Hewitt-Hill Limited

# The Old Vicarage

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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 unannounced comprehensive inspection took place on 5 April 2018. The Old Vicarage is a 'care home', where people receive accommodation and personal care as a single package. CQC regulates both the premises and the care provided, and these were looked at during this inspection.

The Old Vicarage accommodates people in individual rooms, each with an en-suite toilet and basin facility, and one had an en-suite shower room. Each floor has some communal bathrooms and further communal toilets. The Old Vicarage is a residential care home for up to 29 older people. It is one of three services owned by the provider Hewitt-Hill Limited, also known as the Ashley Care Group. At the time of our inspection, 26 people were living in the home, which was situated across two floors.

We last inspected this service in January 2017. At that inspection, the service was rated 'Requires Improvement' in two areas, which were safe and well-led. The service had not always managed risks associated with certain medicines, and the provider did not have fully effective quality assurance systems in place. The service was rated 'Good' in effective, caring and responsive. The overall rating for this service was 'Requires Improvement' and therefore we asked the provider to make some improvements to the service. At this inspection in April 2018, we found that the service had not made all of the improvements required and was rated 'Requires Improvement' in all areas. There were also three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post. A registered manager is a person who has registered with the 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 not consistently safe for people. This was because risks to people were not always thoroughly assessed and staff did not always have guidance on how to mitigate risks to people. Risk assessments and care plans were not always in place for the safe management of people's conditions.

Topical medicines were not always administered and recorded consistently, and there was not sufficient guidance for staff on how to administer them. Oral medicines were stored securely and administered safely.

Although there were audits in place, the quality assurance systems did not always identify areas where improvements were needed. The systems in place were not fully effective in monitoring and improving the service.

People did not always receive person-centred care and support in a way that reflected their individual preferences and needs. Care plans did not always contain details of how people wanted to be cared for, and therefore there was not always enough guidance for staff.

People were not always involved and consulted about their care and how they wished to be supported. Staff did not always support people to engage in activities which reflected their interests.

The potential of the environment was not always used to enhance people's wellbeing. There had been some trips out during the appropriate season, with further trips planned this year in summer.

Staff did not always interact with people appropriately and engage with them effective during their delivery of care. They did not always provide sufficient prompting to eat and drink when needed. There were not always full records of people's care where they relied on staff for the majority of their daily living tasks such as eating or drinking. Therefore the registered manager did not always have full oversight of whether people were receiving a high standard of care.

Staff received training which supported their roles, however training was not followed up by competency checks. There were employment checks in place which contributed to people's safety.

People had access to privacy, for example when a healthcare professional needed to see them. Staff knocked on people's doors before entering, but they did not always behave in a manner that promoted people's privacy and dignity as much as possible. Staff did not always promote independence.

There was a choice of freshly cooked quality meals available to people, and the cook was aware of who had special diets, and accommodated these. People were able to access healthcare when they needed to.

Staff asked people for consent before delivering care to them, and knew about individuals' mental capacity. However, records showed that best interests' decisions had been made without the required mental capacity assessment in place. People were also deprived of their liberty without the required capacity assessments being in place.

## 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.

Oral medicines were administered as prescribed, but there was a lack of recording and consistency around administration of topical medicines.

Risks to the health, safety and wellbeing of people who used the service had not always been fully identified, assessed and mitigated.

There were new staff recruited and due to start, as it had been identified that there were not always enough staff.

Recruitment processes were in place to ensure that staff suitable to work in care were employed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People were not always appropriately prompted to eat and drink enough to meet their needs.

Mental capacity was understood and staff asked for consent before delivering care to people, although records did not always reflect full and accurate decision-specific assessments.

Staff received training relevant to their roles, however this was not followed by competency checking.

People were supported to access healthcare.

People were not always able to take advantage of the home's environment such as the garden.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People did not always receive care that was compassionate care

from staff who interacted kindly with them.

