St Vincent's Hospital

St Vincent's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The unannounced inspection took place on 24 and 25 October 2017. During the last comprehensive inspection in August 2015 we found the service was meeting our regulations.

St Vincent's Nursing Home provides accommodation for a maximum of 60 people. The service has four units each of which accommodates 15 people in single rooms each with en suite facilities. Each unit has communal dining, sitting rooms and bathing facilities.

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

We identified a number of shortfalls with medicines management which could place people at risk of not receiving their medicines safely.

Individual risk assessments were in place but risks were not always accurately recorded. The staff had not always identified risks in the care records and updates did not always accurately reflect changes in people's needs and risk levels so appropriate plans could be put in place to mitigate these risks.

Input from people and, where appropriate, their representatives was not evidenced in care plan reviews. Although the service had auditing and monitoring processes in place, these were not robust and did not always identify changes and shortfalls so they could be addressed.

People, visitors and healthcare professionals were happy and praised the good quality of care being provided at the service. Staff treated people with dignity and respect and care was person centred. The service was homely and staff worked hard to cater for each person's individual needs and preferences. People's religious needs were identified and being met and the service offered care to people from any faith or culture and respected diversity.

Recruitment procedures were being followed so that only suitable staff worked at the service. There were enough staff to meet people's needs and staffing was reviewed if dependency levels changed. Staff received

safeguarding training and knew to report concerns.

Risk assessments for equipment and safe working practices were in place to mitigate risks to people visiting and working at the service and were updated annually.

Infection control procedures were in place and being followed to maintain a clean environment and protect people from the risk of infection.

Staff received training to provide them with the skills and knowledge to care for people effectively. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA).

People's dietary needs were identified and met. People enjoyed the food provision and choices were available to meet people's preferences. People received input from healthcare professionals and changes in care and treatment were recorded and implemented.

Care plans were person-centred and reflected people's individual care and support needs. There was a wide range of activities that were provided and people were encouraged to join in as much or as little as they wished to.

The complaints procedure was available and people, relatives and staff felt able to express concerns so they could be addressed.

Staff said the registered manager was visible and very supportive. Meetings and surveys took place so people, relatives and staff could discuss any matters and provide their feedback about the service.

We found two breaches of regulations at this inspection. These were in regards to safe care and treatment and good governance. You can see what action we have asked the provider to make at the end 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

Aspects of the service were not always safe.

We identified shortfalls with medicines management which could place people at risk of not receiving their medicines safely.

Individual risk assessments were in place, however risks had not always been identified and updates did not always accurately reflect changes in people's needs and risk levels so appropriate management plans could be developed to minimise the risks.

Staff received safeguarding training and knew to report concerns. Recruitment procedures were being followed so that only suitable people worked at the service. There were enough staff to meet people's needs and staffing was reviewed if dependency levels changed.

Risk assessments for equipment and safe working practices were in place to mitigate risks to people visiting and working at the service and were updated annually. Systems and equipment were being serviced and maintained in good working order.

Infection control procedures were in place and being followed to maintain a clean environment and protect people from the risk of infection.

Is the service effective?

Good

The service was effective.

Staff received training to provide them with the skills and knowledge to care for people effectively. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA).

People's dietary needs were identified and met. People enjoyed the food provision and choices were available to meet people's preferences. People received input from healthcare professionals.

Is the service caring?

Good

The service was caring.

People, visitors and healthcare professionals were happy and praised the good quality of care being provided at the service. Staff treated people with dignity and respect and care was very person centred.

The service was homely and staff worked hard to cater for each person's individual needs and preferences. People's religious needs were identified and were being met and the service offered care to people from any faith or culture and respected diversity.

End of life care was planned and people's dignity was preserved and people and their families could spend time together.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and reflected people's individual care and support needs. There was a wide range of activities that were provided and people were encouraged to join in as much or as little as they wished to.

The complaints procedure was available and people, relatives and staff felt able to express concerns so they could be addressed.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Although the service had auditing and monitoring processes in place, these were not robust and did not always identify changes and shortfalls so they could be addressed.

