St Vincent Care Homes Limited

St Vincent House - Gosport

Inspection report

St Vincent House
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 14 and 26 January 2015 and was unannounced.

The home provides care and accommodation for up to 34 older people including those living with dementia. At the time of the inspection there were 32 people living at the home. There was ramped access to the home to assist people with mobility needs. Communal areas consisted of two lounge areas, a conservatory and a dining room. The home also had a garden area for people to use.

Bedrooms consisted of five shared double and 24 single rooms. Twenty three rooms had an en suite toilet facility. The home had a staff team of 29 care staff plus additional staff for cleaning, maintenance and cooking.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

At our last inspection on 20 August 2014 we found the service was in breach of two regulations. Firstly, the provider had not followed the Mental Capacity Act 2005 Code of Practice by assessing the capacity of people to consent to their care and for making 'best interests' decisions where people did not have capacity. The provider sent us an action plan to say they would be compliant with this by 14 November 2014. At this inspection we found the provider had implemented the procedures as required by the Mental Capacity Act 2005 where people lacked capacity to consent to their care. We did find, however, that for those who were able to consent that care plans did not always state people were consulted about their care. We have made a recommendation about this. The previous inspection also identified a breach of regulations as care records were not always readily available and contained duplicate information. The provider sent us an action plan to say they would be compliant with this by 14 November 2014. At this inspection we found care records now met the regulations.

People told us they were consulted about their care but this was not always clearly recorded in people's care plans. We have made a recommendation about this.

People told us they felt safe at the home and that staff listened to what they said. Staff were aware of safeguarding adults procedures and their responsibilities to report any concerns they had.

Care records identified any risks to people, which were assessed and a care plan recorded of how staff should support people to reduce these risks so people were safe. Staff, however, did not aways follow these procedures to keep people safe. Social services staff told us the registered manager and staff worked with them in addressing areas of care where risks were identified.

Sufficient numbers of staff were provided to meet people's needs. Pre-employment checks were made on newly appointed staff so that only people who were suitable to provide care were employed.

People's medicines were safely managed with the exception of one person whose medicine stock did not match the records of medicines administered. This indicated the person had either not received their medicines as prescribed or there was an error in the records.

People told us they were supported by staff who were well trained and competent. Staff had attended a range of training courses in providing care to people. A community nurse said staff did not always have the required knowledge and skills to carry out tasks they had instructed staff in such as supporting people who had a catheter. Another community nurse said they provided training for staff in care procedures but that staff frequently failed to attend these. Whilst staff said they were supported by their manager and could ask for advice at any time there was a lack of supervision and appraisal for staff.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The registered manager had assessed the capacity of those who were unable to consent to their care. 'Best interests' care plans were devised for these people. The registered manager had referred people to the local authority where their liberty needed to be restricted to keep them safe by the use of a DoLS authorisation.

People were supported to eat and drink and to have a balanced diet. There was a choice of food and people said they liked the food. Care plans included details about any special diets or support people needed with eating and drinking. We observed one person was not given the right support to eat as set out in their care plan.

People's health care needs were assessed and recorded. Care plans included details about how people were supported with needs such as how to maintain skin pressure areas so they did not become injurious. Community nurses told us they worked with the registered manager and staff to assess and meet people's health care needs. However, comment was made by members of a community nursing team included reference to staff not always being aware of the procedures in people's care plans about health care needs, and, that staff had not always used equipment correctly.

Summary of findings

Staff had a caring attitude towards people and time to talk with people. However, we also found some examples where staff did not listen to people or where staff could have been more polite when they spoke to people. Relatives and people said staff treated them well. Privacy screens were available in shared rooms and in communal areas. There was no communal toilet available in the lower ground floor as it was being used as a storage area. There were three bedrooms in this area which included two rooms which could be used as double bedrooms, which did not have an en suite toilet. This meant the room's occupants had to use a commode in the night and although there was a privacy screen this did not afford people adequate privacy or promote their dignity. At the time of our second visit the communal toilet had been made available to people.

Care needs were reassessed and updated on a regular basis. There were two activities coordinators who arranged a range of outings and activities for people.

People were not always given accurate information about the names of staff and the date on the notice board. We have made a recommendation about this.

