Barchester Healthcare Homes Limited

Vecta House

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 19 and 26 April 2017 and was unannounced. Vecta House provides accommodation, nursing and personal care for up to 54 people living with dementia. There were 54 people living at the home when we visited.

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. People's families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role.

The provider's quality assurance procedures had failed to identify the areas of concern we found. These included the recording of restraint and the failing to ensure all medicines were administered as prescribed. Nursing and care staff had failed to self-monitor their practice such as leaving potentially dangerous fluid thickening powder available to people and not following up on gaps in administration records for insulin.

There were generally enough staff to meet people's needs although activities staff were supporting care staff meaning they were unable to provide a full range of activities and management staff were supporting nursing shifts meaning they were not able to complete all management tasks. Relatives identified that people would benefit from additional mental and physical stimulation. We have made a recommendation about this.

Whilst the majority of interactions we observed between staff and people were positive, with people being cared for with kindness and compassion we also observed occasions when this was not the case. People felt safe and staff knew how to identify, prevent and report abuse. Staff offered people choices and respected their decisions. People were supported and encouraged to be as independent as possible and their dignity was promoted.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. Reviews of care were conducted regularly. People had access to healthcare services and were referred to doctors and specialists when needed.

Relatives and external health professionals were positive about the service people received. People enjoyed their meals and received support if required to ensure they had a nutritious diet. At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

The recruitment process helped ensure staff were suitable for their role. Staff received appropriate training and were supported in their work.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

Staff worked well together, which created a relaxed and happy atmosphere that was reflected in people's care.

We found three 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 end of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Where people placed themselves or others at risk of harm action was taken and staff knew how to identify, prevent and report abuse. Staff understood how to keep people safe in an emergency situation.

Not all risks were managed safely although immediate action was taken by the registered manager to rectify these concerns including ensuring the correct storage of fluid thickening powder. Medicines were not all administered as prescribed however systems did ensure they were ordered, stored and destroyed safely.

There were usually enough staff although shortages of qualified nurses were meaning some management tasks were not being promptly completed. Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider's policy and procedure for the use of restraint to provide essential personal care had not been followed. People were supported to access other healthcare services when needed.

People received a varied and nutritious diet and they were supported appropriately to eat. Staff knew how to meet people's needs; they were suitably trained and supported in their work.

The environment and equipment were suitable for people living at the home.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst the majority of interactions we observed between staff

and people were positive with people being cared for with kindness and compassion, we also observed occasions when this was not the case. Staff understood people's needs and knew their preferences, likes and dislikes which they met.

People (and their families where appropriate) were involved in assessing and planning the care and support they received. At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

People's privacy was protected and confidential information was kept securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Relatives told us people would benefit from more activities which we found were reduced due to the activities staff supporting care staff and people with other tasks.

People received personalised care and support. Staff demonstrated a good awareness of people's individual needs and responded effectively when their needs changed.

There was a complaints policy in place and people knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's quality assurance procedures were not sufficiently robust and had failed to identify the areas of concern we found.

When untoward incidents or accidents occurred, procedures were in place to ensure people received the care they required.

People and their relatives felt the home was well managed. Staff understood their roles, were motivated, worked well as a team and felt valued and supported by the management team.

Vecta House

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 26 April 2017 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the home 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 three people living at the home and 12 visitors. We spoke with the registered manager, deputy manager, three nursing staff members, eight care staff and ancillary staff including administration staff, maintenance staff, activities staff, the chef, kitchen staff and housekeeping staff. We also spoke with five visiting health professionals and with one other health and social care professional by telephone. We looked at care plans and associated records, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas.

The home was last inspected in October 2015, when we did not identify any concerns.

Requires Improvement

Is the service safe?

Our findings

Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable diets to reduce the risk. However, the risk to people individually and in communal areas from a fluid thickening powder had not been safely managed. On several occasions, when staff were not present, we saw a tin of the powder located in a communal area within people's reach. There were people who were independently mobile moving around within this area. Staff and the registered manager were aware of the risk this presented to people but had not ensured action was taken to minimise the risk. On the second day of the inspection we saw that action had been taken to ensure the fluid thickening powder was stored safely when not in use. Other risks associated with the environment and the running of the home had been assessed and actions identified to reduce those risks. They included, the use of electrical equipment, the laundry, clinical waste disposal and handling and the control of substances hazardous to health (COSHH).