Staff said the registered manager was visible and very supportive. Meetings and surveys took place so people, relatives and staff could discuss any matters and provide their feedback about the service.

St Vincent's Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 unannounced inspection took place on 24 and 25 October 2017. Before the inspection we reviewed the information we held about the service including notifications and information received from the local authority. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

The inspection was carried out by two inspectors, a specialist advisor pharmacist 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. The expert by experience had experience with care services for older people and people with dementia.

During the inspection we viewed a variety of records including the care records for 11 people, some in detail and some looking at specific areas, the medicine administration record charts for 25 people and carried out stock checks of 22 medicines. We also looked at five staff files, risk assessments for nine people and sampled those for the premises, systems and equipment, kitchen records, servicing and maintenance records for equipment and the premises, audit reports and policies and procedures. We observed the interaction between people using the service and staff on three units during the lunchtime meal and on all units throughout the inspection.

We spoke with the registered manager, the deputy manager, six registered nurses, six care workers, one activities coordinator, two domestic staff and the chef. We also spoke with 16 people using the service, seven relatives and volunteers and one visiting health care professional. Following the inspection we sought feedback from five other healthcare professionals and received this from three of them.

Requires Improvement

Our findings

Each person had a care file which contained a section for risk assessments with a separate sheet for each identified risk. These included physical and medical risks as well as behavioural and environmental risks. Each risk assessment identified the level of risk and possible harm, along with measures or actions required to mitigate the risk. There were assessments for the use of bed rails or wheelchair lap belts with action plans to minimise the risks. In addition there was a range of other risk assessments such as risk of falls and risks in respect of skin integrity and nutritional status, with associated care plans. The assessments and care plans were updated on a monthly basis so that any changes could be identified and addressed.

One person had shown a slow but steady loss of weight during the year. This person's weight was now low enough to fall into the high risk section of the nutritional risk assessment which, according to assessment, should have triggered a referral to a dietitian. However, the monthly evaluation recorded their weight as 'stable' and there was no mention of closer monitoring or referral to a dietitian. Another person had had a number of falls recently which had been recorded in a falls diary in the risk assessment section. The care plan had not been updated to reflect this change and the monthly evaluation noted that there had been no falls since the use of a reclining chair had been introduced. However there had been a number of falls since the last evaluation so the information was not accurate.

One person's care plan specified they were to maintain fluid intake of 1.5 to 2 litres per day due to risks associated with medical conditions. However, although staff said they made sure to provide adequate fluids every day and saw how much had been taken, they did not record this. Another person had an allergy to nuts which had been noted on their admission form at the front of the care file. This had not been included in the care plan for eating and drinking and there was no risk assessment form completed. Although the care staff were aware of the allergy, the kitchen staff had no record or awareness of this risk so they could take the necessary precautions when preparing meals for the person.

We saw evidence of people's currently prescribed medicines on the Medicines Administration Records (MAR). The allergy status of all people was recorded to prevent the risk of inappropriate prescribing both on cover sheets and the MAR. However for one person they were recorded as being allergic to penicillin but had been prescribed and administered a course of amoxicillin. The registered manager said they would investigate this after the inspection. The investigation identified that the person was in fact not allergic to penicillin. However, had the person been allergic to penicillin they would have been placed at risk of harm because staff had not noted the allergy status written on the MAR.

We counted 22 random samples of supplies of medicines and could reconcile 15 of the samples with the records of receipts, administration and disposal. The seven samples we could not audit were mainly for the anticoagulant medicine, warfarin. For one person the doses recorded did not correspond with the dose prescribed by the anticoagulant clinic although the dates and results of blood tests were kept with the MAR. Overall we were not always assured that medicines were administered as prescribed.

If people were prescribed medicines to be given as required (PRN) there were no protocols in place so that staff knew when and how often they should be given. This was raised during a previous inspection of the service and the provider gave assurances that it had been addressed. It was also identified in an audit by the supplying pharmacist in July 2017 and by the local authority quality assurance monitoring report in September 2017. When a variable dose of a medicine such as one or two was administered, this was not always accurately recorded so that the prescriber could determine the effectiveness of the medicine.