The complaints procedure was available in the home. A record was made of any complaints along with details of how the issue was looked into and resolved.

The provider had a management team to support the registered manager and for monitoring the performance of the service. Although there were a number of systems of audit to check the quality of care provided, these had not identified and addressed areas of improvement we found such as medicines records errors and a lack of supervision for staff. The provider had devised plans for developing and improving the service, such as, redecoration which involved the input and choices of people. Sufficient support and appraisals of staff were not completed so that staff could receive feedback about their work and in order for the registered manager to check the attitudes of staff.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were supported to take their medicines but we found one person's medicines records did not show they received medicines as prescribed.

There were sufficient numbers of staff to meet the needs of people safely. Checks were made that newly appointed staff were suitable to work with people.

People's needs were assessed where any risk was identified and there was guidance for staff to follow so people were safely cared for. These procedures, however, were not always followed by staff.

Staff knew how to recognise, respond and report any suspected abuse of people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had access to training so they could provide effective care but were not supported by regular appraisal and supervision.

People told us they consented to arrangements for their care and staff sought people's consent before they provided care. Where people were able to consent to their care this was not always recorded as being agreed with them.

People were supported to eat and drink sufficiently.

The registered manager and staff liaised with community health services so people's health care needs were met. Community health care professionals reported that staff did not always know about the health care advice they gave and were not always confident in assessing and meeting people's health care needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff expressed a commitment to caring for people in a way that promoted people's privacy and dignity. Some staff treated people with kindness but this was not consistent and we observed people were not always treated with respect and dignity.

The service did not have a policy or procedure regarding people sharing bedrooms and at the time of our first visit there was a lack of a communal toilet in one area which could have affected people's privacy. This was rectified by the time of our second visit.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst each person's needs were assessed, these were not always in sufficient detail and we observed staff did not always follow people's care plans.

People had access to a range of activities, such as outings, quizzes and crafts.

People were encouraged to express their views about the home and could make suggestions about how the service could be improved. There was a complaints procedure and complaints were looked into and responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a management structure and staff were able to seek support from these line managers. Staff had a good awareness of their role but the supervision of staff was not sufficient to enable the registered manager to review the culture of the service.

There were systems to gain the views of staff, people and their relatives about the standard of service provided. The provider monitored and audited the service but this had not always identified and resulted in timely action being taken. This included the impact of the environment on people's dignity and where care was not provided as set out in care plans.

St Vincent House - Gosport

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. The inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 and 26 January 2015 and was unannounced.

The inspection team consisted of an inspector and an Expert by Experience, who had experience of older people's care services. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

Some people who used the service were unable to verbally share their experiences of life at St Vincent House- Gosport because of their complex needs. We therefore spent time observing the care and support they received in shared areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with six people and a relative. We also spoke with four staff, the registered manager and a representative for the provider.

We looked at the care plans and associated records for five people. We reviewed other records, including the provider's internal checks and audits, staff training records, records of when people attended activities, staff rotas, accidents, incidents and complaints. Records for five staff were reviewed, which included checks on newly appointed staff, supervision records and the training of newly appointed staff.

We spoke with two community nurses from the local health trust who visited the home on a regular basis to provide advice and support to care staff. We spoke to social services commissioners and members of the social services' safeguarding team regarding recent concerns raised with them. These people gave us their permission to include their comments in this report.

Requires Improvement

Is the service safe?

Our findings

The home did not always follow safe procedures for supporting people with their medicines. The home used a monitored dosage system for administering medicines to people. Staff recorded a signature each time they administered medicines to people. One person who had recently moved into the home had arrived with their own medicines which were not part of the monitored dosage system. There were errors in these medicines records as the amount recorded when the person moved into the home and the amounts given did not tally for three medicines. For example, for one medicine the person had 34 tablets when they moved in and had been given three tablets, as prescribed, according to the records. This meant the person should have had 31 medicines left but they had 32. This indicated the person had not received a medicine which staff had recorded as being given or had recorded the incorrect amount at the time the person moved into the home. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. This meant the service was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked that the procedures for the handling, storage and administration of controlled drugs. Controlled drugs are drugs which are liable to abuse or misuse and are controlled by the Misuse of Drugs Act 1971 and misuse of drugs regulations. These were stored securely and the appropriate records were maintained. Stocks of medicines and the records made by staff each time they administered a controlled drug showed people received these medicines as prescribed.