People were supported to maintain their dignity and privacy in some respects, although staff did not always follow best practice to ensure they encouraged people's independence.

People were not always involved in their care, however families were consulted if staff had any concerns.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People's needs were not always met in a person-centred way.

People's health, emotional and social needs were not always fully planned for. Improvements were needed in respect of plans to meet people's preferences and health conditions.

Activities were on offer to people through the week, and further improvements were required to the provision and quality of these.

There were care plans in place for people's end of life but these were not detailed.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Systems in place for auditing and monitoring the service were not always effective as they did not always identify concerns or lead to actions.

The registered manager was approachable and available to support staff when they needed, and also for people and families to speak with.

# The Old Vicarage

**Detailed findings**

## Background to this inspection

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

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection, we reviewed the information available to us about the home, such as the notifications and the action plans that they had sent us. A notification is information about important events which the provider is required to send us by law. We also obtained feedback from interested parties, such as the clinical commissioning group.

During the inspection, we spoke with six people using the service, three family members and one visiting healthcare professional. In addition, we spoke with two care workers, the care coordinator, the cook, the maintenance person and the registered manager. We looked at how the service managed people's medicines and how information in records and care notes supported the safe handling of their medicines. We observed lunch time, activities, and how care was delivered throughout the day of our inspection. We looked at four care records. We also looked at a range of management documentation relating to how the home is run, such as audits and staff training.

Requires Improvement

# Our findings

During our last inspection in January 2017, we found the service was not always safe, and was rated 'Requires Improvement' in this area. Meds were not always stored according to best practice guidelines, and there was limited direction for staff around 'as required' (PRN) medicines. We found at this inspection that these issues were resolved. However we found concerns in other areas which meant that the service was not always safe, and continue to be rated 'Requires Improvement' in this area.

Where people were prescribed topical medicines, there were no records in place to show how these were administered. They were not signed on a medicines administration record (MAR) and there were no body maps in place to guide staff on how and where to put creams. People did not always receive these medicines as prescribed. For example, we saw that one person had two prescribed creams. Only one of these was mentioned in the care plan, which stated it should be used in place of soap. However, one staff member told us they used it as an emollient to put on the person's skin to moisturise when they felt it was necessary. Two staff members told us the person had another prescribed cream for preventing pressure areas, which was not mentioned in the care plan or in the MAR. One staff member said they applied this when they supported the person with personal care. We asked staff where they recorded if they had given it. One staff member said they would write this in the daily care notes, and the other confirmed they thought this was the case too. We saw that another person had a prescribed cream, with no further information about how and when to administer it. We could therefore not be assured that these were given as prescribed as feedback and recording was inconsistent. The lack of consistent planning and recording also meant that the use of topical medicines could not be properly audited.

Risks associated with manual handling were not always properly planned for and mitigated. For one person, we saw that care staff lifted them under their arm. This was whilst prompting them to hold onto their walking frame to pull themselves up, rather than push themselves up from the chair. This is not safe moving and handling practice and placed the person and staff at risk of physical injury. The person's care plan stated that instructions were to be given loud and clear to this person, and 'assistance needed'. It did not say what the instructions were or what assistance was needed. The person was at high risk of falls and the falls risk assessment did not contain sufficient detail for staff to be able to mitigate the risk of falls, such as footwear or what prompting was needed. The person had fallen five times in the last six months within the home, and the registered manager explained that this was at night predominantly. They said they had not felt it would be appropriate to refer to the falls team as they may not be able to take any action and they felt they had mitigated the risks as much as possible. They had a pressure mat in place at night which mitigated their risk of falls, and we saw that the person was no longer having frequent falls during the night as a result.

Other risks to people were not always mitigated. We saw during the inspection in the morning that one person was left with a spouted beaker cup in front of them and they were drinking from it. We saw that when they drank from it they coughed. We checked the person's care plan which stated to avoid spouted beaker cups. We saw that for the rest of the day, the staff ensured they had a cup without a spouted lid. However, we were concerned that the person had been put at risk of aspirating or choking because staff did not always support the person in a way that kept them safe.