Where individual risks to people were identified action was taken to reduce the risk. These included, for example, the risks to people of falls, choking, nutrition and skin damage. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. A system was in place to monitor the use of pressure relieving equipment and ensure it was used correctly. People were assisted to change position regularly to reduce the risk of pressure injury. Moving and handling assessments set out the way staff should support each person to move. Staff had been trained to support people to move safely and we observed equipment, such as hoists, being used in accordance with best practice guidance.

Procedures to administer medicines had not always ensured that people had received these as prescribed. One person was prescribed a medicine which was to be given once a day or more often if required to prevent seizures. However, nursing staff had failed to read the prescription correctly. The nurse on duty told us they had assumed that this was only to be given when required for agitation as this was prescribed for other people for agitation. The person had not been receiving the medicine for several months and their 'as required' (PRN) care plan stated it should be given if they became agitated and made no reference to seizures. We discussed this with the registered manager and a senior nurse who stated they were going to discuss this with the GP. The failure to ensure medicine was administered as prescribed increased the risks to the person of seizure. One week before the inspection the person was found by staff on the floor in a corridor and thought to have fallen. The description of the incident given by nursing staff who had attended the person included fluctuating levels of consciousness and indicated that the person may have had a seizure.

Nursing staff said that if they identified a failure of the previous nurse to correctly record or administer medicines they would immediately raise this and take any other necessary action. However, nursing staff had failed to follow-up when a previous nurse had not recorded on the Insulin medicines administration record that they had checked a person's blood sugar levels and administered insulin. This meant that action to confirm if the person had or had not received the medicine and any necessary action required to ensure the person's safety had not been taken in timely way placing the person at risk. It also meant that we could

not be assured the person had had their medicine.

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

We also noted that when nursing staff made handwritten additions to Medicine Administration Records (MARs) these were usually, but not always signed by two staff. This is considered good practice and helps protect people from potential transcribing errors.

Some people were prescribed medicines which were required to be administered up to four times per day. This included medicines such as paracetamol which should be given at least four hours apart. There was no system to accurately record the times these medicines were administered placing people at risk that these may not always be administered with an adequate gap between doses. We noted that the morning medicines round continued in one part of the home until almost 11.00 am with the next commencing at 13.30pm. We discussed this with the registered manager who took immediate action to introduce a new system to record the exact time of administration for medicines prescribed to be administered several times per day.

The provider used 'as and when necessary' (prn) protocols for pain relieving medicines. A recognised pain assessment tool was available although nursing staff were not regularly using this to determine when people who were unable to state they were in pain should receive as required pain relief. There were suitable systems to ensure other prescribed medicines, such as nutritional supplements and topical creams, were provided to people.

There were appropriate arrangements in place for the safe storage of medicines and the safe disposal of unused prescribed medicines. There were also effective processes for the ordering of stock and checking stock into the home to ensure the medicines provided for people were correct. Registered nurses told us they had received training in medicines management and administration at the home in addition to that completed during their nurse training. We observed nursing staff administering medicines to people in a patient, unrushed manner, and informing people what the medicine was for.

Most visitors felt there were not enough staff to meet people's needs. Comments from relatives included "They don't have enough staff to cope with it all. The level of service is top notch, but if they have to deal with incidents, then there's not enough to cope with everything". Another visitor said "Staff are not always around. I know the staff ratio is high, but then I think 'why am I sat by myself in the living room with residents?" Visiting health professionals told us there was always a staff member available to support them and felt there were enough staff.

Staff also had mixed views about staff levels. They told us their workload was manageable but did not have time to provide additional individual support or activities. One staff member told us, "There are usually enough staff, unless one goes sick at short notice and can't be replaced." Another staff member said, "On the whole there are enough staff but more time to spend with people would be good." We were also told that staff may not be able to immediately respond to some requests such as if people wanted a bath or shower in the morning. A staff member said "We would have to offer them another time, maybe in the afternoon". We saw a nurse who needed to take a phone call asking a member of the housekeeping team to observe and support a person who was unsteady but wanted to move around the corridor. At that time all the care staff in the area were supporting other people.