Staff received training in the handling and administration of medicines and underwent an assessment of their competency to safely handle medicines. Guidance was recorded for staff to follow so they knew the signs and symptoms when a person needed medicines on an 'as required' basis.

Risks to people were assessed and care plans recorded these so staff could take action to reduce these risks. However, the guidance was not always followed so people were not safely cared for. One person's nutritional needs were assessed as being at risk of not being met and the care plan included guidance that staff should help the person to eat with a teaspoon. For three meals we observed this did not happen and the person ate without support. This included an observation of the person spilling the food from the plate onto a table from which they ate their food with cutlery. This meant the person was not supported to have adequate nutrition.

This person rested their head on a small table in front of them and this caused their spectacles to push into their face. The care plan said the person needed to have a cushion in place to prevent any injury but we observed this did not always take place. The registered manager told us the person often refused the use of the cushion but this was not recorded in the person's care plan risk assessment. When we raised this with the registered manager action was taken to ensure the cushion was in place which we observed at our second day of the inspection. The care plan had also been updated to include reference to the person refusing to use the cushion. The provider had not taken action by following the assessed care procedures to protect this person from risks of malnutrition and potential injury. The registered person had not protected people against the risks of receiving care or treatment that was inappropriate or unsafe. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's risks regarding the prevention of skin pressure areas developing due to prolonged immobility were recorded along with the need for any equipment, such as air flow mattresses to alleviate any pressure. Each person had a personal evacuation plan for their safe movement from the building in the event of an emergency. Staff were observed to take immediate action where a spillage had occurred in a communal area so people and staff were not put at risk of slips and falls. Mobility needs were assessed and there were guidelines for staff so people were safely moved according to their individual needs.

People told us they felt safe with the staff. For example, one person said, "I feel safe because the carers are good and well trained". People said there were enough staff on duty to provide safe care. However, a community nurse told us

Requires Improvement

Is the service safe?

they considered the home did not have enough staff on duty and that people were sometimes left unsupervised in the lounge areas. We observed people in the lounge areas and they were supervised by staff at all times.

Staff told us there were enough staff to look after people safely apart from times when there were unexpected absences such as due to sickness. One staff member said the staffing levels had improved and another staff member said the staff team worked well together. Staffing was planned and organised on a duty roster which took account of the needs of people. On the day of the inspection there were seven care staff on duty to provide care and support to 32 people.

Staff were aware of the need to protect people's rights and knew how to protect people from possible abuse and harassment. We looked at the service's policies and procedures regarding the safeguarding of people and these included guidance for staff on the signs of possible abuse and the different types of abuse . The registered manager and staff were aware of the procedures to follow if they suspected someone had been abused and knew about the different types of abuse people might experience. They were trained in the safeguarding of vulnerable adults procedures and knew they could report any concerns to the local authority safeguarding team. A member of the local authority safeguarding team told us the provider cooperated with any safeguarding investigations and always cooperated with any requests for information or to carry out investigations as part of the local authority safeguarding procedures.

Staff told us their recruitment involved the completion of an application form which included details about their employment history. Staff said they attended an interview where they were asked about their work experience and their understanding of personal care. Records of staff being interviewed regarding their suitability for work were available. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

The registered manager had a plan for introducing one to one supervision with staff but staff told us they had not recently received any supervision sessions or appraisal of their work. One staff member said they could not recall when they last had supervision with their line manager. Another staff member said they had "some" supervision in the last year but there was no record of this. Records for two other staff did not include any evidence of supervision for 2014. One staff member had a record of supervision in 2013 and two other staff had records of supervision in 2012. We found that the registered person had not protected people against the risks of receiving care or treatment of an appropriate standard by the provision of supervision and appraisal of staff. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were supported in their work and that they could ask for support and advice from their line manager. They also said their performance was monitored by direct observation of their work with people. People considered the staff to be well trained and provided the support they needed. Staff were observed to seek people's consent before providing care and support. People confirmed they received support as they preferred.