There were not always dedicated care plans in place for people's conditions, such as diabetes, Parkinson's, angina or stroke. For example, whilst there was some information about people's diabetes available, it did not guide staff on how often to check their blood sugars.

Where other people had been identified as high risk of developing a urinary tract infection (UTI) or becoming constipated, there were no care plans in place for this. We saw that where staff recorded details of people's personal care, the registered manager had not always looked at these records and identified gaps. This meant that there could be a potential problem with the person's health which had not been identified. No further action had been taken to check whether this was a recording issue, or that the person was well, or that they had been offered a PRN ('as required' medicine) where applicable. We could not be assured that there was safe management of people's specific health needs.

One person in the home was on a food and fluid chart so that staff could monitor what they were eating and drinking. The person was at high risk of weight loss and was of very low weight in appearance. However, the staff had not been able to weigh the person because they were cared for in bed. They had not sought out another way to check if the person was continuing to lose weight or not, such as ulna measurement.

We saw that the person had very little to drink, and the registered manager had not identified this. For example, over a three day period the person had drunk 1040 mls in total. There was no target and the records kept by staff were not being monitored. We discussed this with the registered manager, as this meant risks to the person not eating and drinking enough were not always identified and acted upon in a timely way. The registered manager created a new document which included the total and if the person was offered and refused a drink, and checked half hourly.

The above concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their oral medicines as prescribed. One person said, "I have medication four times a day, no I'm not kept waiting." Medicines were given as prescribed by a trained member of staff. The Medicine Administration Records (MARs) were signed by the staff to confirm when medicines had been administered to people. Where medicines were time-specific, these were given according to people's needs. The MARs also contained a cover sheet which helped minimise risks of errors, as they contained information about allergies and people's preferences with regards to taking their medicines. We saw that medicines were stored securely at a safe temperature, and dated when opened. Where people had 'as required' (PRN) medicines, there were individualised protocols in place which guided staff on how and when to administer these. For one person who administered their own medicines, we saw that there was an appropriate risk assessment in place.

We found that records for the administration of topical medicines were not always completed, and care plans did not contain sufficient guidance for staff for administering them. This may lead to increased risks associated with the development of pressure areas. However, this risk was partly mitigated by the district nurse being involved in people's care when they had any pressure areas. We saw that these visits were well

documented with what action they had taken and what they had checked. We saw that staff supported one person who was cared for in bed, to reposition regularly to mitigate their risks of developing a pressure area. Where needed, we saw that pressure relieving equipment was in place, such as pressure boots, cushions and specialist mattresses.

There were risk assessments in place for the equipment people used, for example associated with the use of bed rails, and we saw that risks were mitigated. However there were some risks associated with people's environment which had not been assessed, for example, the open staircase.

The registered manager reviewed incidents and accidents and analysed these. This meant they were able to observe any trends in accidents, and take action to reduce the risk of these occurring again.

There were systems in place for the safety of the home, such as electrical tests, water safety maintenance processes and lifting equipment was kept safe. The maintenance staff were carrying out regular water temperature checking, flushing and cleaning in line with their legionella risk assessment. However, they had not had a legionella bacteria test for two years. The registered manager ensured that this was organised immediately following the inspection. There were regular fire alarm tests and we also saw records of fire drills that had taken place and were carried out regularly. This contributed to people living in a safe environment.

Three people we spoke with told us they felt there were not always enough staff. One staff member told us they could do with an additional member of staff. They said, "When we're full it's rushed." The registered manager was aware that some tasks took up more time from staff, such as laundry and making beds. They had acknowledged that care staff were stretched at times. They had therefore employed a member of staff who was due to start the week following the inspection, as a 'general assistant.' This member of staff would support staff in making drinks, laundry, bed-making and general work across the home which was not related to personal care delivery. This member of staff would free more time for care staff to spend with people. The registered manager told us they were able to cover sickness and absence with their own bank staff. We saw that they used a dependency tool to calculate the number of care hours required to deliver care to people according to their needs. We saw that the registered manager had good oversight of the dependency tool and had identified that they were a few hours short at times. They had therefore advertised and employed more staff.

