Mr Andrew Kevin Hill

# Vine House Older Persons Residence

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

The inspection took place on 5 and 7 July 2016 and was an unannounced inspection.

Vine House Older Persons Residence provides accommodation and care for up to 17 older people, some of whom are living with dementia. At the time of our visit, there were 13 people in residence.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had been absent in the months preceding our visit and some aspects of the service had fallen behind. Whilst the quality assurance process had delivered improvements in many areas, it had not been used effectively to monitor all aspects of the service.
Staff took prompt action to respond to changes in people's care needs but records for each person were not always accurate or complete. We did not identify a direct risk to people but the lack of accurate records meant staff were unable to demonstrate that effective care had been planned and delivered at all times.

People spoke very highly of the service and that care that they received. They told us that they enjoyed the company of staff and were well looked after. One person said, "All of the staff are lovely". Another told us, "Everyone is so friendly". The atmosphere during our visit was very happy, with people and staff laughing together. There was a varied activity programme which people enjoyed.

People were valued as individuals and staff involved people in planning their care. People were encouraged to be as independent as they were able and to contribute to the life of the home. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People told us that staff treated them with respect.

People felt safe at the home. Risks to people's safety were assessed and reviewed. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. People received their medicines safely.

There were enough staff to meet people's needs. Staff had received training and were supported by the management through supervision and appraisal. People and relatives had confidence in the staff and their abilities.

Where there were changes in people's needs, prompt action was taken to ensure that they received appropriate support. This often included the involvement of healthcare professionals, such as the GP, district nurses or Speech and Language Therapist (SALT).

People enjoyed the food and were offered a choice of meals. Staff were attentive to people's needs and supported those who required assistance to eat or drink.

People, their relatives and staff felt confident to raise issues or concerns with the registered manager or provider.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the 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?

Good

The service was safe.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risk assessments were in place and reviewed to help protect people from harm.

There were enough staff to meet people's needs and keep them safe.

People received their medicines safely.

### Is the service effective?

Good

The service was effective.

Staff had received training and support to carry out their roles.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

### Is the service caring?

Good

The service was caring.

People received person-centred care from staff who knew them well and cared about them.

People were involved in making decisions relating to their care.

People were treated with dignity and respect.

### Is the service responsive?

Good

The service was responsive.

People received care that met their needs. Care plans were individualised and reflected people's preferences.

People were involved in planning their activities and enjoyed a varied programme of entertainment and events.

People were able to share their experiences and were confident they would receive a quick response to any concerns.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

Records relating to people's care were not always accurate or complete.

There system to monitor the quality of the service had not always been operated effectively.

The culture of the service was open and staff ideas were valued.

People and staff felt able to share ideas or concerns with the management.

# Vine House Older Persons Residence

**Detailed findings**

## Background to this inspection

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

This inspection took place on 5 and 7 July 2016 and was unannounced.

One inspector undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed feedback we had received regarding the service and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We looked at care records for four people, medication administration records (MAR), monitoring records including for fluids and repositioning, accident and activity records. We also looked at five staff files, staff training and supervision records, staff rotas, handover records, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with nine people using the service, two relatives, the registered manager, the care manager, two duty managers and three care assistants. We also met a visiting Speech and Language Therapist (SALT) and external activity professional. On the second day of the inspection we met with the provider. Following the inspection, we contacted the former and current clinical nurse lead, a service commissioner and a chiropodist to ask for their views and experiences. They consented to share

their views in this report.

This was the first inspection of Vine House Older Persons Residence since its registration under a new provider on 8 July 2014.

Good

# Is the service safe?

## Our findings

People told us they felt safe at the home. One person said, "I'm quite happy, I never worry". Another told us, "I wouldn't go anywhere else". Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. Staff told us that they felt able to approach the registered manager if they had concerns. They also knew where to access up-to-date contact information for the local authority safeguarding team and knew how to report any concerns.

Before a person moved to the home, an assessment was completed. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in moving and handling, pressure areas or from known medical conditions such as diabetes, these had been assessed. For each risk identified, guidelines were in place to describe how to minimise the risk and the support that people required from staff. For example, where people were at risk of falling, the assessment considered their visual perception, their gait and detailed how to safely support them when rising from a chair, washing or walking in the home. There was also detail on how to adapt support depending on their alertness, for example, we read that one person required the support of two staff members to transfer if they were tired. We observed staff supporting people to move safely within the home and to use stand aids to transfer from one chair to another. Staff were mindful of risk and reminded people to use their frames or to keep their elbows in when being pushed through a doorway in their wheelchair. Staff had kept people's risk assessments under review and updated them when changes occurred.