Records were available of newly appointed staff having an induction to prepare them for their role. Staff said they had access to a range of training courses. The registered manager told us staff had up to 12 training days per year. The registered manager maintained a staff training matrix so she could monitor that staff member had attended courses and any updates in subjects considered essential to their role. Each staff member also had a record of the training courses they had completed which included skin and pressure area care, catheter care, dementia care, moving and handling, health and safety and first aid. Community nurses from a local NHS Trust provided some of the training courses such as in pressure area and catheter care. One of these nurses told us they met with the registered manager to discuss staff training needs and worked with the staff team to provide identified training. They said staff were "keen to learn" and that the level of staff skills had improved, but there were still occasions where staff did not follow the advice given regarding procedures such as personal care and catheter care as well as the use of equipment. One of the community nurses also said staff frequently failed to attend pre-arranged training sessions provided by them.

Staff told us they were able to complete training in nationally recognised courses such as the Diploma in Health and Social Care or National Vocational Qualifications in care. These are work based awards that are achieved through assessment and training. To achieve these qualifications candidates must prove that they have the ability and competence to carry out their job to the required standard. Sixteen of the 29 care staff had an NVQ level 2 or 3 qualification and a further six staff were studying for NVQ 2 and one NVQ 3. The registered manager had NVQ at levels 3 and 4 as well as a diploma in Leadership and Management (LMA).

At our last inspection in August 2014 we found people's capacity to consent to their care and treatment was not being carried out and included one person who did not have capacity to agree to their care who was referred to the local authority for an assessment of a Deprivation of Liberty Safeguards (DoLS) authorisation. At this inspection we found improvements had been made in this area. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) which are procedures which must be followed when people do not have capacity to consent to their care and treatment, or, in the case of DoLS, need to have their liberty restricted in some way to keep them safe. Where people did not have capacity to consent the provider had carried out an assessment of this using a local authority assessment tool designed for this purpose. In accordance with the legislation, 'best interests' care plans were devised for those people who were unable to consent to their care. Procedures were recorded so staff knew how to support and supervise those people subject to a DoLS authorisation made by the local authority to keep people safe.

People told us they liked the food. There was a choice of food which people confirmed.

People were asked in advance what they would like to eat and staff recorded this. The day's menus were displayed in the dining room so people could see what the meals for the day were. The provision of food was flexible so people could change their minds. The menu plans showed varied

and nutritious meals. Staff were observed to help and encourage people to eat with the exception of one person where staff did not provide support as set out in the person's care plan. Drinks were available for people at meal times and during the afternoon and mid-morning when people were served hot drinks and snacks. Drinks were also available for people in communal areas and in their rooms. People's nutritional needs were assessed and care plans included details about any special diets such as pureed food or dietary supplements to ensure people received suitable nutrition. Details about any specific support or equipment people needed was recorded to enable people to eat and drink. Where needed a record was maintained of the food and fluid people ate. Records of people's weight were maintained so any weight loss or gain could be monitored and appropriate action taken.

People's health care needs were assessed prior to them being admitted to the home. This included details about the need for dental care and eye sight checks. Care plans included details about specific support people required such as skin care to prevent pressure areas developing along with the provision of any equipment that was needed. The registered manager described "good" working relationships with the community nursing team who they asked for advice and guidance regarding care procedures. A member of the community nursing team described how they worked with the registered manager and staff to identify and plan specific care procedures for people. This community registered nurse said the provision of care had improved in the home but said staff did not always know about the advice and guidance the community nursing team had given as they had not read the care plans. Consequently staff sought advice from the community nursing team which had already been given and was recorded in care plans. Another community nurse said there were occasions when staff did not utilise equipment correctly, such as pressure relieving air mattresses, which increased the risk of people receiving pressure skin injuries.

Requires Improvement

Is the service caring?

Our findings

The provider did not always provide sufficient privacy for people. There were three bedrooms in the lower ground floor area. Two of these rooms could be used as double bedrooms but did not have an en suite toilet. There was a toilet nearby but this was being used as a storage area and could not be used by people. At our second visit the toilet was cleared and made available to people. For the period when the communal toilet was not available to people in this area the options for using the toilet at night were limited to the use of a commdode which had the potential to adversely affect people's privacy and dignity if they shared a room. The provider did not have a policy on shared rooms to say what people could expect regarding privacy and any options people might have in the future for being moved to a single room. We recommend the service devises its own policy on shared rooms so staff and people know what people can expect regarding shared rooms.