Not all staff had a thorough knowledge of how to report safeguarding concerns outside of the organisation. However, staff were aware of concerns or issues which may constitute abuse, and said they felt comfortable to report safeguarding concerns to the registered manager. We fed back to the registered manager that not all staff were fully aware of the safeguarding authorities, and they assured us they would reiterate this to staff.

There were recruitment practices in place which contributed to the safety of people. For example, there were Disclosure and Barring (DBS) checks, which identify whether potential staff have any criminal convictions. There were also references and identity checks in place before recruiting new staff.

The home was clean and the equipment people used was clean. However, we saw that staff did not always wear aprons when in the kitchen, which is best practice for preventing contamination. We saw that gloves and aprons were available for staff to use when carrying out personal care.

Requires Improvement

# Our findings

During our last inspection in January 2017, we found the service was effective and was rated 'Good' in this area. At this inspection, we found that the service was not always effective and was rated 'Requires improvement.'

Staff were supported to undertake qualifications in health and social care such as a National Vocational Qualification (NVQ) or Qualification and Credit Framework (QCF) diploma. Mandatory training, as identified by the provider, included safeguarding, food hygiene and manual handling. However, we saw areas where knowledge required improvement in these areas despite staff training. We saw poor manual handling take place on one occasion. We also saw that staff were not wearing aprons in the kitchen. We also reminded kitchen staff to date all food left in the fridge. We found that not all staff had a thorough knowledge of how to report safeguarding concerns outside of the home.

Staff, on the whole, told us they received enough training for their roles. One staff member stated they felt they could benefit from further training in dementia, and they had requested this from the registered manager, which had been agreed. Another stated they had received dementia training, but felt knowing people well helped them to understand their individual needs. We observed that staff did not always communicate effectively with people living with dementia. Some staff told us they had received training in safe swallowing for people with dysphagia (swallowing problems). However, we saw that on one occasion a person was not safely supported with equipment to mitigate the risk of choking. We discussed staff competencies with the registered manager. They stated that they worked with staff at times to observe their practice, but did not do formal competency checks.

The registered manager told us they were planning to have staff 'champions' in different areas, who would take the lead in disseminating knowledge. They planned to have these in infection control, safeguarding and dementia. They felt this would improve the oversight of these areas ensuring staff followed best practice, carry out audits and ensure training remained up to date.

Staff inductions included a week, or more if required, of shadowing a more experienced member of staff. Inductions also included basic health and safety within the home, and staff were provided with leaflets to read around relevant learning areas, including the Mental Capacity Act 2005 (MCA). Staff had quarterly supervisions organised, where they could bring any extra training needs to a meeting with a senior, and discuss their role.

People were supported to eat and drink, but improvements were needed around the management of this. During the afternoon we observed seven people sitting in the main lounge, only one of whom had a drink present and within their reach. This was the period in between lunch and the afternoon drinks round, which meant that people did not always have access to a drink. We spoke with four people about the quality of the food, and they said they enjoyed the meals, but two people stated that the portions were too big.

We observed lunch being served to people in the dining room where three tables were laid with plastic table cloths, plastic patterned table mats, cutlery and table decorations. People had been served their choice of drink, sherry, wine or soft drinks were available, and a covered jug of water was present on each table. A staff member was observed to check on people during the meal and offer to top up their drinks.

Two staff members supported lunch time in the lounge where six people ate from portable tables whilst sitting in their armchairs. Two people required full assistance and staff members had positioned themselves appropriately to support their needs. A third staff member entered the room after a period of time and proceeded to assist the two other people present in the room who were slowly proceeding to eat their meals.