The registered manager told us their main concern with staffing was the recruitment of qualified nurses and

they were using agency nurses at night and members of the management team including the registered manager were frequently undertaking nursing shifts. They acknowledged that this meant they were not always able to promptly complete other management duties. The registered manager told us new nurses had been recruited and were due to commence employment when all relevant checks on their suitability had been received. The registered manager told us staffing levels were based on the needs of people using the service, together with feedback from people, relatives and staff. When setting the staffing rotas, they took account of the skill mix to help make sure staff with the necessary qualifications and experience were available throughout the day. Care staff absence was usually covered by existing staff working additional hours; this benefitted people as they were cared for by staff who knew and understood their needs.

Fire safety equipment was maintained and tested regularly. There was an emergency 'grab bag' in the foyer which contained a 'resident's dependency' fire safety chart which identified people's ability to respond in case of a fire. However, the chart identified people by their bedroom number, which did not take account of those people who were mobile and could be found in other parts of the building. We looked in the fire [safety] box and saw the evacuation plan for the home had not been updated since July 2012. We raised this, and the room based 'resident's dependency chart' with the registered manager who undertook to review the evacuation plans.

There was a plan in place to deal with foreseeable emergencies in the home, this included access to emergency numbers and contact details for emergency services and there was a plan in respect of responding to a fire. Staff had been trained to administer first aid and there was a programme of fire safety training and fire drills in place. During the inspection a person set off the fire alarm. All of the staff responded calmly and confidently to the alarm, providing reassurance to people while following their fire safety procedures. Once it was confirmed as a false alarm the system was reset and further reassurance was given to people who appeared concerned.

People told us they felt safe at Vecta House. When asked if it was a safe place one person said "Yes, I feel safe". Other people able to respond also said they felt safe. Visitors said they felt their relative was safe at Vecta House. One relative said "They [relative] need vigilance and observation. They [staff] try not to restrict people. I would say he's as safe here as he could be anywhere". Another visitor told us "I can go home and sleep", whilst a third visitor said "I trust the staff". One visitor described the action that was taken when they felt their relative was not safe. They told us "I did have to talk to the manager. My wife was attacked by another resident and I wanted assurance it wouldn't happen again. This happened twice. I wasn't happy with her being in the same section as my wife. She was moved and when she came back she had one of the staff with her continually". Where people placed themselves or others at risk care plans contained information to guide staff about the actions they should take to manage the risk. This showed action was taken where risks to people's safety were identified.

All staff including ancillary staff such as housekeepers had received safeguarding training and knew how to identify, prevent and report abuse. They told us they would have no hesitation raising concerns and had confidence that the registered manager or other senior staff would take appropriate action. One member of staff told us "I would go straight to [name of the registered manager]". Another staff member told us "I would tell the nurse, if they didn't do anything, which they would, I could go to the manager or up higher in the company". Staff were also aware of external organisations they could contact for support, including the local safeguarding authority. The registered manager took their safeguarding responsibilities seriously and was aware of the actions they should take should safeguarding concerns be brought to their attention. When necessary they had reported concerns to the local safeguarding team and worked with them during investigations.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. However, recruitment records did not always show where gaps in the employment history of potential new staff were fully explored. We raised this with the registered manager who took action to ensure this was correctly recorded in the future.

Requires Improvement

Is the service effective?

Our findings

A person told us they were offered choices and their decisions such as what time to get up in the morning were respected. Other people were less able to comment. Care staff told us how they offered choices and sought consent before providing care. One said "If they said no, we don't do it but try later or get another care staff member to try." Another staff member told us "If people say no, or show they don't want something, like a wash I would try to encourage them and explain in a different way. If that didn't work I'd leave them for a bit and try again". We saw in daily records that staff had recorded when people had declined baths or showers and that they had been offered these at an alternative time.

Staff described how they sometimes held a person's hands to prevent them hitting staff who were providing essential personal care. They described how they would try to explain to the person why care was required and wait to see if the person was in agreement however they would on occassions need to provide essential care without the person's consent. The person's care plan did not include an assessment of their mental capacity to agree, or not, to the use of restraint for essential personal care. Their care plan also did not specify which particular techniques should be used, the circumstances in which it was appropriate to use them, or how their use should be recorded and monitored. The provider had a 'restraint policy' which required the person or their family to be involved in care planning and risk assessment and for staff to document the use of physical intervention and complete an incident form, but this was not being done. The person's care plan did not detail how staff should support the person should they refuse essential personal care and there were no records or incident reports maintained of when restraint had been necessary. Therefore the provider was unable to confirm that the restrictive interventions were necessary and proportionate to support the person with their personal care needs. We discussed this with the registered manager, who said they would review the person's care plan and ensure the provider's policy was adhered to.