The above paragraphs are in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Several people were able to self-administer some of or all of their medicines and we saw a record of the assessment to determine that this was safe. On two units of the service individual medicines cabinets had been installed in all the bedrooms to facilitate a more personalised administration. We were told that this had been well received by some more active people and that it was more accessible for those who stayed in bed. There were plans to install the same in the other units,

We looked at 35 MAR in detail and saw no gaps in the recording of administration of medicines. We observed lunch time medicines administered in one unit. We saw that this person liked her medicines to be given in her room so we saw her escorted back after lunch and then given the medicines with patience and explanation.

We noted from the MAR and GP record sheets that medicines were reviewed regularly and dosage changes were clearly documented. The GP visited weekly and also when a specific concern arose. Many people had received a flu vaccination and we saw consent forms for these had been completed.

People had assessments to identify whether they were in pain and these were kept with their care plans and regularly reviewed. Several people could not swallow and had their medicines crushed and given covertly and we saw that this was agreed with the person's family and GP as being in their best interests. One person had an enteral tube to administer food and medicines and we saw the protocols and records to monitor their fluid intake, tube flushes and tube maintenance and records of review by the dietician.

All medicines were stored safely in the service in locked clinical rooms and cupboards and trolleys. Temperatures were recorded daily in the clinical rooms and for the medicines fridge to monitor that the medicines were being stored appropriately. Controlled drug records were all accurate and regularly checked by staff. The registered nurses checked the MAR at each shift change and we saw records to support this. The provider had medicines policies and procedures available and these were currently under review.

People confirmed they felt safe at the service. One person told us, "I'm perfectly safe here there's never been any problem with staff." Staff told us they had been trained in safeguarding and all were able to provide definitions of different forms of abuse. They were aware that the provider had policies and procedures for safeguarding and whistleblowing and were able to explain the procedure for reporting any concerns to the nurse on the unit, followed by the service manager and then the CQC. Telephone numbers for the local authority safeguarding team were displayed on noticeboards in the service. Staff all said that they had never

had any cause for concern with regard to people's safety and well-being.

The last fire risk assessment had been carried out in November 2016 and work had been completed to address the areas identified for action. There were emergency plans for each person with details of individual mobility needs in the event of an emergency evacuation, any equipment required and the number of staff needed to assist them. Fire systems and equipment were serviced at the required intervals and action was taken to address any maintenance required. Each care file contained a recent photograph and a physical description of each person, along with a brief overview of their communication abilities, so this could be provided to the emergency services if required. Risk assessments for premises, equipment and safe working practice were in place and had been reviewed in the last 12 months to keep the information up to date.

The premises were being well maintained and systems and equipment were being serviced at the required intervals to maintain them in good working order. Accident and incidents were recorded, however we did not see any audits to identify trends and patterns so action could be taken to prevent reoccurrence. The registered manager said they had two staff that had attended recent falls management training and were the Falls Champions for the service. They said people were referred to the falls clinic if a pattern emerged but this had not been evidenced in the records. We discussed recording the actions taken to manage falls and the methods in use to minimise them.

Employment checks were carried out to ensure only suitable staff worked at the service. Prospective staff completed application forms which included a medical fitness declaration and their work history, with explanations for any gaps in employment. Other checks included pre-employment checks with two references including one from the previous employer, a Disclosure and Barring Service (DBS) check, proof of identity including copies of passports and evidence of people's right to work in the UK.

We observed that there were enough staff on duty to attend to people's needs and saw that they responded swiftly at all times when people asked for help or required assistance. Staff confirmed that they considered there were adequate staffing levels at all times and said that the number of staff had increased in response to increased dependency levels of people living at the service. The service also provided placements for health care students who worked alongside the permanent staff to gain experience.

All areas of the service were clean including communal areas and bathrooms. All bedrooms had en suite facilities and all those inspected were clean. Staff wore protective aprons and gloves when delivering personal care and when serving food. Staff told us they received regular training on infection control and policies and procedures for infection control were in place. Domestic staff were observed using colour coded cleaning equipment and were able to explain how this was used for different parts of the service.

