that some staff demonstrated a good knowledge of people's care needs, preferred routines, interests and personalities.

At the previous inspection we found that the provider had not implemented an appraisal system for all staff, hence appraisals were being conducted only for managerial staff. This meant that all staff did not benefit

from an annual assessment of their performance and development, which took into account their own views regarding the quality of their work, training needs and career aspirations. At this inspection we found that an appraisal system had been developed for all staff and the process had commenced. We looked at some of the documentation for appraisals that had been carried out and noted that the system was clearly linked to staff attending regular one-to-one formal supervision meetings, which provided opportunities for staff to discuss any issues that required guidance and support and receive constructive feedback about their performance from their line manager.

Comments about the quality of the food were mixed. People told us, "You don't get much rice. I'd like more rice, cooked like back home", "The food is alright, you get to choose what you want to eat the day before" and "The food has improved, the veg is still shocking and very soft, but there is enough choice and they always give you snacks in-between meals." One person told us that although the menu plan offered choices that reflected their culture and staff had encouraged him/her to sample these options, they preferred to have meals brought in by their family.

Records showed that people's nutritional status was assessed using the Malnutrition Universal Screening Tool (MUST). MUST is used to identify adults who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan. We found that any risk of malnutrition was recorded and appropriate measures were documented in people's care plans. People were weighed once a month, unless their care plan identified an increased frequency, and we saw electronic and hard copy records to demonstrate this level of monitoring. Information in relation to people's food preferences and their dietary requirements, for example soft and/or fortified food, assistance to eat or diagnosed swallowing problems, were well documented. Daily food intake and fluid charts were kept in a separate folder and although these records were noted to be up to date, the handwriting was sometimes illegible. This could present difficulties for health care professionals who require accurate information about people's food intake in order to appropriately address their nutritional needs.

We visited the kitchen which provided food supplied by an external catering organisation. The chef informed us that the kitchen staff received regular training about all aspects of their work, such as food hygiene, fire safety and infection control. The monthly menus showed that people were offered daily choices and could also choose items from additional food prepared by the kitchen staff, such as omelettes and sandwiches. Caribbean and Indian food was featured on the menu. Kitchen staff baked cakes and scones, which were served with the afternoon tea or coffee. The chef told us that the kitchen staff delivered food to each floor using hot trolleys, and feedback about the quality of the food was requested informally by kitchen staff and discussed at residents' meetings, which was attended by a member of the catering team. Additionally, the chef visited each person on a monthly basis to discuss food choices and obtain their feedback on a standard form. We looked at some completed forms and read the minutes for residents' meetings. These documents demonstrated that the provider actively sought and acted on people's views about the food service.

We observed how people were supported at lunchtime on each unit. On the unit for people living with dementia, we found that the dining room was attractively presented. Bold colours were used for crockery and furniture, which was in line with established good practice guidelines to support people living with dementia. We noted that people were served within 10 minutes of sitting down at their dining table. An activity co-ordinator sat at one of the tables and chatted to people, which created a sociable environment. People were supported to put on napkins, and two people were fed by staff in a gentle manner. Staff asked people if they would like a second portion after they had completed their original serving and were offered a choice of soft drinks. We did not observe the use of plate guards and asked a staff nurse about this. (A plate guard is an adaptation that clips on to a plate and is designed to increase people's independence with eating.) Staff told us that the provider had obtained plates with increased depth, in accordance with

guidance from occupational therapists. This meant people could retain their independence while using pleasant and homely tableware.

Observations on other units indicated that most people were served their meals within reasonable timeframes. One person was observed to wait for half an hour although we also saw that another person was supported for 40 minutes to eat their lunch. The person was fed in a dignified way and given kind verbal encouragements between mouthfuls. We spoke with staff about the needs of the person who waited for support. Staff explained that they supported several people to eat at mealtimes and they took into account that some people chose to get up later in the morning, so therefore had a later breakfast and lunch than other people with a different routine.

