SSAFA Forces Help Enterprises Limited

St Vincents Care 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?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

St Vincents Care Home is a privately run care home registered to provide accommodation for up to 25 older people. The home is run by the Soldiers, Sailors and Airmen's Families Association (SSAFA) and provides support to ex-servicemen and ex-service women. At the time of our inspection there were 22 people living in the home. The inspection was unannounced and was carried out on the 19 and 23 October 2017.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The risks relating to people's care and treatment were not always identified and managed effectively.

Although, medicines were administered by staff who had received appropriate training and assessments they were not always managed safely and best practice guidance was not always followed.

Staff sought consent from people before providing care. However, people's ability to make decisions was not always assessed in line with legislation designed to protect people's rights. People were deprived of their liberty without the appropriate authority being in place.

There were systems in place to monitor quality and safety of the home provided, however, these were not robust and did not identify the concerns we identified during this inspection. People's records were not always up to date and did not always reflect people's needs.

There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner. However, the recruiting practices was not robust and did not always ensure that a full employment history for new staff was available or a written explanation for any gaps.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs.

People told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

Staff developed caring and positive relationships with people and were sensitive to their individual communication styles, choices and treated them with dignity and respect. People were encouraged to remain as independent as possible and maintain relationships that were important to them.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff encouraged people, when necessary in a patient and friendly manner.

People and when appropriate their families were involved in discussions about their care planning,

There was an opportunity for people and their families to become involved in developing the service. They were encouraged to provide feedback on the service through residents meetings and an annual survey. They were also supported to raise complaints should they wish to.

People told us that they felt the home was well led and were positive about the registered manager who understood the responsibilities of their role. The provider was fully engaged in running the home and provided regular support to the registered manager. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

We found four 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.

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 home was not always safe.

Risks to people were not always identified, assessed and managed effectively.

Medicines were not always managed safely.

There were enough staff to meet people's needs. However, recruiting practices did not always ensure that there was a full employment history for new staff or a written explanation for any gaps.

There were plans in place to deal with foreseeable emergencies and staff were aware of their responsibilities to safeguard people. The registered manager had assessed risks regarding the environment.

Is the service effective?

Requires Improvement

The home was not always effective.

Staff sought consent from people before providing care. However, they did not always comply with legislation designed to protect people's rights. People were deprived of their liberty without the appropriate authority being in place.

Staff received an appropriate induction, on-going training and support to enable them to meet the needs of people using the service.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The home was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important relationships.

Is the service responsive?

Requires Improvement

The home was not always responsive.

People's records were not always up to date and did not always reflect people's needs.

People were provided with appropriate mental and physical stimulation.

There was a process in place to deal with any complaints or concerns if they were raised. People told us they knew how to complain but had not needed to.

Is the service well-led?

Requires Improvement

The home was not always well-led.

There were systems in place to monitor the quality and safety of the service provided, however this was not robust and did not identify the concerns we found during the inspection.

The provider's values were clear and understood by staff. The registered manager adopted an open and inclusive style of leadership.

People, their families and staff had the opportunity to become involved in developing the service.

St Vincents Care 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and was carried out on 19 October 2017 by one inspector, who was joined by a second inspector on 23 October 2017.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events, which the service is required to send us by law.

We spoke with six people using the service and a relative of one of the people living at the home. We observed care and support being delivered in communal areas of the home. We spoke with six members of the staff, the estates manager, care manager, a kitchen hand, the cook, the finance and admin officer and the registered manager. We also spoke with a visiting health professional and received feedback about the home from two other health professionals.

We looked at care plans and associated records for seven people using the service, staff duty records and other records related to the running of the service, such as, recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was previously inspected in June 2015 when it was rated good.

Requires Improvement

Is the service safe?

Our findings

People were sometimes placed at risk because risks associated with their conditions had not been identified, assessed and appropriate measures had not been implemented to ensure that risks for people were minimised. One person's care plan stated that they refused to wear their dentures when eating. Their care plan stated 'Lack of teeth can cause chewing problems'. Their care plan also recorded that they regularly ate late at night, items such as, taco type crisps, hard mints and biscuits. However, the staff had not identified that the lack of dentures and their problem chewing could lead to a risk of choking. There was no risk assessment in place with regard supporting this person to eat safely or the action staff should take if they started to choke. The same person who was diabetic had chosen not to follow a diabetic diet. However, there was not a risk assessment in place to identify how the risk in respect of this lifestyle choice was being managed, such as more frequent blood glucose monitoring or more frequent interaction with health professionals.