A member of the community nursing team told us how people's privacy was promoted by the use of screens when they treated people People told us the staff were kind and treated them well. For example, one person said, "I love being here, cared for all the time, food and entertainment". People were asked how they wanted to be helped. Staff were observed to treat people well, but we also found some isolated examples where staff were abrupt with people.

There were examples of positive and caring relationships between staff and people. We observed staff knew people's needs and interacted with people in a personal and friendly manner. This included staff having the time to talk with people and staff and people were observed sharing jokes and laughter. Staff were patient and calm when supporting people with their food. Reassurance was provided to people who were disorientated or needed support. However we observed three examples where where staff could have spoken to people in a kinder and gentler manner. These included staff being rushed in their work and being short when speaking to people as well as a staff member not talking respectfully to one person whose trousers were beginning to fall down as he did not have a belt.

Staff described their own philosophy of care as treating people with respect and dignity and in a manner they would treat one of their own family members. Staff said they treated people as individuals who were able to make choices in how they spent their time and in how they were supported. Staff said they addressed people by their preferred name. Reference was made by staff to providing person centred care reflecting people's choices and preferences, which were recorded in care records. Care plans were recorded to include people's preferences and wishes. People told us they had agreed to their care but we found the care plans did not always include reference to people being consulted about their care. For example, we saw one care plan was written to include the person's preferences in how they wished to be helped but the person had not signed their care plan to show they were in agreement with this. One care plan had a section called 'Resident's Identified Needs and Care Plan,' with space for the person to record their signature to say they agreed with its contents. This had not been completed. We recommend the service has a more structured method of demonstrating people have been consulted about their care.

People were able to express their views by the use of surveys and during the monthly audit visits by the provider. There was a notice board called a 'Wishing Tree' where people's views and suggestions, such as for activities, could be included.

A relative told us how they were able to visit the home without being unnecessarily restricted.

People were observed to be able to move around the home independently where this was appropriate. This included the use of outside areas. The provider had created a place where people could spend time outside by using a sheltered area. This was particularly used by one person who liked to go outside.

People were provided with information about meals and activities but we noted one of these had the incorrect date on it which could mislead and confuse people. Not all staff had name badges which did not assist people to identify staff. We recommend people are provided with accurate information about staff on duty and the correct information on notice boards.

Requires Improvement

Is the service responsive?

Our findings

People told us they received the care they needed and that staff responded to their changing needs. For example, people said staff acted promptly when they asked for assistance by using the call point in their room. Staff asked people if they needed any additional help. People's requests were acted on, such as when people had a change of mind and asked for a different meal. People said they had enough to do as there were a range of activities provided including small theatre performances, entertainment from singers, religious services, walks, films, art and bingo.

Care records showed people's needs were assessed before they were admitted to the home. These included mobility, nutrition, personal hygiene, continence, oral care, and mental state. The registered manager told us people were consulted during this pre admission assessment but we found this was not recorded. Records also included copies of assessments by agencies, such as social services, who referred people for admission. This enabled the provider to obtain relevant information so people's care needs could be met.

Each person had care plans for a variety of needs including personal care, emotional support, a life history and daily activities. These were in a format which reflected the person's needs and preferences. Care plans were reassessed and updated to reflect people's changing needs. For example, one person's care plan included an update where the risk of the person developing pressure areas on their skin was identified along with action to prevent this occurring. One person's care plan included details about the need for staff to have additional training in wound management which was then arranged with the NHS Trust community nursing team.

We observed examples where staff were flexible in how they provided care and support to people in response to people's changing requests. For example, people requested a different meal when they did not like the meal they were served which was responded to. Staff were observed to respond promptly to people's immediate care needs.