People and their relatives told us they thought the provider understood and met their health care needs. One person told us, "I tell them that I need to see the doctor and it's arranged." Records showed that people's health and wellbeing was continuously monitored, for example the daily records written by staff contained information about whether there was any significant change or deterioration in people's health, which was referred for the attention of the visiting GPs. A GP visited the home on a twice weekly basis, or more frequently if required for people that presented with acute health care concerns. The records were well maintained for these visits and showed that people were seen for consultations when necessary, and also met with the GP for general health and medicines reviews. People's records also confirmed that they had access to a variety of health care professionals, which included dietitians, speech and language therapists, podiatrists, opticians, specialist nurses and dentists. A health care professional informed us that they did not have any concerns in relation to how staff adhered to instructions given and updated them about changes in people's needs.

Requires Improvement

Is the service caring?

Our findings

People and their relatives generally told us that staff were kind and caring. Comments from people included, "The carers' are patient", "I'm very independent, I'm grateful to be here", "They are all very patient" and "They are very kind here. I am very lucky." One person told us they were not pleased with their care but declined to discuss the reasons for this.

We mainly observed that staff spoke cheerfully with people. However, we saw one occasion when a person called for assistance to be taken back to their bedroom and was informed that this was not permitted by a care worker. We asked the care worker if there was a valid reason for this decision and was told that there wasn't. The person was subsequently provided with the assistance they requested but we were not assured that their wishes would have been met without our intervention. The care worker's conduct did not uphold the person's entitlement to be provided with care and support that respected their rights.

Staff appeared to be familiar with people's needs and were able to explain to us how they supported different people. However, staff were generally noted to be focussed on supporting people with their personal care. Sometimes there was limited interaction or meaningful engagement between staff and people who used the service, including people whose care plans indicated that they were at risk of social isolation and needed regular contact. We observed that staff responded fairly quickly to answer call bells or to people who called out for assistance, but did not engage with people in discussions separate to the immediate care and support people needed. One person who used the service told us, "The staff are nice, very obliging, but I'm so bored. There's never anything going on and no-one to talk to unless I have visitors, which isn't very often. I don't want to make a fuss though in case I get into trouble." We saw that most people remained in their bedrooms and appeared fairly isolated. One person's care plan stated that they were able to mobilise with assistance and should be encouraged to do so, but we saw no evidence of this.

We found that significant improvements had been achieved in relation to the premises, in order to provide people with a more comfortable, welcoming and homely environment. The programme of improvements included communal areas, bedrooms and bathrooms. The deputy manager told us that programme of refurbishment was still ongoing and explained about the plans to create a café area and activities room on the ground floor. People and relatives commented favourably on the current improvements and told us that it had created a happier and more optimistic ambience.

People's preferences were documented in their care plans, such as their food choices, sleeping and waking routines, and whether they wished to be supported by same gender nursing and care staff with their personal care needs. One person told us, "I don't mind whether I am helped by a man or woman, I told them when I first came here."

Staff explained their understanding to us about how they ensured that people's privacy and dignity was respected. They told us that they would make sure that doors and curtains were closed when providing people with personal care, and ensured that people were covered with towels at the appropriate times during the delivery of a bed bath, shower or bath. Our observations indicated that these principles were

satisfactorily maintained. Confidential information was securely stored. We saw that nursing and care staff did not discuss people's needs in communal areas used by people, relatives and visitors.

We were informed by nursing staff that none of the people using the service at the time of the inspection were receiving palliative care. Staff told us they were well supported by visiting specialist nurses from a local hospice for the planning and delivery of end of life care. Staff training had been provided by the hospice team, which addressed how to meet people's health care needs, and how to support the emotional needs of people and their relatives and friends.

Requires Improvement

Is the service responsive?

Our findings

Most people who used the service told us they were satisfied with the care and support provided by staff. Comments included, "I still do most things for myself but I know if I wanted help I would just have to ask", "Everything's good, they take care of you and you're treated well" and "very nice care, they look after me well." Other people told us that their care and support could be improved on. One person told us they were not happy about the bed provided by the service and felt bored, "There's not a lot to do to keep occupied here." The person confirmed to us that they did not have any concerns about the conduct of the staff and said, "The carers' know what to do as I tell them" and stated that the staff were respectful and listened.