Each person had a personal evacuation plan in place which described the support they would require from staff to leave the premises in an emergency. Evacuation equipment was available to safely evacuate people from the first floor. The provider had an agreement with nearby services to share facilities in the case of emergency.

People told us that staff came quickly if they needed assistance. They also said that staff took time to chat with them, especially in the afternoons. One person said, "I don't often have to wait long, they're usually very good". There were a number of staff vacancies at the service and some staff absence. This had put the staffing of the home under some pressure. However, we found that the home was staffed to a safe level. The registered manager had employed agency staff to make up some of the shortfall and staff had taken on additional shifts. People and staff told us that they were familiar with the agency staff and that they asked for them by name. This helped to provide continuity of care for people. One staff member said, "It's stressful but manageable. Never have I felt anybody's at risk".

The registered manager was in the process of recruiting additional staff to support the development of the home's activity programme and to ensure adequate cover at the weekends. We looked at the recruitment information for staff who had recently started work at the service. Records showed that before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and

past employers. These measures helped to ensure that new staff were safe to work with adults at risk. One staff member told us, "I couldn't start properly before they (DBS and references) came through. I did a week's shadow. By the time I'd done that I was able to work".

People received their medicines safely. Staff who administered medication had received training and their competency had been assessed before working independently. Each person's medication was stored in a locked cabinet in their bedroom. Medicines that needed to be kept cool were stored in a fridge and the temperature was recorded daily. Creams and ointments had been dated on opening. This helped to ensure that they remained within date and effective. Medication Administration Records (MAR) demonstrated that people had received their medicines as prescribed. Medicines for disposal were recorded and returned to the pharmacy. The stock of medicines was checked regularly by nominated staff, which helped to identify any anomalies.

We noted that one person had recently been prescribed a medicine for their heart. Before administration the person's pulse should be checked. We saw that guidance to staff on when the medicine should be withheld was written in the communication book but had not been transferred to the MAR. This was quickly addressed by the duty manager to ensure that staff had a quick reference and knew when administering the medicine would be unsafe for the person. Topical creams were administered by care staff and recorded by ticking on a chart to indicate that the creams had been applied. For most people, there were body maps detailing the creams prescribed to the person and when they should be applied. This information was missing for some people. You can read more about this in the 'Well-led' section of this report.

Good

# Is the service effective?

## Our findings

People had confidence in the staff who supported them. One person told us, "You can tell they've been trained. They're very good". Staff received a combination of face to face and online training. The registered manager had introduced the online courses to supplement the training and to offer flexibility in how staff members approached their own learning. Training made mandatory by the provider included moving and handling, health and safety, medication, safeguarding, first aid, infection control, Mental Capacity Act 2005 and fire safety. Some staff had completed additional courses in palliative care, dementia awareness and pressure care. The registered manager also encouraged staff to achieve diplomas in health and social care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

The registered manager had made available best-practice information to staff. There was a reference folder on infection control and on skin integrity. This provided additional details for staff, for example, the action to take and who to contact in the event of an outbreak, such as flu or vomiting. To further staff knowledge and improve practice, the registered manager had arranged for the Care Home In-Reach team to work with the home for a period of 16 weeks. This team works in care homes to provide advice, training and information and support homes to deliver improved care, especially to those living with dementia. This was due to begin over the summer and staff were in the process of completing self-assessment forms to assess where support would be most beneficial. The registered manager told us, "It will give the staff assistance, help with what kind of activities to offer, we will go through the care plans and check medication".

Staff felt confident in their skills and abilities. New staff completed a period of induction which included orientation to the home, meeting people and other staff, training courses and time shadowing experienced staff. Staff told us that the length of the shadowing period depended on the skills of the new staff member, for someone new to care it could be a month or more. New staff were also able to work towards the Care Certificate which is a nationally recognised qualification. New staff told us that they had felt ready to start working independently. One said, "I started off from the beginning in the right foot".