The kitchen was clean and well organised. Records of daily safety checks for fridge and freezer as well as food temperatures were up to date. There was a cleaning schedule and associated cleaning records were up to date. The last environmental health officer food hygiene rating score was 5, which is the maximum score for being very good. The laundry was well organised with separate colour coded and labelled laundry bins for delivering items to be washed. Bed linen was delivered in separate large laundry bins. Each person had their own named container for returning clothes which had been washed. All items of clothing were marked or labelled with the relevant name or room number.

Good

Our findings

Staff said they received regular training in all relevant aspects of their work and were able to give examples of recent training such as fire safety, health and safety and safeguarding. Staff said they understood the needs of the people they cared for and could access information by reading the individual care plans. Care staff were able to explain how to support specific people and it was clear that they were familiar with people's individual needs and characteristics. The activities coordinator told us that specialist training had been undertaken by activities staff to help them in their work. Training records showed several staff had undertaken a recognised qualification in health and social care, mandatory health and safety training topics and training relevant to people's diagnoses.

Staff said they had supervisions every six months and annual appraisals to review their performance and discuss any training needs along with any concerns or queries about their work. The registered manager said they arranged more regular supervisions for staff if any issues arose, so that they could guide and support them. Catering staff received relevant training in food hygiene and other mandatory training such as first aid and infection control.

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 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The staff used observation and a 'mini mental' assessment to assess a person's mental state. DOLs applications had been made for several of the people living at the service although this was not recorded in the care plans. However, the care plans did identify if people lacked mental capacity to make decisions and the registered manager said they would add the DoLS information. The nurses had received recent training in MCA and DoLS and were knowledgeable about the processes followed at the service if a person lacked mental capacity and were aware that decisions must be made in the person's best interests. Knowledge about MCA and DoLS among the care staff was limited but they said they always sought consent before offering to assist with care and support and this was confirmed by observation where we saw staff offering

choices and ensuring agreement, communicating clearly and appropriately with each person. The registered manager said she would arrange MCA and DoLS training for the care staff. Care staff said they would report any signs of deterioration in people's mental capacity to the nurse on duty. Staff knew those people who were on DoLS authorisations and who could not exit the service alone and would accompany people if they wanted to go out for walks.

People, or, where appropriate, their legal representatives had signed and dated the care plans to indicate they had agreed to care and treatment. One representative told us, "Yes I am involved in every decision, which is for [person's] interests." Another said, "Yes I do feel I have time to make decisions on my own and my views are heard, even though we might not always agree on everything." The involvement of people or of their representatives were also seen in other aspects of care such as the use of bed rails, lap restraints and in making advanced decisions such as admissions to hospital and resuscitation wishes. Advance decision forms were also signed and there was evidence of consultation with people and their representatives for 'do not attempt cardiopulmonary resuscitation' decisions.

People were happy with the food at the service. One person said, "I have choice to choose from, if I don't like it, I can request for something else like sandwich." Another said, "If you want to know how many stars I'd give the food I'd give five." People's nutritional status was assessed and updated monthly and people were weighed each month. The admission details highlighted any allergies and any special dietary requirements, such as a diabetic diet. There was a section of the care records for eating and drinking which provided information about any dietary needs, for example if the person needed assistance with eating or required soft food along with any particular preferences or dislikes and meal time routines.

There was a four weekly menu plan which offered a varied and balanced selection of food. There were choices at breakfast, lunch and supper including vegetarian options. The kitchen staff had a form for each person with any dietary requirements noted, such as pureed food, diabetic or vegetarian diet. Information on requirements such as the need for soft or pureed food or other special requests, for example, no rich or spicy food, was also typed onto the menu choice forms for each day to avoid the risk of omission. Hot and cold drinks were available at all times during the day and we saw that people were promptly provided with these when they asked. Coffee and tea was served in the morning and afternoon with biscuits and also cake in the afternoon. There was a water dispenser on each unit and jugs of water were available in individual rooms.