The registered manager told us there were four people living at the home who were diabetic. Two people managed their diabetes through insulin injections, which were administered by an external community nurse on a daily basis and the other two people managed their diabetes with tablets. None of these people had a diabetic care plan in place to help staff understand how to support them safely and manage the risks associated with diabetes. Staff were required to test these people's blood glucose level at various frequencies, as advised by the community nurse. However, staff were unaware of what a person's usual blood sugar level would be. As their care records provided no guidance about this, staff were not able to determine what might be too high or too low for a person and when they should seek medical advice. One person's blood monitoring records indicated high levels on two occasions and this had not been recognised and staff confirmed no action had been taken.

We raised these concerns with the registered manager who accepted that this was an area for improvement. By the second day of our inspection, each person who was diabetic had a diabetic care plan in place. The care plans had been completed with the guidance of the community nurse and identified people's safe blood glucose range and the interventions staff should take if their readings fell outside of those ranges.

The home in conjunction with community nurse team used a recognised risk assessment tool to assess if people were at risk of pressure sore injuries. However, one person who was being cared for in bed was at risk of pressure sore injuries because they were receiving end of life care and unable to move position. We identified that this person had an airflow pressure relieving mattress, which is a specialist mattress designed to help prevent pressure injury sores. These mattresses need to be on a specific setting in order to be fully effective. However, it was set incorrectly placing them at risk. The mattress was set at a maximum setting for a person who weighed in excess of 100 kgs. At the time of requesting the mattress, the person weighed 75 kgs, and staff told us they had lost weight since then. Staff confirmed that they did not regularly check the setting on the airflow mattresses of people who were at risk of pressure sores. By the end of our inspection, advice had been obtained from the community nurse as to the correct settings for mattresses, how to check they were functioning correctly and a daily check had been instigated.

The registered manager also told us they did not use a recognised risk assessment tool, such as a Malnutrition universal screening tool (MUST) to assess people's risks of malnutrition. This is contrary to the National Institute of Health and Clinical Excellence (NICE) guidance in respect of 'Pressure ulcers: prevention and management' and 'Nutrition support in adults'.

The failure to identify, assess and manage the risks to people's health and safety is a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had identified other risks to people's health and wellbeing, such as the falls; and risks relating to self-administered medicines, smoking, bathing and behaviour that staff or other people using the service may find distressing. They had also identified risks relating to the environment and the running of the home. These included fire safety, infection control and accessing the kitchen. They had taken action to minimise the likelihood of harm in respect of these risks in the least restrictive way. There was a clear record made of when an incident or accident had occurred. These were reviewed by the registered manager to provide an opportunity for organisational learning and risk identification.

People's medicines were not always managed safely. The daily records of care for one person showed that on the 13 October 2017 at 15:30 hours they had been administered pain relief medicine. However this was not recorded on the person's medicine administration record (MAR) to show they a received that medicine on that day. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. The failure to record when pain relief medicine was given meant that there was a risk that staff may administer an additional dose.

Most people had clear information in place to support staff in understanding when 'as required' (PRN) medicines should be given and the expected outcome. However, the guidance for one person, who was prescribed a PRN medicine to help manage their anxiety and aggression, did not provide sufficient information to help staff understand when it should be given or suggest any alternative strategies to try before a medical intervention was used. MAR charts for this person detailed that it had been administered on nine occasions between the 18 September 2017 and 15 October 2017. We checked the person's record of care for those dates and found there was an inconsistent approach to its use. For example we identified one occasion where the medicine was given and the daily record of care for that time showed the person was 'Checked resting in bed.' There was a further entry on a different day when the medicine had been given without any explanation as to the reason it was given or reference to any anxious or aggressive behaviour. A senior member of staff said the medicine was, "given usually when [the person] starts coming out of [their] room, makes noises and despite attempts to calm [them] down, [they] won't calm down". "Or if [the person] is being incontinent." Another member of staff told us, "We give the [anxiety medicine] if [the person] is more agitated, not sleeping, eating, drinking or disturbing other residents." They added, "We don't give it more than two or three times a week." We raised this concern with the registered manager who told us they were unable to explain why the medicine was given when the person was resting in bed.