Staff felt supported and told us that the registered manager and provider were approachable. One staff member told us, "The managers ask you, 'How are things?'. They're very open and you can talk to them whenever you like". Formal supervisions were arranged for staff to discuss their performance, any training needs and their ideas on how to improve the service. With the exception of two night staff, all staff had attended a minimum of one formal supervision during 2016. The provider wrote to us following the inspection to say that supervisions for all staff had been scheduled over the next four weeks. The registered manager had also introduced competency assessments for staff in medication and moving and handling. These assessments were an observation of staff practice, for example ensuring that they checked equipment was safe and respected people's dignity during moving and handling. Annual appraisals were underway and staff had received a letter inviting them to complete a self- assessment form. This form asked staff to consider their strengths and weaknesses, the support they needed to be effective in their role and their aspirations for professional development.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, one application had been made to deprive a person of their liberty, which was awaiting assessment by the local authority.

We checked whether the service was working within the principles of the MCA. Staff understood the requirements of the Mental Capacity Act (2005) and put this into practice. One staff member told us, "We assume everyone has capacity and they all have the right to choose what happens". We observed staff involving people in day to day decisions, offering assistance and waiting for people to respond to questions. At the time of our inspection, the majority of people were able to consent to their care and treatment. They had signed their care plans to demonstrate their agreement and given their written consent for staff to administer their medicines. The five key principles of the MCA were displayed in the care office as a reminder to staff. Where people had appointed a representative to act on their behalf, this was clearly recorded along with a copy of the authorisation. Staff were able to describe the action they would take if a person lacked capacity to make an important decision. They spoke of involving people close to the person and professionals to make a best-interest decision on their behalf.

People enjoyed the food at the home. One person told us that the food was very good indeed, another said, "You can have meals in your room or in the dining room. They bring a menu out". Copies of the menu for the week were shared with people in their rooms and placed on the noticeboard. Individual choices were collected by staff and passed to the kitchen. The kitchen staff also had a record of people's likes and dislikes. The chef on duty told us, "(Name of person) enjoys a really hot curry, so when others have korma she has a vindaloo. She still says it isn't hot enough!" People had also made suggestions which had been added to the menu, a recent one was Coronation chicken with a jacket potato. Mealtimes were a sociable experience, with most people choosing to eat together in the dining area. People also told us that they were able to have snacks whenever they wished. One said, "There's always fruit available in a bowl in the hallway".

Where people had particular dietary needs, these were accommodated. The chef told us that they had recently baked a gluten and dairy free birthday cake for one person. Speaking about one person who ate a Vegan diet, the chef told us, "We've got to grips with what she can have and what she enjoys". Staff assisted people by cutting up their meals and were on hand to offer assistance to those who needed it. Some people used adapted cutlery or beakers to help them eat and drink independently. Throughout our visit we observed that drinks were within reach and that staff supported people to drink. For one person who was at risk of dehydration, staff recorded their fluid intake on a chart. At handover staff gave detailed information to the next shift regarding people who had not been eating or drinking well. Where people had lost weight or were struggling to manage their meals, staff had requested advice and support from external healthcare professionals, including the dietician and speech and language therapist (SALT).

People had access to healthcare professionals and the service worked in collaboration to ensure that people's needs were met. One person told us, "They'll always make me an appointment". Another said, "They consult the doctor. They take special care that we have proper medical care". People received support from the community nurses and had been referred to the GP when concerns arose. The former clinical nurse lead told us, "I found the staff to be well informed about their clients and they contacted the community

nursing team with any concerns they had in a timely fashion, or to request a visit if required'. The SALT we spoke with said that staff had provided detailed information about the person and had listened attentively to their recommendations which they put into practice.

Good

# Is the service caring?

## Our findings

People were extremely complimentary about the staff. One person said, "They do all they can to make you feel wanted and cared for". Another told us, "The staff are lovely, I haven't met one that isn't". A third explained, "I enjoy the company, they're all very nice. I really do enjoy it". Many of the staff had worked at the home for a number of years and knew people well. Each person was given a named staff member to act as their key worker. Keyworkers took the lead in ensuring that people were happy with their care and had everything they needed. One person had written to all of the staff following their birthday. We read, 'You all made the (date) a special day for me'. Throughout our visit, we observed kind and sensitive interactions between people and staff. There was also a sense of fun, with people and staff enjoying a joke together. On a review website, one relative had written, 'Since being at Vine House my mother's health and outlook has improved by a lot. She is very happy at Vine House and thinks of the staff as family'.