People's needs were assessed so the provision of activities reflected their needs and preferences. People were asked what activities they would like to do and these were included on a notice board called a 'Wishing Tree.' There were two activities coordinators. Activities were provided which enabled people to have links with the local community, such as outings to the pub and for walks. We observed people going on an outing from the home with a member of staff on the day of the inspection. There were also quizzes, crafts, entertainment, movie afternoons and games which took place in the home. People were given information about activities in the home's newsletter and on a notice board. These showed three to four activities a day for people to ensure people remained active and engaged.

A relative told us they were aware of the complaints procedure and said they had opportunities to raise any concerns they had with the registered manager. The complaints procedure was displayed in the home. Records were maintained where people, or their relatives, had raised any issues with the provider or where they had made a formal complaint. These showed the provider looked into the complaint and made a response to the complainant of the findings of any investigation into their complaint. The provider also sought the views of people and their relatives about the home when they carried out their monthly audit visits.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and provider's system of audit and monitoring had not always identified omissions in care procedures, errors in the medicines procedures, the lack of privacy for people and the lack of supervision for staff. A member of the community nursing team told us the registered manager did not always use the reporting system set up by the NHS hospital team to report occasions when the hospital had not followed the correct procedures when they discharged three people from hospital to the home. This is a system introduced by the local NHS hospital to monitor that people were discharged from hospital in a safe and appropriate way. Although the provider monitored the standard of care through regular audits, these failed to identify concerns found at this inspection. Medicines audits took place weekly but errors in the procedures for one person's medicines showed a more thorough check was needed. Action to address the lack of staff supervision had not taken place. The audit of the environment included an annual development plan for ongoing maintenance and redecoration of the home. Arrangements for accessing a toilet in the lower ground floor area had the potential, to adversely affect people's privacy and dignity and was not acted on until after the first day of our inspection. We found that the registered person had not protected people against the risks of receiving inappropriate or unsafe care by the effective operation of monitoring the quality of services and identifying and managing risks to people. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt included in decisions in the home such as choosing activities. The provider had systems to communicate and check people's views about the home. People, and their relatives, said they felt able to approach the staff and registered manager with any queries or concerns.

Staff expressed a set of values of compassion towards people and to treating them as individuals. They knew how to report any concerns about people's welfare. However, there were instances where the values of compassion and dignity were not promoted by all staff. The lack of formal appraisal and supervision of staff did not enable the registered manager to keep under review the attitudes of staff or to give staff opportunities to raise any concerns they had. Staff were able to approach the home's management with any concerns and their views were also sought by the use of a staff survey to identify any improvements which could be made. The latest staff survey showed staff gave positive feedback about their development as a member of the care staff team. The provider identified an area raised by staff as an issue which was acted on. Community nurses described the registered manager and staff as open to learning from them and to suggestions they made although staff did not always attend pre-arranged training.

The provider used monthly audit visits to speak to staff, people and their relatives regarding their experiences of the home. Copies of these were available and included action plans for addressing any issues raised. Staff meetings took place and were recorded. Staff said these offered them to the chance to discuss people's needs, training and other relevant issues. Staff said there was a supportive culture in the service and that staff worked well as a team. The provider also communicated with people by the use of surveys and people could make suggestions about the home by including this on a 'wishing tree' in the hall. Relative's views were sought by the use of surveys . The provider told us relatives' meetings had taken place in the past but were not always attended so more informal cheese and wine evenings with relatives had been introduced to encourage communication.

The service had a registered manager and there were senior care staff with the role of supervising care staff. The provider and regional manager for the provider took an active role in monitoring the service and in its operation. This included attending safeguarding meetings with the local authority and dealing with any concerns which arose. Social services staff told us the service's management cooperated with any investigations and worked with them to address any issues.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not always assessed the risks to service users when receiving care and treatment and doing all that is reasonably practicable to mitigate those risks. Assessments and care plans did not always include all the relevant information to reflect the risks associated with people being injured or receiving support with eating and drinking. Care staff did not always provide support to people as set out in care plans particularly for one person who was at risk of injury and at risk of not receiving sufficient nutrition and fluid. Regulation 12 1. 2. (a) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not made suitable arrangements for the proper and safe management of medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive such appropriate support, training, professional development, supervision and appraisals as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The provider did not have a system which was effective in monitoring the quality of the services provided to people and for assessing, identifying and mitigating risks to people. Regulation 17 1. 2. (a) (b)