Other PRN medicines were not always managed effectively. For example, one person was prescribed pain relief medicine on a PRN basis. We saw from their MAR chart that they had been administered this medicine every day for at least two months. There was no information recorded on the medicine records or their records of care as to why the pain relief was being given. A member of staff told us it was "Given because the person had asked for it to be given daily [rather than PRN]." No request had been made for the GP to review this prescription or the cause of the regular pain. Another person was prescribed an analgesic cream on a PRN basis. We found this cream was being applied daily. There was no information recorded on the medicine records or their records of care as to why it was being administered. No request had been made

for the GP to review this prescription or the cause of the regular pain.

The National Institute for Health and Care Excellence (NICE) guidelines state: Care home providers should ensure that a new, hand-written medicines administration record (MAR) is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used. The MAR chart for one person had a hand written entry for some new medicine. The entry did not identify who had written it and there was no signature to confirm that the record had been checked and was accurate.

NICE guidelines also identified the need for care home providers to monitor the temperatures where medicines are stored. A senior member of staff told us they did not monitor the temperature in the room where the medicines were kept. This meant the registered manager was not able to assure themselves that medicines were being stored in compliance with the manufacturer's instructions.

We raised our concerns with the registered manager who took immediate action to ensure medicines were being managed safely.

The failure to ensure that medicines were managed safely is a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines from staff who had completed the appropriate training and had their competency to administer medicines checked. There was a medicine stock management system in place to ensure medicines were stored appropriately and a process for the ordering of repeat prescriptions and disposal of unwanted medicines. Staff engaged with people to check that they were happy to take their medicine. Staff supporting people to take their medicines did so in a respectful and unhurried way.

The provider had a service wide recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. This was managed by the provider's human resource team in conjunction with the registered manager for the home.

All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, the provider had not ensured there was a complete employment history and there was no written explanation for any gaps in employment. This meant that the provider could not always be assured as to the suitability of the staff they employed.

We raised this with the registered manager who took immediate action to ensure that the organisation's recruitment practice complied with the regulations.

People told us they felt safe. One person said, "I feel very safe here all the girls help whenever you need it. I still like to do a lot for myself and do my own medication but if I need help it's there." Another person told us, "We get treated well, we are comfortable and warm." A family member said, "I would say [my relative] is safe here. They are very good with [my relative]." The health professionals we spoke with and provided feedback told us, they did not have any concerns about people's safety. One health professional said, "I think this is a lovely home. People appear well cared for and safe. I have never witnessed anything I thought was dangerous." Another health professional told us, "I think they provide an excellent level of care."

People told us that there were sufficient staff to meet their needs. They said that if and when they needed staff, they were able to get help quickly. The registered manager told us that staffing levels were based on the needs of the people within the home. We observed that staffing levels in the home provided an opportunity for staff to interact with the people they were supporting in a calm, relaxed and unhurried manner. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime, bank staff, who were employed by the provider and agency staff. One member of staff told us they felt there was enough staff and added, "We use agency quite a bit at the moment as we are waiting for new staff members to start." Another member of staff said, "I feel there are enough staff on shifts, this is one of the best homes I've worked in." A third member of staff told us, "We have enough time to talk to residents; we've always got time for them."

People were supported by staff who had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and the registered manager had received appropriate training in safeguarding. All of the staff we spoke with were able to explain the actions they would take if they had a concern about people's safety. They were aware of the provider's policy and the other organisations they could report concerns to, such as the local authority and the Care Quality Commission. One member of staff told us, "If I came across any abuse I would tell [the registered manager] straight away. If she did not do anything I would contact CQC." A member of staff from an agency said, "I know what to do and would report anything to [the registered manager] and my agency". A third member of staff told us, "I would notify the senior on shift if I had any concerns. If they or manager did not do anything I would contact Safeguarding and make sure everything was documented and I had completed a body map."

There were plans in place to deal with foreseeable emergencies. Staff had been trained to administer first aid and there was a programme of fire safety training and fire drills in place. Fire safety equipment was maintained and tested regularly.

Requires Improvement

Is the service effective?

Our findings

People's ability to make decisions was not always assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Although staff and the registered manager had received training in respect of MCA and were able to demonstrate an awareness of the principles, they did not always apply this to the people they supported. For example, the care plan for one person included comments such as, 'due to worsening dementia [person] is unable to understand how to brush [their] hair' and 'due to dementia [person] is unable to make wise choices with [their] diet'. The memory service who saw the person in September 2017 stated the person's dementia 'has worsened and now would be classed as severe'. However, no assessment of capacity had been completed to allow staff to understand what particular decisions the person was able to make for themselves and which decisions they needed help to make.