People were involved in planning their care and were free to make choices about their daily routine. One person told us, "I get up at 7am by choice. I've always been used to early starts". Another said, "You can express your opinion". In the minutes of a managers' meeting we read that one person had chosen to keep their old mattress rather than moving to a higher-grade one that had been ordered for them. A relative of one person who had recently moved to the home told us, "They very thoroughly went through all the medicines and care needs. I couldn't praise it more highly".

People were asked for feedback on their care by the registered manager. This included a question on whether they felt their choices were respected. The responses in the feedback that we reviewed were all positive. Residents' meetings were arranged on a regular basis and minutes of the meetings were distributed to people. In addition people were asked for their feedback on the meals and also on entertainers who visited. This was done in an informal way, for example, following the morning activity people were asked for their opinion on whether or not they should book the entertainer again. The registered manager also produced a seasonal newsletter providing an update on the renovation works at the home, details on forthcoming events, birthdays and new staff appointments.

People were encouraged to be as independent as they were able. One person told us, "I get up and wash myself. I make the bed". They told us that staff assisted them according to their need and allowed them time to complete daily tasks for themselves. Another person explained that they were working towards using sticks rather than a walking frame and described how staff were supporting them with this. We observed that staff allowed people time and allowed them to walk, eat and respond to questions at their own pace.

People felt valued and said that they were treated with dignity and respect. One person said, "I'm understood. That's a wonderful thing". They told us that staff welcomed their family members and friends into the home. When staff spoke to us about people they described them as "Amazing" and "Wonderful". It was clear that they cared about them and admired their achievements.

Staff were mindful of people's privacy. They took care to offer support discreetly and did not discuss people's care within earshot of others. A relative told us, "The carers aren't obtrusive, there's a good

balance". Another relative had written on a review website, 'He is treated with dignity and great kindness and his relaxed response and improvement since he came to Vine House is obvious to everyone who visits him'.

Good

# Is the service responsive?

## Our findings

Staff knew people well and understood how they liked to be supported. When a person moved to the home they and their relatives were asked for information about their experiences and interests. One person told us, "They ask what you like and all that sort of thing". A relative had written on a review website, 'The home is small and all the staff are very caring and know mother-in-law's likes and dislikes'. There was information for most people regarding their background, such as their family, where they lived and worked and their hobbies and interests. The registered manager had completed a 'personalisation checklist' to assess whether people's care was person-centred. It asked people whether they were helped to be self-directing and fully involved in their own decisions. One person had responded, 'Carers allow me to help myself' and, 'Yes, they do everything I want them to'. People told us that staff responded promptly if they needed assistance. One said, "They come quickly. There are alarms (call bells) all over the place".

Each person had a care folder which detailed the daily tasks they were able to manage independently and those where they required support from staff. Information was arranged into sections such as communication, eating and drinking, mobility and oral care. The care plans included details of people's preferences, such as the time they like to get up, if they preferred a bath or a shower and whether their door should be open or closed at night time. Where people were living with specific illnesses such as Parkinson's or Coeliac disease, additional information on the symptoms and management of the condition had been included for staff. A summary care plan was kept discreetly and available to staff at each person's room. This provided key information on how to communicate with the person and their support needs with mobility and continence. Care staff completed a daily log to record the support they had provided, for example if they had had a bath or shower, a shave, nail care and if their skin was in a healthy condition.

Changes in people's care needs were discussed during the handover meeting and recorded in the staff communication book. We heard staff discussing how much people had to drink, new medicines that had been prescribed, feedback from professional visits and the time of day that support, such as repositioning to reduce the risk of pressure injury, was due. Staff took action to respond to changes in people's needs or health. When one person had presented with behaviour that was out of character, staff had responded by seeking advice from external healthcare professionals. They had also started to record the details of any incidents on an ABC (Antecedent-Behaviour-Consequence) chart. This record should help staff to identify any patterns in behaviour and to ascertain what is triggering the behaviour. Another person's record had been updated to reflect that they now preferred a shower to a bath. The duty manager said, "All the staff know the clients, know their way, know their needs. They know if they are not quite right". The clinical nurse lead said, 'We never get inappropriate referrals from them and they also call us promptly if they need us to see a patient'.