There were well maintained records of input from health care professionals, including GPs, opticians, chiropodists and physiotherapists. There was evidence of input from the tissue viability nurse specialist in wound care files with guidance on wound management and dressing regimes. People living at the service were registered with a local GP practice and a GP visited the service each week and when required for consultations with people or to conduct general health or medicines reviews. We spoke with one GP who was extremely positive about the quality of care and support provided at the service. They said communication with the staff was excellent and staff responded quickly and efficiently to any health concerns and always sought appropriate advice and input from other health professionals when needed.

Feedback received from three other healthcare professionals was also very positive. Their comments included, "The staff are very engaging and attentive. They are always very sensitive to each resident's [healthcare] needs and always happy to help and assist at visits as well as after with any discussion. There is regular communication between the staffing team and myself and I have always found any advice I have given to be implemented with the relevant resident", "I have found the communication among the staff is good and effective as there is continuity and consistency in the staff. At reviews the staff were able to give me a feedback on patients' progress and their response to treatment" and "The staff communicate very well

with myself with regard to the [healthcare need] and if I make any recommendations with regards to [healthcare need] or suggest any referrals (i.e. for further investigation by the patient's GP), I am informed that this has been implemented."

The environment and premises at the service were of a very high standard and were suitably adapted for the needs and comfort of people living there. All areas of the service had high quality floor coverings, furnishings, fixtures and fittings. Communal areas, bathrooms and bedrooms were very well appointed and all bedrooms had en suite facilities which were easy to use. All doorways, corridors, lifts and other access points were wide and hazard free making them easy to navigate for those with limited mobility, walking aids or wheelchairs. There were communal lounges and dining rooms on each unit as well as smaller, quieter rooms and seating areas. There was a large, well maintained and secure landscaped garden with wide, level pathways that could be used for those in wheelchairs and ramps from doors into the garden, and a variety of good quality seating areas throughout the grounds.

Good

Our findings

People living at the service were positive about the care provided and the attitude of the staff. One person said, "The staff are very good and compassionate, they work very hard." Another told us, "They [the staff] do a very good job, very caring and loving people." A volunteer who visited the service frequently said, "I think the staff are exemplary. There is a very warm atmosphere and everyone is made welcome." Another told us, "The staff work as a team. I am very happy with staff work and conduct, the resident feels valued, I am positive about the care they deliver." We saw that relatives and visitors were made welcome and that there were positive and friendly relationships with staff.

Feedback from healthcare professionals was also positive. One told us, "The care is excellent. The home goes to great lengths to care for people, including end of life care and always try to avoid hospital admission if they possibly can. They are very quick to identify any concerns and always get in touch with us promptly when they need our input. I would have no hesitation in recommending them." Another said, "I have no negative comments whatsoever to make. In my opinion the service offered to the residents is excellent, and I am sure their needs are fulfilled as best as is possible." A third fed back, "I cannot speak highly enough of the team at St Vincent's."

Staff communicated well with people and understood their differing care and support needs and how best to support each individual. One person told us, "The staff here are lovely they're always very helpful." Staff were cheerful and patient, made good eye contact when talking with people, offered choices and took time to listen to what people needed. Call bells were promptly answered and staff were available to help people to move around the service, provide drinks and assistance to those who required help with eating. Staff were proactive in engaging and interacting with people throughout the day.

People's preferences were documented in care plans, such as food preferences, sleeping and waking times and mealtime routines and there was information about activities and hobbies people enjoyed. One person said, "I can do as I choose here. I get up and go to bed when I want and they don't bother you if you just want to stay in your room." Care records contained a 'life history' which provided background on their past including information on their career, family and any significant events. This provided staff with talking points and information to identify common interests and to use when planning activities. People were encouraged to maintain their independence, for example by ensuring people could store and use mobility aids and their own transport and carry on their social lives in and outside of the service.