We saw a member of staff supporting one person with their dessert, and they also had a cup of tea on the table. We saw that the staff member was supporting them to eat without interaction and explaining what was on the spoon. The staff member made no mention of the cup of tea to prompt the person to drink it. The staff member then got up and left, with the dessert only half eaten, without explaining to the person what they were doing. They did not return to support or prompt the person more. They came back later in the afternoon and took away the then cold cup of tea and left over dessert. We saw that this person did not receive effective support to eat and drink. Over the same time period, another person had a cup of tea in front of them which they did not drink, and care staff supported the person to go to the toilet, returned, took the tea away and did not offer another or prompt them to drink any more. We concluded that support for people to eat was not always carried out in a considered individualised manner.

We saw that where people needed full support to eat and drink from staff, there was no way of monitoring this because they were not recording food and drink for them, with the exception of one person who was cared for in bed.

We saw that the registered manager monitored people's weights on a monthly basis, with the exception of the person cared for in bed, and saw that they took action where they identified weight loss. This included referrals to a dietician and providing fortified diets to increase people's calorie intake. However, we saw for one person the dietician had recommended for them to be weighed weekly but they had continued to be weighed monthly.

People said they chose what they wanted for breakfast. The cook was aware of who required special diets and what their preferences were. A family member confirmed this to us, saying, "The head chef goes above and beyond, talks to all the residents and treats them very personally."

People were able to seek medical support easily, one person telling us, "I can ask to see the doctor, she comes in once a week." This was closely echoed by everyone we spoke with. A visiting healthcare professional told us they felt staff followed advice well. They also stated that they had a good relationship with the home and felt this benefitted the people living there, as they received timely healthcare treatment.

People were also supported to access additional services to enhance their health and wellbeing. One person explained, "They have a hairdresser and a chiropodist comes in." They went on to say that an optician

visited the home, "I didn't know I was going to have my eyes tested but they were very good." Another person confirmed that a dentist visited the home when needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager had documented specific best interests decisions and involved healthcare professionals and family members in these when appropriate. However, we found that the registered manager had not always ensured a decision-specific mental capacity assessment had been carried out prior to making best interests decisions. This meant that the service had not assessed whether the person could make the decision before making the decision on their behalf. However, we found that the staff and registered manager had a good understanding of individuals' mental capacity. We saw that staff sought people's consent before delivering care.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Some people in the home were subject to a DoLS, and we were assured that they were only deprived of their liberty in the least restrictive manner possible. However, the registered manager had not carried out mental capacity assessments prior to applying for the DoLS, which is required in order to establish whether or not one is needed. We found that again, the staff understood people's capacity and required restrictions well, however improved documentation around mental capacity assessments was required.

The home was being updated and the registered manager explained to us that new furniture was being delivered shortly after our visit. Although the environment was suitable for most people's needs, we saw that there were two lounges, and only one was used regularly and seemed full most of the time. Therefore the environment may not have been used to its' full potential, as we saw all the people in the main lounge had the television on all day on the same channel. It may have been possible to have an alternative option in the other lounge, for example another programme or activities. Activities were carried out in the main lounge, and people were not offered the option of remaining somewhere quiet to watch the television whilst these were going on. The people we spoke with told us there were some concerns around accessing the garden, because it was difficult to access for people with mobility problems and was not secure for those living with dementia. The potential of the environment was not always used to enhance people's wellbeing. We also saw that the staircase did not have a gate at the top, and this was managed safely by the home as they knew people's requirements who were living upstairs. However, this may need further risk assessment regarding people coming into the home living with dementia, who are mobile and may use the stairs. There was some signage on doors such as bathrooms, which assisted people to orientate around the home.