When a person lacks the mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The section of the person's care plan entitled 'ability to decision make' stated, 'due to dementia unable to decision make.' We saw that staff were making decisions on behalf of this person in respect of their medicines, personal care and nutrition. However, staff did not follow the principles of making best interests decisions; the views of family members and other professionals involved in the person's care were not always sought; and the decisions were not recorded.

The failure to ensure people only received care and treatment with the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the registered manager was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider and the registered manager were not following the necessary requirements. No applications for a DoLS authorisation had been made for anyone at the home. The care plan for one person who lacked capacity stated, 'has no awareness of surroundings outside [their] room' and '[person] has no concept of danger'. Their daily record of care included the comment '[Person] very agitated and keeps saying [they] have to leave to see [their] family.' The registered manager told us they would 'only allow [person] to go out if accompanied because [they] would not be safe'. They confirmed that there was no DoLS authorisation in place because they did not feel a DoLS authorisation was necessary. We explained the requirements of the MCA and DoLS and they agreed to submit a DoLS authorisation application immediately.

The deprivation of a person's liberty without the appropriate authorisation is a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff asked for their consent when they were supporting them. Throughout the inspection, we observed staff checking with people that they were happy before they provided support and care.

People told us they felt the service was effective and that staff understood their needs and had the skills to meet them. They said, the staff were all trained to look after them effectively. One person added, "The girls look after me. I am happy here it is good." A family member told us, "Staff are very good. [My relative's] needs have changed and they have adapted things so that they can meet [their] needs. For example, they have put a mirror on the back of the lift because [my relative who mobilises with a wheelchair] can back out." All of the health professionals we spoke with told us they felt the staff understood people's needs and had the skills to meet them. One health [professional told us, "Staff know people very well. I would say they are well trained, they seem to know what they are doing." Another health professional told us, "The staff know the residents well and seem to have a very good and close relationship with them." A third health professional in their feedback said, "The staff keep good records of clients' needs for me, so when I arrive I have an up to date list of clients and there needs".

People were supported by staff who had received an effective induction into their role. Each new member of staff had undertaken a six months' probation including an induction programme, which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. They also spent time shadowing a more experienced member of staff who assessed their suitability to work on their own. One member of staff told us, "I completed a three month induction. It was very good and I was pleased I could do it even though I had previous experience. I did a full two weeks of shadowing before I was able to carry out any direct work."

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, manual handling, infection control and first aid. Staff had access to other training focused on the specific needs of people using the service, such as, managing challenging behaviour, end of life care and dementia awareness. Staff were also supported to obtain vocational qualifications in care. One member of staff told us, "The training is really good. I have done my level three diploma and just done my team leader course. So if you see one [training course] you want you just ask and you can do it." Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, how they supported people to mobilise with the help of walking aids, such as a walking frame.

Staff had regular supervisions and staff who had been at the service for longer than 12 months also received an annual appraisal. Supervisions provide an opportunity for management teams to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff said, "I find them [supervisions] useful. You can sit and chat and bring up things you want to. It is nice to have one and find out how you are doing."

People said that they were happy with the food at the home. They told us they were offered choices at lunchtime and other alternatives, if they did not want what was offered. One person said, "Yes, the food is good, they ask the day before what you would like to eat." Another person told us the chef was "a trained cook anyway, yes she is very good". A third person said, "The food is really good here and there is lots of it."

We saw different people had different meals. Staff who prepared people's food were aware of their likes and dislikes, allergies, preferences and portion size. The cook told us, "People who are diabetic have the same meals as the others but using non sugar substitutes." The cook said they, "followed a six week menu cycle and do themed lunches to make things different for people".