Although the service primarily catered for those of the Catholic faith, people of other religious beliefs or

secular lifestyles were also welcomed at the service. There was a chapel and a Catholic Mass was held daily for those who wanted to attend and this could be relayed to people's rooms if they wished. There were also activities that took place during the morning so people had options and also to provide for people who did not wish to attend or listen to the service. People had their own napkin rings in the dining room and they were encouraged to bring in favourite items of furniture and pictures to personalise their rooms and make them homely. Staff listened to what people wanted and were willing to change items to better meet someone's preferences. For example, changing the colour and design of the curtains in someone's room.

Personal care preferences were recorded along with any wishes with regard to the gender of the care staff providing personal care. We saw these preferences were reflected in care delivery records, for example, people had baths or showers according to their recorded wishes. Food preferences were being met. One person said, "The meals are very nice, we do have choices to select from. I am [nationality], they provide [nationality] food I can always choose from." The chef told us that dietary ethnic or cultural requirements would be accommodated if necessary.

We observed that people's privacy and dignity was respected and staff ensured that bedroom and bathroom doors were closed when delivering personal care. We saw that staff knocked on bedroom doors before entering. Staff offered people choices about the care and support they received and respected these. People looked well cared for and were dressed to reflect their individuality and, where appropriate, their religious vocation. A hairdresser attended the service regularly and there was a hairdressing salon where people could book appointments.

There was an advance decision form in the care records which set out people's wishes regarding admission to hospital, continued treatment and resuscitation. These gave a clear overview of each person's wishes and were signed by the person or, where appropriate, their representative. Care plans specifically for end of life care were completed at the appropriate time and followed by staff. Nursing staff had received end of life care training to include the administration of fluids under the skin and administration of prescribed medicines via a syringe driver, to keep people hydrated and comfortable when they were no longer able to take fluids or medicines orally. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documents had been completed and were kept at the front of the person's care records and staff were aware of those people who had a DNACPR order in place, so this could be respected.

There was a 'no one should die alone' (NOSDA) policy that had been implemented at the service. This meant that when loved ones were not present, someone from the service, either a volunteer or a member of staff, would be available to sit with a person who was dying to provide companionship and comfort. The NOSDA policy had been reviewed in February 2017 to gain feedback from those who had sat with people. One member of staff had said, "I remembered what you said that no one should die alone so I went to sit with this lady while her daughter went home to freshen up, and I am glad I did because she died soon after her daughter left." People living at the service were also able to volunteer for this. One person had commented, "I went to sit with her before I went to bed and went to see her in the morning." The nurse who had implemented the system had observed, "The positive outcome of NOSDA is I feel I have raised awareness among staff" and they used the feedback they had received to evidence this. The registered manager said if necessary they allocated additional staff to ensure the NOSDA policy could be implemented for anyone nearing the end of their life.

Funerals could be conducted in the chapel. Although the service was Catholic, they were happy for funerals for people of other Christian denominations to take place there also. We spoke with a Church representative who told us that in addition to Catholic funerals they had been asked by families to conduct funerals for people from the Church of England and the Church of Scotland. They said they had been happy to do so and

said they were 'honoured' to have been asked.

Good

Our findings

People confirmed they felt staff responded to their needs and wishes. People were assessed to ascertain their needs and wishes. There was a form with admission details providing an overview of the person's details, including date of birth, date of admission contacts for next of kin, GP, a physical description, communication abilities, medical history, dietary needs, allergies, and information about people with power of attorney, advanced decisions and resuscitation status. Care records contained a form outlining the daily routine for that person, including details on sleeping and waking routines, personal care preferences, eating habits and social routines. These forms were well completed and gave a clear picture of each person's normal routine and preferences. This meant that daily care could be tailored to each individual to suit their needs and wishes. There were person centred care plans for different aspects of care, including physical, medical, spiritual and social needs. Care records provided a good picture of the person, their needs and how these were to be met.