We received mixed feedback about whether people were supported to go outside in the garden and on trips. One person told us, "This is the pity here, the grounds are open to the outside so there's no garden fence. It's difficult for them to allow people out." A family member said, "[Relative] spent their entire life in the garden, and as I have said I wish there was a bit more secure space. I have emailed the manager and asked her to forward it to somebody [access to garden space]." Another person we spoke with was not aware that the property had a main garden, as they only knew about the courtyard area. The registered manager told us one person enjoyed going out into the courtyard to do gardening.

Requires Improvement

# Our findings

During our last inspection in January 2017, we found the service was caring and was rated 'Good' in this area. At this inspection, we found that the service was not always caring and was rated 'Requires improvement.'

One person described staff as, "Very friendly, helpful. I think you probably could talk to them." Another said, "They're quite willing, they never say no." This person went on to describe an example of staff helping them, saying, "I use an electric shaver, when I dropped my razor a staff member said do you mind if I fix it, and she put it back together, just like that." One person told us how their family members were welcome, "They're offered tea and coffee, they [family] came to the Christmas party, oh yes, they can visit anytime."

However, one person felt that staff did not always consider their feelings, "They [staff] never tell you when anybody passes away, I have to ask." We saw some task-led care during our inspection. Care staff did not always talk people through what they were doing. For example, we saw one staff member push someone into the lounge in their wheelchair, and then turn them and leave, to get another member of staff. They did not interact with the person to let them know what they were doing. We also saw that staff did not always interact with people whilst supporting them to eat.

People and their families were not always consulted about their care or involved in care planning. However one family member told us, "If they're [staff] worried about anything they phone us." Although people did not always feel that their views were acted upon, the registered manager was able to give us examples of times when they had acted on people's views. For example, with regard to choosing certain foods people wanted to try.

We gathered mixed information about how staff protected people's privacy and dignity. A visiting healthcare professional told us that the staff managed people's privacy well, and they were able to treat people in private. We did observe however, that a member of staff applied cream to one person's skin in the lounge, without offering them the option of privacy. We also heard two staff members discuss one person's sore throat in the corridor, without considering their privacy. We observed that staff knocked on doors and respected people's privacy within their bedrooms.

Staff did not always promote independence through prompting people to stand in a way that would support them to do so as independently as possible. For example, staff prompted one person to put their hands on the walking frame to pull themselves up, instead of prompting the person to push themselves us

from the chair and tuck their feet underneath them so they could attempt standing. This was not safe and did not promote their independence as staff had to pull them up. For another person, who was seen to be walking about the lounge with their walking frame, care staff did not offer to walk with them but guided them back to their seat. This did not fully support the person to be in control and as independent as possible.

The service supported people with diverse beliefs. For example, supporting people with different religions and backgrounds through sourcing appropriate materials for them to support their faith.

Requires Improvement

# Our findings

During our last inspection in January 2017, we found the service was responsive and was rated 'Good' in this area. At this inspection, we found that the service was not consistently responsive to people's needs and was rated 'Requires improvement.'

People did not always receive care according to their preferences and individual needs. Two people told us they had to wait for assistance to use the toilet, and this caused them anxiety at times. One told us, "Today I needed to go to the loo when I got up, but they had a queue." Preferred times to have baths and showers were not always discussed with people and reviewed. One person told us, "My bath day is Thursday, the time doesn't really bother me but I know it bothers a lot of people here." The registered manager told us they had recently improved the provision of baths for people and had implemented a bathing rota for staff to support people with baths regularly. This however, along with the feedback we received about people's preferences regarding baths, meant the home had an institutionalised approach for supporting people with baths. This did not always take into account individual preferences.

We had mixed feedback from people about whether they were supported to get up and go to bed at a preferred time. One person said, "[Staff] say are you ready for your breakfast? I say I'm not even up yet! They say, come on, get up, just part of the routine I suppose." People told us they were not asked their opinion of whether they wanted a male or female care worker for personal care. One person told us, "They're [the service] going to get a man [staff member], I don't know how I feel about it, no they [staff] haven't asked me my opinion." The registered manager told us there was one person who preferred female care staff, however, it was clear that staff had not been proactive in asking people's views. The registered manager told us there were two staff on at night, and there was a male member of staff starting at night. It was not clear how they would provide personal care where two staff were required, if some people only wanted female staff assisting them with their personal care.