Mealtimes were a social event and staff engaged with people in a supportive, calm and relaxed manner. At one point during lunch, we observed that a birthday cake was brought out for one person. This was decorated in their favourite colours and they looked very pleased with the cake. Care staff and other people all sang 'Happy Birthday' to them. We observed staff interacting positively with people throughout the lunchtime and staff continually referred to people by their preferred names. Drinks, snacks and fresh fruit were offered to people throughout the day.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. One health professional said, "Staff are quick to call us if they have any concerns. We work together very well and they are responsive to what we ask them to do." Another health professional told us, "I have always found them able to give a succinct but accurate description of any problems and they are also good at anticipating where problems may develop." A third health professional said, "A member of staff will always accompany me on my rounds so as to introduce me to new clients and reassure more vulnerable nervous clients with a friendly face." All appointments with health professionals and the outcomes were recorded in detail.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. One person told us, "Oh the girls here are lovely, I feel sad when anyone leaves but they are all wonderful." Another person said, "Everyone [care staff] is nice and concerned for each other here." A third person said, "They are all very good. If you want anything, you tell them, they are all very helpful. They are very friendly." A family member told us, "It seems brilliant here. Staff are nice and caring". They added, "[My Relative] gets on with them [the staff]; they have a giggle." The health professionals we spoke with and provided feedback told us they did not have any concerns about how people were cared for. One health professional said staff, "definitely respect people's privacy and dignity. There seems to be a lot of signs everywhere and staff always knock before entering."

Interactions between people and staff were positive and friendly. We saw staff kneeling down to people's eye level to communicate with them. Staff gave people time to process information and choices were offered. Staff did not rush people when supporting them. When supporting a person with their soup at mealtime a member of staff gently advised them, "There you go, be careful it is hot". Another member of staff engaged with a person who was celebrating their birthday and asked, "The ladies on the other table are wondering how old you are." The person gave their age and everyone wished them a happy birthday. We could see from the person's face that they enjoyed sharing their birthday with the other people in the room. We heard good natured banter between people and staff showing they knew people well. People were clearly relaxed and comfortable in the company of staff. Staff spoke warmly about people and knew how to relate to them in a positive way.

People were cared for with dignity and respect. Staff spoke with people with kindness and warmth and were observed laughing and joking with them. We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. Staff told us the action they took to ensure people's privacy and dignity was respected when supporting them with personal care. This included making sure doors and curtains were closed and people were covered as much as possible.

Staff understood the importance of respecting people's choice. One person told us, "If I don't want to do something I don't have to but I enjoy all the things on offer". Staff spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. Choices were offered in line with people's care plans and preferred communication style. We saw one member of staff supporting a person in a wheel chair to access the lounge. They asked the person which area they wanted to sit in and then clarified, which chair they preferred. Where people declined to do something, take part in an activity or wanted an alternative, this was respected.

People and where appropriate, their families were involved in discussions about developing their care plans. We saw that people's care plans contained information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes.

People were encouraged to be as independent as possible. During the inspection, we observed staff supporting one person, who used a walking aid to mobilise. They encouraged them to take their time and followed nearby providing reassure to the person to continue to mobilise. Another person has been assessed as being able to manage their own medicines without supervision. A third person's care plan describe how they liked to be supported when they received personal care and which parts of their care they could do by themselves.

People were supported to maintain friendships and important relationships; their care records included details of the people who were important to them. All of the people we spoke with talked about how their friends and family visited them at the home and that they were able to go out to visit them in the community. One person said, "We can all have visitors whenever we want. Occasionally we have children in and it's very lovely." Another person told us, "My daughters visit every week and can come whenever they want. I go to one of their homes on a Sunday." A family member said, "I can visit anytime I like. My sister and I visit alternate days so we are here pretty much every day." They added, "They make you feel very welcome they have sweets and things for the children as well." People's bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

Information regarding confidentiality formed a key part of the induction training for all care staff. Confidential information, such as care records were only accessed by staff authorised to view it. Any information, which was kept on the computer, was also secure and password protected.

Requires Improvement

Is the service responsive?

Our findings

People received care and treatment from staff who were aware of their individual needs. However, people's records of care were not always up to date or personalised to meet their needs.

For example, although staff were able to explain how they supported a person who was receiving end of life care, this was not reflected in their care plan. The care plan had not been updated to reflect that they had moved to this stage of their life's journey and provided no information to staff on how they should support them with dignity. The same person, who was diabetic, had an anticipatory care plan, which had been completed with their GP on 21 September 2017. Their anticipatory care plan stated they were allergic to one of their diabetic medicines. We looked through other records of care, including their medicine administration records (MAR) and there was no other reference to this allergy. We saw from their MAR chart that prior to being on end of life care they were administered this diabetic medicine on a daily basis. We raised these concerns with the registered manager, who accepted that although staff were aware of how to support the person receiving end of life care their care plan was not up to date. They told us this person was not allergic to the diabetic medicine and it was an error. They undertook to complete an end of life care plan for the person.