People had been invited to review their care. The registered manager had met with people individually during January and June 2016. Questions included whether people felt they were treated with courtesy, if staff spent time when them if they felt lonely, if there was anything they were unhappy about and if any changes were needed in their care. The feedback from people had been positive and any actions had been shared with their keyworker and the care manager. A relative told us, "I couldn't speak more highly. Their

welcome and care and attention has been faultless". Although we found that staff provided responsive care to people, we found that some records were not updated and did not demonstrate effective monitoring of specific needs. You can read more about this in the 'Well-led' section of this report.

People were able to participate in a variety of activities and were asked for their ideas and feedback. There were regular sessions with external entertainers, including discussion, music and craft. Furthermore, special visits from ponies and birds of prey had also proved very popular with people. The home also organised events such as barbeques and afternoon tea to which local friends were invited. Sometimes, local groups including a choir from a local school were invited to the home to meet with people. One person told us, "There are things to do. On Wednesday we have a clergyman do a little service. You can go in the garden, it's a lovely garden". Another person said, "When it's warm we have barbeques out the back". A third person, who was an artist, explained that they had been asked to run a small art group and that three people had already expressed an interest. In the records of activities we saw that some afternoons, staff arranged gentle exercise sessions, nail painting and foot spas. They told us that in the summer months they tried to take people for coffee in the town or to the local pub. People were happy with the activities on offer and told us that they enjoyed the company of staff. At the time of our visit the post of activity coordinator was vacant. The registered manager was working to recruit to this post and to further develop the activities available to people.

People felt able to raise any concerns with staff. One person said, "I can discuss things I need to discuss with them. I never feel shy to do so". Another told us, "If I was unhappy I'd tell them. I know very well they'd take notice". People were invited to join residents' meetings and to share their views on the service. In the minutes of recent meetings we saw that staff vacancies had been discussed, an update provided on the renovation works and that people had been asked about the menu and activities. People had provided feedback on the new call bell system saying that they found it easier to use and that they would like the owls to come again. Visiting professionals told us that staff listened to their suggestions and concerns. The SALT said, "They're very obliging, caring and friendly". An activity provider told us, "They're accommodating and helpful"

The complaints procedure was displayed in the home. This explained how to make a complaint and the anticipated timescales for response. We saw that the complaints procedure had been explained during residents' meetings. We looked at a complaint that had been received during 2016 and found that it had been addressed in line with the provider's policy. The registered manager said, "I'm very honest and upfront about complaints. If somebody asks for something we get it straight away. We don't know unless they tell us". We noted that the provider's complaints policy did not make reference to the Local Government Ombudsman as a point of contact. This would be useful to complainants should a complaint not be resolved to their satisfaction. Following our inspection, the registered manager sent us an updated version of the policy where this information had been added.

Requires Improvement

# Is the service well-led?

## Our findings

The registered manager had been in post for a year and had registered with the Commission in February 2016. In the months preceding our inspection, the registered manager had been on a period of planned absence. While there was evidence of positive improvements in the service during the registered manager's time at the service, some areas of the service had suffered from a lack of oversight and had fallen behind. The registered manager was present during our inspection. She told us, "Everything is behind. I haven't been here for three months. It's playing catch up".

The records of people's planned care were not always complete and detailed written guidance was not always available to staff. In one file we found that the care plan was missing. Details of their support could be understood from the assessment but the description of how to deliver care to this individual had not been included. In another file the detail on the person's background and interests was missing. For some people, there was no guidance on the topical creams they had been prescribed and on where they should be applied. This information was intended to be included in a file used by care staff to record the personal care they had provided to people. We also found that some records had been duplicated. For example, staff used body maps to record injuries, such as bruising or skin tears that people sustained. Where body maps had been included in different folders relating to the person's care, the information was fragmented and not always documented. This meant that it was difficult to build up an accurate picture of what had happened, to monitor the person and to spot any patterns in order to minimise future risk.

Records describing the care that each person received were not always complete. We found gaps in monitoring records including for bowels, weight and repositioning. For one person, the records indicated that they had not had a bowel movement for 11 days. This person was cared for in bed and was unable to use the toilet independently. This same person was assisted to change their position every four hours by staff to reduce the risk of developing pressure areas. Although we heard staff discussing the time the person was next to be turned, we found that staff were not regularly recording this person's turns during the day shifts.