People's needs had been assessed prior to their admission, to ensure that their needs were identified and understood. These assessments were undertaken by a range of health and social care professionals. One of the nursing staff told us that people were usually admitted to the service following a period of hospitalisation, which meant that their need for nursing care had been assessed by a multi-disciplinary team. The provider carried out their own assessments and risk assessments, and the collective information was used to develop an individual care plan. Care plans were recorded on a central electronic system but were made available in hard copy versions to people and their chosen representatives. The care plans contained information about how to meet people's personal care, social care and health care needs, as well as information about their preferred routines, wishes and other preferences, and they outlined how to meet people's needs and wishes. Each person was assigned a named keyworker although we were told that in practice this was not operational, which meant that people and their representatives did not have the input of a designated person to ensure that their needs and wishes were identified and met.

We found that all elements of the electronic care files we viewed were fully completed and contained a suitable degree of detail in most care files, although sometimes identified risks had not been fully addressed in the care plans. For example, we found that although one person was prescribed a barrier cream for application to areas of the body at risk of developing pressure ulcers, this was not recorded in their care plan. The person's medicines administration record chart evidenced that the cream was being applied as prescribed.

Although people's needs had been identified, the monthly reviews of these needs provided limited information about whether there were any significant changes in their needs. This meant it was sometimes difficult to know whether care had been delivered in line with the care plan, how people had responded and whether problems had been resolved. For example, two people's care plans identified that they were at risk of social isolation because they did not leave their bedrooms. Both care plans stated that the two people would benefit from one-to-one contact with staff but the monthly reviews did not provide any information regarding how people had responded to their one-to-one social contact with staff. This meant that people and their relatives did not have a named member of staff to help ensure that a person's needs and wishes were understood and met.

It was not always easy to track the delivery of care over a period of time as some care plans were not clear as

to whether a health care need was current or resolved. We had to speak with staff to find out if a person was still catheterised and if another person had a pressure ulcer, as the care plans had not been updated to show that these were resolved health care needs. We found an example of where pressure ulcer care had not been well documented in order to demonstrate how the provider responded to people's needs. The care file's section for external health and social care professionals showed that the person had been seen by a community tissue viability nurse (TVN) but the important guidance from the TVN had not been used to update the person's wound ulcer care plan. There was a centrally maintained wound care file held in the manager's office which provided a summary overview of all pressure ulcers in the service that included information about the grade and type of pressure ulcer, date that pressure ulcer developed and how it was responding to treatment. Most of the documentation for pressure ulcers was of a satisfactory standard although we noted that one care plan stated that weekly photographs of the pressure ulcer needed to be taken, which had not occurred for two months.

We looked at the repositioning charts for eight people and found some discrepancies. The charts for four people did not indicate the frequency that repositioning was needed. One chart had not been completed for 10 hours and on another day several charts had no entries of the care delivered for seven hours. It was sometimes difficult to decipher when people had been repositioned as the staff signature on the chart had sprawled across a two hour period.

The above issues in relation to accurate record keeping meant that the provider could not demonstrate that people's needs were responded to in accordance with their individual care plans. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People expressed mixed views about the activities and entertainments offered by the provider. One person told us, "They have a man that comes to play the piano, he's very good" and another person said, "They always let me know what's happening, it keeps me occupied." However, other people told us they were often bored and would like a wider range of activities. We were informed by the deputy manager that the activities team comprised two full-time staff and one part-time staff. Some activities took place during the inspection, which included bingo, a karaoke session, soft ball throwing and catching, flower arranging and a visit from the pianist. We noted that the pianist was popular and over 20 people attended this entertainment. People told us that the monthly cheese and wine party was another well received event.