The behavioural assessment in the care plan for another person who occasionally behaved in a way that staff or other people using the service may find distressing did not reflect their current needs. The behavioural plan stated they were not verbally or physically aggressive and did not disturb others. However, the daily records of care for this person included frequent comments such as, 'shouting in the corridor', 'shouting and screaming', 'very aggressive, tried to bite carer', 'still very aggressive to carers' and 'Very aggressive hitting out and shouting at carers.'

The medicine administration records (MAR) for a different person stated they had an allergy to specific medicines, however, these allergies were not recorded in their care plan. Each person had a hospital form, which is used as a 'grab sheet' if the person needed to go to hospital in an emergency. We looked at this person's hospital form and found that it did not contain any information in respect of their allergies.

Another person, who had lived at the home for nearly four months, only had their pre-admission assessment care plan, which did not provided detailed information in respect of how staff should support them. For example, under mobility it stated, 'Mobilises with crutches. Unable to walk long distances.' However, it did not explain what a long distance would be for this person and the action staff should take if they were unable to walk that far. There was no nutritional care plan and the section in respect of the different foods they liked or disliked was blank. Their pre-assessment care plan stated they were living with mild dementia. However, there was no detailed information as to how this affected them and their ability to make decisions for themselves. In answer to the question 'can the person cope with and solve day to day problems independently?' the answer was 'No.' However, there was no other information to assist staff in understanding how to support this person with their dementia and day to day living. There was information in the care plan about the person's personal history to help staff understand their background or memories that were important to them.

A different person who had also lived at the home for nearly four months only had their basic pre-admission assessment care plan. Since being at the home this person had undergone major surgery, which impacted on their care needs but was not reflected in their care plan.

The registered manager told us that there was a full care plan written for these two people but they had not yet been printed out and placed in their file. We spoke with the staff supporting these people and they were able to demonstrate that they were aware of the people's needs. The updated care plans, which were detailed and focused on the individual needs, were in place by the second day of our inspection.

The failure to ensure people's records of care were accurate and up to date was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the records were not always up to date and accurate, staff were able to describe the care and support required by individual people. For example, one member of staff was able to describe the support a person required when mobilising. Handover meetings were held at the start of every shift and provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting.

People told us they were happy with how staff looked after them. One person said, "I couldn't be happier, this is a lovely place." Another person told us, "I like being here, I find it very good." A family member said, "You can't fault it. This is a really nice place". The health professionals we spoke with and provided feedback told us that staff were responsive to people's needs. One health professional said, "Staff always know where people are when we come in and they will call us if they have any concerns." Another health professional told us that St Vincents Care Home was, "The best care home I have ever worked in due to the balance between effectiveness and caring being handled so well."

Each person had an allocated keyworker, whose role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. They supported them with their shopping, managing their clothes and maintaining their room. They were also responsible for making sure care plans and preferences of each person are up to date. The registered manager accepted that this has not been happening and stated she needed to establish a new keyworker team.

People were provided with appropriate mental and physical stimulation; and supported to access activities that were important to them. One person said, "There is always something on here and that's great. There is a particularly good pianist who comes and he is brilliant." Another person told us, "We have Halloween coming up and remembrance, it's all very good, it makes you feel you are with the outside world." Most of the people living at the home were independent and able to access the community on their own. The registered manager told us they held regular activities and events at the home, such as, a special remembrance day where they talk about memories and remembered people who have died in the last year. They said they had recently had a display where a group, who look after birds of prey, brought them into the home to do an indoor display. There were also themed lunches, such as a Halloween lunch and lunches focused on foods from different countries.

During the inspection, we observed people taking part in both individual activities and group activities, such as dominoes. Other activities included beanbag tossing, music mayhem, bingo, music for health, zoo lab, and reminiscing. There were also regular entertainers, such as singers and musicians who visited the home. Family and friends were also invited and encouraged to take part in the activities.