People's care plans did not contain details about their preferences, for example what times they preferred to get up, go to bed, or have a bath. Where people required support with their continence, care plans did not contain any information to guide staff on promoting this. For example, offering support to take people to the toilet regularly. We did see that staff discreetly offered people support to go to the toilet during the day of our inspection visit. The care plans did not contain preferences of what people enjoyed to eat. However, we found that some staff we spoke with knew people well and their likes and dislikes.

Staff did not always pay attention to details of people's preferences through supporting them. One person

told us, "The jug over there, I never drink it, it's like straight from the river. I just don't like water." We saw there was a covered jug of water in the person's bedroom, which they were referring to. The person told us they preferred orange drink but we observed there was no alternative drink, or a glass present in the person's bedroom.

One person told us, "They don't have any church services here, which I think is a pity." However, we had mixed views on whether staff asked people's views on what they wanted to do. One person said, "To be honest it's like being in a prison, you can't get out without someone being with you. I've never asked them, if they came to me and asked me oh yes, I'd go [out]." They said, "I like swimming but I've not done that. I gave up asking." Two people said the activities were not really things they enjoyed doing. We observed an activity during our inspection which was jigsaw puzzles. The puzzles available had 1000 pieces each, and people did not have a table big enough to use, and nowhere to put the lid to see the picture they were making. We concluded that the activity had not been considered properly in light of people's needs. There was no consideration especially, of people's needs who were living with impairments associated with dementia.

Care plans did not contain sufficient detail around their conditions and specific needs, and their capacity was not always assessed so that they could be engaged and involved in their care planning and making choices. People did not always receive individualised care that reflected their needs and preferences with regards to how they wanted to live their lives.

The above concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that they were asked what they would like to do. Another person was able to independently access the community, "I can enjoy village life, I belong to the church band, it's great fun and we get out and about." They added, "I can come home when I like." The registered manager told us they had not been able to take people out recently due to the cold weather in the winter, and had trips planned for the Summer. We looked at some photographs of trips out last Summer and saw people enjoyed trips such as to the pub and to wildlife gardens. Other trips out included to the sealife centre, the muckleburgh collection, and afternoon tea.

People gave us examples of when visitors had come to the home to entertain them, "We had the children from the school sing to us at Christmas." Another person said, "We went to a Christmas Fayre, we had a New Year's party here. We celebrate people's birthdays." The cook confirmed they always made a cake for people's birthdays. One person said they did not have as much visiting entertainment now, "The one thing I miss, and perhaps a lot of others [people] is music. We don't have any music, other than at Christmas, not music entertainment or singers."

There was a member of staff dedicated to activities in the afternoons for people living in the home for the afternoons during the week. These included quizzes, crafts, bingo and games, and on one occasion, chair exercises. One person told us they were planning to start up a knitting club in the home. The cook told us they did a cookery session once a week with people.

People's end of life care wishes were documented in their care plans, such as whether they would prefer to stay in the home rather than go to hospital, however not all details were recorded. The registered manager was working through end of life care plans with people and their families.

People and their relatives felt comfortable to raise any concerns with staff or the registered manager. There was a complaints procedure available to people. The home had not received any formal complaints recently

since November 2017, and we saw that this was resolved appropriately.

Requires Improvement

# Our findings

During our last inspection in January 2017, we found the service was not consistently well-led and was rated 'Requires Improvement' in this area. Not all of the quality assurance monitoring systems were effective and we found that not all concerns were identified. At this inspection we found the service required further improvements for it to be well-led, and further work on the quality assurance systems in place was needed.