We viewed the wound care plans for two people and saw that they were generally well maintained with records of dressing changes and wound progress, photographic evidence of wound status and wound management advice from the tissue viability nurse. We looked at the care plan for a person who was being fed through a tube and saw the detail of care which included their feeding regime and care they were to receive. Some people had specific care plans to address their individual medical needs such as caring for in-dwelling catheters or managing diabetes. There were good practice guidelines for the care required with information on signs and symptoms and effective monitoring to identify any concerns.

There was a display board in each unit with photos, names and designation of staff including nurses, care assistants and domestic staff. All staff wore uniforms and name badges so that they could be easily identified by people and visitors.

There were dedicated activities staff and activities were provided every day, including weekends. Staff had undertaken training with the National Activity Providers Association (NAPA). We spoke to the one of activities coordinators who outlined the wide variety of activities on offer for those living at the service. This included activities and events which took place inside the service and outings and trips organised on a regular basis. There was a large, well equipped activities room with materials for arts and crafts and we saw that people had made decorations and other items for upcoming events such as Halloween and Christmas.

External entertainers including a variety of musicians visited the service regularly. Notice boards displayed photographic collages from these sessions as well as photos of other events including summer garden

parties, a canal boat trip, animal and wildlife visits, outings and birthday celebrations. A Halloween party was planned with decorations made by people and there were trips planned for the upcoming festive season for Christmas shopping and to see the Christmas lights. There were arrangements with local schools for children to visit the service, for example, to sing carols during the Christmas period.

The activities coordinators said there were one-to-one sessions with people who preferred to stay in their rooms and we saw evidence of this during our inspection. There were daily records of participation in separate activities sessions as well as records of one to one sessions. Activities staff were also supported by a group of volunteers who came to the service most days and spent time visiting people in their rooms and supporting them in their daily lives.

As well as services from the chapel being relayed to televisions in the individual bedrooms for those that were unable to attend, there was a poetry group who met in the chapel and these sessions were also transmitted to people's bedrooms so they could listen and watch if they wanted to. The registered manager said they were looking at other areas where the television system could be used for information sharing, so people who were bed bound or chose to stay in their rooms could be better informed about events around the service. We saw several people enjoying the garden during our visit, either with family members, with other people living at the service or with the assistance of staff if required.

There was a complaints procedure that was displayed in the service. People said they felt confident to raise any concerns so they could be addressed. We saw one complaint for 2017 and this had been investigated and an action plan put in place to address the concerns raised. We asked people about their experience of raising concerns. Although people felt they could raise any concerns, some were unsure if they had received feedback when they had raised concerns. The registered manager did not keep a record of concerns that had been raised, so we could not follow this up. We discussed complaints and concerns with the registered manager who said she would review the process so that any concerns, however minor, were recorded along with the response to the individual, to evidence the concerns had been addressed.

Requires Improvement

Our findings

Monthly evaluation forms were completed by nursing staff for each separate care plan to provide information on progress, highlight any concerns and document any changes. However, although all evaluation sheets were up to date, they were often repetitive, lacking in detail and did not always reflect increased risks that had been identified over the last month. For example, for someone who had fallen during the previous month, the evaluation form did not include this information. For another person the review had not identified they had a nut allergy and that this was not noted in the appropriate care plan. The audit diary listed that medicine audits were to be carried out internally every month, however only one had been completed in the last three months. This had not identified the areas for improvements we found at this inspection such as the prescribing of amoxicillin to a person recorded as being allergic to penicillin.

Although there was a system of care plan audits being carried out, these had not always identified discrepancies within care plans and were not sufficiently detailed in relation to issues that had been identified and provide action plans with timelines for addressing the shortfalls. For example, the mobility care plan for one person who had experienced frequent falls had not recorded this effectively with inconsistencies in other care documentation, but this had not been picked up by the audit. Care plan audits had not picked up the fact that information regarding DoLS authorisations was not being included in the care records. At the inspection in August 2015 we commented that the monthly care plan evaluation sheets sometimes lacked detail. At that time the registered manager said this would be reviewed as part of the care plan auditing process that was being introduced, however we saw at this inspection that improvements were still needed.

Although there were monthly evaluations of different aspects of care plans, there were no records of a review of the care plans and the person's needs with them or their relatives. The registered manager told us that there was on-going communication with each person and their family members relating to their care and any change in needs or risks.