The providers had a policy and arrangements in place to deal with complaints. They provided detailed

information on the action people could take if they were not satisfied with the service being provided. People had access to an independent advocate, if they needed one. All of the people we spoke with told us they knew how to complain but did not have any complaints. One person said, "I've never had to complain about anything." Another person told us, "I have never had to complain about anything but if I did I would speak to the manager." The registered manager told us they had not received any formal complaints over the previous year. They said that when concerns were raised they dealt with them straight away before they developed into a complaint. The registered manager was able to explain the action they would take if a formal complaint was received.

Requires Improvement

Is the service well-led?

Our findings

There were systems and processes in place to monitor the quality and safety of the service provided to people living at the home. The provider's quality assurance process included governance and quality inspections. The registered manager had established their own quality assurance checks and audits, which were managed through the department team leaders, such as care monitoring, estates and health and safety. The registered manager also carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified these were managed through team meetings. However, this approach to quality assurance was not robust and did not identify the concerns we found during the inspection, regarding the failure to assess and manage the risks to people effectively, manage medicines safely, comply with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and the failure to maintain accurate and up to date records.

The failure to ensure that there were effective systems and processes in place to assess, monitor and improve the quality of the service people received was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt the service was well led. A family member told us, "The leadership here seems good, their door is always open. You can say whatever, queries or concerns you have. I often pop in and when I ask them to do something for [my relative] they always do." The health professionals we spoke with and provided feedback told us they felt there was good leadership at the home. One health professional said, "This is a lovely home. I would put my family here. It's one of the best." They added, "I have no concerns whatsoever. It is a really good home." Another health professional told us the management team, "Manage conditions and circumstances that might tax other residential homes. It seems to be very well led, and all processes seem efficient and well organised." A third health professional said in their feedback, "St Vincents is a warm friendly home for its clients with excellent care and top class management. Should my own family ever need care, I hope I would be able to have them stay somewhere as good as this."

There was a clear management structure, which consisted of the director of client services, who is the provider's representative, the registered manager, the principal care and training officer, the estates and care officer, and senior care staff. Staff were confident in their role and understood the part each person played in delivering the provider's vision of providing the highest standard of care while supporting them to have a quality of life. The registered manager explained it was about, "Caring for those who have cared for us." The management team encouraged staff and people to raise issues or concerns with them, which they acted upon. One member of staff told us, "I feel supported by the management. There is an open door policy. The manager never says no. If you have a problem they will deal with it". Another member of staff said, "I feel listened to and [the registered manager] acts on it really quickly."

The provider was fully engaged in running the service. The registered manager told us their line manager visits the home monthly and then sends them a visit report. The registered manager explained they had been on a long term absence from the home and told us they were in the process of catching up on the areas that had slipped while they were away. There was a positive culture in the home and both the

registered manager and staff were responsive to the concerns we raised and took immediate action to address the issues we had identified.

The registered manager had an open door policy for the people, families and staff to enable and encourage open communication. The registered manager sought feedback from people and their families on an informal basis when they met with them at the home or during telephone contact. They also sought feedback during resident meetings, which were held on a monthly basis. We looked at the minutes of the latest meeting, which had taken place in October 2017 and included discussions about new staff, activities, catering and the care people received. People all said they were happy with the service provided. A family member told us, "They [the registered manager] ask how things are going. They ask [my relative] about what he thinks about the care they provide. We are very happy with the home and definitely recommend it". One person said, "We have meetings, they tell us what they think of us and we tell them what we think of them." Another person told us, "I have been to nearly every one [residents meeting] since I've been here. I enjoy being involved." The provider also sought formal feedback about the home through the use of a quality assurance questionnaire, which was sent out to people, their families, professionals and staff.

The provider had suitable arrangements in place to support the registered manager; for example regular meetings, which also formed part of their quality assurance process. The registered manager confirmed that support was available to them from the provider through their line manager, the governance team and the HR and finance teams. They told us they also had regular contact with their line manager by telephone and said, "I do feel they listen to me and have concerns for my welfare." The registered manager told us they keep themselves up to date with best practice and new legislation through, enhanced training, the CQC website, and various newsletters. They said they were also a member of the confederation of service charities.

The home had a whistle-blowing policy, which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. They also understood and complied with their responsibilities under duty of candour.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider has failed to ensure that people only received care and treatment with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to identify, assess and manage the risks to people's health and safety; and failed to manage medicines safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider has failed to ensure that people are only deprived of their liberty when it was legally authorised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to ensure that people's records of care were accurate and up to date; failed to ensure that there were effective systems and processes in place to assess, monitor and improve the quality of the service people received.