There had been a recent meeting for people living in the home, as an opportunity for them to give feedback. Two people we spoke with felt that the feedback had not been taken on board. One was that meal portions had not been altered. Another person said, "Yes, we had a meeting about a month ago, when you could say your piece. I said about the knives and forks, you can't eat anything. I think they just disregarded what I said." This was with regard to the cutlery being blunt.

We found that the registered manager had not identified all of the concerns we found on our inspection. The registered manager told us that the provider's representative visited the home every three months and carried out their own checks. These included care plans, overseeing the registered manager's audits, and talking with people and staff. However, these had not raised any of the concerns we found either.

There were quality assurance systems in place, such as audits, and some of these had effectively led to action being taken, for example in areas such as staffing. However, some audits, such as the care plan audit, were not fully effective at picking up areas for improvement. We saw that care file audits checked whether care plans were in place, but it did not check the accuracy and detail of them, therefore not picking up gaps where we identified them. Training was not followed up by regular competency checking of staff to ensure a quality service was provided. We identified some concerns around manual handling, correct drinking apparatus, and supporting people to eat and drink effectively. These had not been identified by the provider's quality assurance systems.

The registered manager had reviewed any falls and incidents within the home, but we found that they had not always taken further action such as seeking further advice from healthcare professionals or involving the falls team where needed.

Medicines audits had been carried out regularly and these had not picked up the lack of recording or body maps around topical medicines. This meant there was an important area of prescribed items not included and properly covered on the audit, so concerns and inconsistencies were not picked up.

The registered manager showed us their planned infection control and prevention audit, which was extensive, but had not been completed. Although we did not have serious concerns around infection control in the home, it is important to maintain auditing of infection control to mitigate risk.

We had some concerns around the provider's ability to make and sustain improvements. The home was rated 'Good' in three areas at our last inspection in January 2017, and is now rated 'Requires Improvement' in all areas. Therefore the provider's oversight had not identified areas within the service that had deteriorated since our last inspection.

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

There were quality assurance surveys gathered from people, relatives and healthcare professionals. We looked at a sample of these and found that people gave predominantly positive feedback about the home. We saw that the service had received a number of compliments from families about the care provided to their relatives.

One person described the registered manager as approachable, and told us, "[Registered manager] usually comes round once a day, and the office door is always open when she's here." Staff said they felt he registered manager was approachable and always had their door open so people could speak with them. The registered manager told us they sometimes worked with staff delivering care.

Staff had knowledge of whistleblowing and told us they felt comfortable to report poor practice. The registered manager understood what sort of notifications they were obliged to send us.

People and their relatives said they felt happy to speak with the registered manager. We saw that they had the door open and were available for people and staff to speak with, and they knew people well. The registered manager told us they worked with staff at times in order to oversee work and carry out care with their team, and get to know people living in the home.

The staff we spoke with said they worked well as a team and generally they were happy in their roles. The registered manager told us they organised team meetings whenever they felt they were needed. We saw that a recent staff meeting had been held where they discussed the importance of teamwork. The registered manager had managed staff performance appropriately when they had identified areas for improvement. This included ensuring that people were supported regularly to have baths.

The service had engaged with working in partnership with other agencies to improve the home, for example, they had worked with a consultant to support them in identifying some areas for improvement. However, we found that this had not been fully effective in identifying all of the areas requiring further attention.

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Care was not always provided in line with peoples preferences and individual needs and they were not always supported to make choices about their care.<br><br>9 (1) (a) (b) (c) (3) (a) (d) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People did not always receive safe care. They were at risk because care plans had not always accurately recorded information related to risks consistently. Staff did not always mitigate risk as is reasonably practicable.<br><br>12 (a) (2) (a)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems for assessing, monitoring and improving the quality and safety of the service were not fully effective. They did not properly |

identify and mitigate risks. Records were not always complete and accurate.

17 (1) (2) (a) (b) (c)