On the second day of the inspection we observed one of the activities team took a trolley of fresh flowers and vases into people's bedrooms to carry out flower arranging sessions. We noted that there no assumptions were made in regards to whether this was an activity that would mainly interest women, therefore males who used the service were invited to participate. We were told by an activities co-ordinator that the activities budget for the service was £300.00 per month, which the activities team found sufficient to cover all in-house activities and also pay for an external entertainer to visit the service. Positive interactions were observed between people and the activities staff. On the second day of our inspection we observed an activities co-ordinator informing people that it was 'International Women's Day' and how it was being marked by different communities.

People and their relatives told us they felt able to raise any concerns and complaints. Positive views were expressed about the open approach of the temporary peripatetic manager. We were informed that they had warmly introduced themselves to people and their visitors, and made themselves available to respond to any problems. We looked at the complaints received by the provider since the previous inspection and noted that these complaints had been appropriately investigated to. Complainants were sent a letter if their complaint could not be investigated within the stipulated timescales due to complexities. The provider prominently displayed information about how people, and their relatives and friends, could make a

complaint. This included information about how to escalate the complaint if people were not satisfied with the provider's response.

Requires Improvement

Is the service well-led?

Our findings

The previous registered manager left the service late last year and the service was being managed by a peripatetic manager at the time of this inspection. People who used the service, relatives and staff were extremely complimentary about the peripatetic manager and their visible, approachable and responsive style of management. We saw that systems were in place to seek people's opinions through regular residents' meetings and meetings for people's relatives and friends. People and their relatives had not had an opportunity to properly meet the newly appointed manager. The area manager told us that a social event was being planned so that people and their representatives could meet the new manager in a relaxed situation.

One of the staff said, "Working here is good, I enjoy it, I love it." They told us that the provider motivated staff through supporting them to attend training courses and through providing sufficient resources, for example equipment to carry out their roles and responsibilities. The staff member believed that this was due to the approach of the interim manager. Another staff member told us they were being offered training that had not previously been available, which would extend their knowledge and competence. Staff told us the peripatetic manager had been very effective in introducing improved systems for managing their work, and dealing with queries and concerns, which had created better team work.

Staff reported that their views were sought through regular meetings. Some staff told us that they felt undervalued due to issues related to their terms and conditions of employment, which they had raised with the provider.

There were systems in place to monitor the quality of the service. We looked at a range of documents which demonstrated that the provider regularly monitored various aspects of how people's care and support was organised and delivered. The monitoring included unannounced 'spot checks' by the management team. The deputy manager showed us the report for an unannounced night time visit that took place earlier this year, which detected issues of concern about accurate and transparent record keeping in regard to people's care and support. Audits were conducted every month, which addressed areas including the management of medicines and pressure ulcer care, although we found issues of concern in relation to the record keeping for the treatment of pressure ulcers. Environmental checks were carried out on a daily, weekly and monthly basis, in order to ensure that people were provided with a safely maintained home, and all accidents and incidents were recorded and analysed, to determine whether there were any identifiable trends that could be addressed.

We noted that the provider had not fully dealt with some of the issues we raised at the previous inspection report. For example, at the previous inspection we were informed that some people didn't wish to leave their bedrooms or participate in any group activity. At this inspection we found that the provider had attempted to introduce different ways to support people that did not want to engage in activities or were not able to because of their health care needs. For example, the provider had placed memory boxes on the bedroom doors on the unit for people who lived with dementia and assembled 'rummage drawers' in the communal areas. (The rummage drawer is a means of tapping into memories from the past and helps

people living with dementia feel empowered and secure in familiarity, and can be used as an activity or as a reminiscence tool.) We were informed by staff that a new music therapy group was due to start soon after the inspection, which was designed to support people living with dementia. Although the memory boxes and rummage drawers were still being put together at the time of the inspection, these actions demonstrated that the provider had attained some progress with supporting people to enjoy meaningful activity.

The peripatetic manager and the new manager demonstrated their understanding of the legal requirement to notify the Care Quality Commission of incidents and events that affected the safety and welfare of people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The Registered Person did not ensure that care was provided with the consent of service users. The Registered Person did not ensure they acted in accordance with the Mental Capacity Act 2005. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The Registered Person had not maintained an accurate, complete and contemporaneous record in respect of each service user. 17(1)(2)(c)