We discussed our concerns with the registered manager. She told us, "There is too much information (in the care plans) and it crosses over". The care manager said, "We need time to make sure all (care plans) have got what they should do. If it's not there it becomes verbal". The care manager was in the process of reviewing and updating people's care records. At the time of our inspection five of the 13 had been updated. She told us that due to staffing pressures, time allocated to administration had been lost as senior staff had been required to provide direct support to people. We observed that staff were attentive to people's needs and that they were proactive in discussing any concerns or changes to the person's health. A community nurse who worked with the service during 2015 told us, 'They monitored their clients for pressure injury and sought advice if a client appeared to be deteriorating or was losing weight'. Although we were confident that people were receiving safe and responsive care, the lack of accurate records could put people at risk of inconsistent care.

Following our inspection, the provider informed us that the registered manager had checked the body maps and guidance regarding topical creams for each person. The registered manager added that they had employed a member of staff from an agency to allow the care manager to focus on updating the care records.

The registered manager had introduced a series of audits to monitor the quality of the service. This included audits of medication, infection control, health and safety, mattresses and maintenance. The frequency of these audits varied, with most areas being assessed twice between October 2015 and July 2016. There was evidence of improvement as a result of the audits, including the timely return of medicines that were no longer required, thorough cleaning of the home and improvement in staff use of personal protective equipment (PPE). Action had also been taken in response to external audits, including a fire risk assessment commissioned by the provider in June 2016.

Although a system to monitor the quality of the service was in place and had delivered some improvements, it had not been effective in all areas. Most of the registered manager's audits were intended on a monthly basis. Due to absence, these had not always been completed. For example, the audit on care plans was last completed in January 2016. This had not been repeated and issues relating to the completeness of people's care records had not been addressed. Accidents and incidents had been reviewed in July, but prior to that the last review was in February 2016. This could mean that trends or patterns were not promptly identified. Regular audits would help to pick up any issues in a timely way and to take any necessary action.
The lack of an accurate and complete record in relation to each person and the failure to effectively audit all aspects of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff spoke highly of the registered manager. One staff member told us, "It's been much better. She seems to know her stuff. She's done a lot of updating. She is approachable". The chiropodist said, "They've made some positive changes, it gets the thumbs up from me". There had been improvements in the training available to staff, the breadth of the activity programme and in monitoring the service. The registered manager had made arrangements with external companies to carry out checks and cleaning on a rolling programme, this included checks on equipment such as hoists and the cleaning of carpets and chairs. A new call bell system had been installed in the home and the provider had continued to make improvements to the environment and facilities. At the time of our inspection a new shower was being fitted in the downstairs bathroom and there was a new cooker in the kitchen. The registered manager was keen to develop the service and improve people's experience. There was a printed copy of an inspection report for another service rated 'Outstanding' by the Commission. The registered manager told us, "I always read it to see what we can do better".

Staff felt valued and said that the management listened to them. The provider was usually based at the service and was available to staff. Before each staff meeting, there was a suggestions box where staff could propose topics to be added to the agenda. Staff told us that their suggestions, such as to increase staffing during the afternoons, were being acted upon. A staff survey in June 2016 had shown over 80 percent of staff as 'Very satisfied' or 'Satisfied'. Staff said that they were able to approach their seniors for advice. They suggested made suggestions for improvement including the recruitment of an activity coordinator and ensuring regular supervision. The registered manager had responded to this feedback.

There was an open atmosphere at the home and everyone we spoke with was happy to raise any concerns they had. Relatives told us that they were kept informed of any changes or incidents. The registered manager was able to describe their responsibilities under duty of candour. This regulation sets out the provider's responsibilities to look into any accidents or incidents involving people and reporting these to

any representatives or relatives along with an apology if applicable. At the time of our inspection, the provider did not have a policy regarding duty of candour. Following our visit the registered manager sent us a copy of a new policy which had been introduced and shared with staff.

People and their relatives were complimentary about the home. One person told us, "It's a lovely home". A relative had written on a review website, 'She (person using the service) calls it home from home and is very happy there. Everyone is very friendly and helpful, can't do enough for her. Excellent place.' The home had been amongst the top 20 recommended care home in south east England for 2016 on a review website. The staff group were positive about their roles and said they enjoyed the work. One said, "It's like coming from our own family to another family. We work really well together. The majority of us have been here long term".

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to maintain an accurate and complete record in respect of each person.<br><br>The system to ensure compliance with the requirements of the regulations had not always been operated effectively.<br><br>Regulation 17 (2)(a)(c) |