The provider had also not been able to maintain and sustain the quality of service they provided at our last inspection because their quality assurance systems and governance arrangements were not very effective. The service has been awarded a lower rating than they had at our previous inspection.

The above paragraphs are in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some care records showed evidence of changes to people's needs and as a result staff had updated people's care plans to reflect these changes. For example, a person who had been managing their own medicines was no longer able to do so and this had been documented in the relevant risk assessment and the care plan.

The service had a system whereby a member of the Board of Trustees would attend and carry out a monitoring visit every two months, however the form in use for this was limited in content and did not cover all aspects of the service provision. There were reports available for two of these visits carried out in December 2016 and February 2017 and the registered manager said a third visit had been conducted in April 2017, but the report was not available. We discussed expanding the areas covered and also ensuring the monitoring visits took place so that areas for improvement could be identified promptly and addressed. The registered manager said she would address this.

Residents' meetings took place every six months so people had an opportunity to share their ideas about the running of the service and receive updates about developments and changes within the service Kitchen staff also attended the residents meetings where feedback on food was provided and ideas for new menu choices could be discussed. A satisfaction survey had been conducted in September 2016 and the results had been positive with people being very satisfied with the service. The registered manager said the 2017 survey had recently been sent out and the results would be collated and any areas for action addressed.

All staff we spoke with were positive about working at the service and many had been in post for several years, providing a consistent staff team. All commented that there was good team work within the service and an open and supportive culture. One said, "It's a lovely home, it's like a big family." Another commented, "There's really good team work here – we all pull together and support each other." Many staff commented that the registered manager was approachable and all said they would not hesitate to raise concerns or queries if necessary. The activities coordinator showed us photographs from staff events held by the service which demonstrated a good level of inclusive management for those working at the service as well as those living there.

The registered manager was a registered nurse and had many years of management experience. They undertook training to keep up to date and had undertaken a training qualification so they could provide training in a variety of topics to the staff. Staff all felt very well supported by the management team and commented that they would feel confident to raise any issues or concerns with their line manager. The registered manager told us, "The residents are important but so are the staff. If you didn't get the right calibre of staff they wouldn't provide the right quality of care." The registered manager said she had an 'open door' policy and this was confirmed by staff. Staff received one to one supervision and had an annual appraisal to review their work and development. Staff said there were regular staff meetings, with monthly meetings for all staff working at the service, and separate meetings every three months for the staff on each unit.

The service had a variety of journals for staff to read to keep up to date with current guidance and improvements in care. The registered manager said they were also working on providing email addresses for all the staff so they could send out training information and other useful bulletins to all staff. The registered manager said she was signed up for the CQC newsletter updates and found these useful. The service had a 'Quarterly Bulletin' booklet that included updates about outings and events at the service as well as care topics. For example, in the last booklet one of the nurses had written an article entitled 'My hopes of rationale for care' and explained about how care options are chosen for and with individuals to achieve goals.

Policies and procedures were available and included reference to good practice guidance and current legislation. They were reviewed every two years and also updated when any changes were required. The registered manager said significant policies such as safeguarding were sent to each unit following updates so staff could read and then sign to confirm they had done so, in order to keep them up to date with any changes. Notifications were sent to Care Quality Commission (CQC) for the majority of notifiable events, so we were being kept informed of the information we required to monitor the service. Notifications for the last five Deprivation of Liberty Safeguards authorisations received for people using the service had not been submitted to CQC. This was addressed at the time of the inspection and the registered manager said they would ensure these were submitted in a timely way in future.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way because when risks were identified the provider did not ensure that appropriate plans were developed to mitigate such risks. The provider's arrangements to manage medicines were not always effective. Regulation 12(1)(2)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The processes in place for the provider to assess and monitor the quality and safety of services provided to service users and to identify areas for improvement were not effective. The provider had also not always maintained a record of decisions taken in relation to the care and treatment provided to service users. Regulation 17 (1)(2)(a)(c)