The failure to ensure the written assessment of the person's needs and their capacity or lack of capacity to consent when restraint was used placed people and staff at risk because the provider could not demonstrate the restraint was necessary or proportionate to the risk of harm to the person or others. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at Vecta House had a cognitive impairment and many were not able to give valid consent to certain decisions, including the delivery of personal care, the administration of medicines, the use of bedrails and the use of pressure relief mattresses. Staff members explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would need to do what was in the person's 'best interests'. The Mental Capacity Act, 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

Care plans contained information about the decisions people could make for themselves. Where people had been assessed as being unable to make decisions about their health or personal care, best interests decisions had been recorded. These covered aspects of care such as for medicines, personal care, continence, mobility, and nutrition. Where possible relatives had been included in best interests decisions. Care plans did not always accurately show where and who had the legal right to make decisions about a person's health care on their behalf. Other people can legally do this if they have been assigned a Lasting Power of Attorney for care and welfare. Whilst some care plans stated relatives did have this legal authority evidence to confirm this was not always available. The administrator was aware of this and was in the process of requesting information from family members to confirm when these were in place.

People can only be deprived of their liberty 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 found the provider was following the necessary requirements and DoLS applications had been made with the relevant local authority where necessary. There was a system in place to ensure that these were reapplied for when necessary and that any individual conditions relating to the DoLS were known and met.

Staff told us they had regular supervisions and felt supported by the management team and senior staff. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. However, we found the records necessary to demonstrate that formal supervisions were taking place and record any concerns or requests for support were sporadic and not always available. We raised our concern with the registered manager who accepted that the records were not up to date.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff who were new to care, received an induction and training, 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.

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, fire safety and first aid. Staff had access to other training focused on the specific needs of people using the service, such as, managing pressure damage, dementia awareness, and the Mental Capacity Act. Staff were supported to undertake a vocational qualification in care. There was a system in place to monitor those staff who need to maintain a professional registration for their role. This was an electronic system which notified the administrator when renewal of the registration was due. Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, we observed staff using moving and handling equipment correctly and care staff were able to describe the actions they would take if they had any safeguarding concerns.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. All relative's we spoke with told us health professionals such as GP's were contacted when required. One visitor said "The doctor comes in every week. He'll come in earlier if he's needed". Another visitor told us "He sees a doctor when he needs to". We spoke with five visiting health care professionals. They told us staff contacted them appropriately and were available to support them when they visited. We were told staff understood the best time for some professionals to visit. One said "They [staff] said it's best to come late morning. A staff member the patient knew stayed with them and talked to

them whilst we were providing treatment and the patient was able to cope with the treatment". Another external health professional told us "Staff are responsive to the things I ask them to do. I gave the nurse a sheet with some hand exercises [for the person I have just seen] and advice on hand care. He got the staff who know [the person] well so I could show them how to do the exercises. The staff were interested in what I was explaining".

Everyone was complimentary about the meals provided. Relatives commented on how people seemed to enjoy their meals. One relative told us "The menus are lovely. It's lovely, there's nothing to criticise." A second relative told us "There's good variety. He eats everything. I've said he needs bigger portions because he's young. He can have a sandwich after." Other relatives commented "She's well fed. The food's good, she doesn't leave anything." And "The food is very good and there's a choice. The portion sizes are appropriate." Most people received appropriate support to eat their meals however staff were interrupted during this and on occasions had to leave the person. Staff supporting people to eat their meals did not rush people and spoke with them throughout the meal.

People received appropriate support to eat and drink enough. People were encouraged to eat in the dining room where they sat in small groups at tables for up to four people. Choices were provided in a way to encourage people to make decisions. We saw a plate of each meal (two choices of the main meal) were brought to each person and the care staff explained carefully what each meal consisted of. A fresh plate of the person's choice was bought out to them. Alternatives were offered if people did not like the menu options of the day. Drinks were available throughout the day and staff prompted people to drink often. Special diets were available for people who required them and people received portion sizes suited to their individual appetites. Catering staff were aware of people's special dietary needs and described how they would meet these. Staff monitored the food and fluid intakes of people at risk of malnutrition or dehydration. They monitored the weight of people each month or more frequently if required due to concerns about low weight or weight loss.

Vecta House was laid out in three separate units, which encouraged freedom of movement by people between units. One relative commented "There's freedom for people who have to walk." An external health professional said "The home seems to have a really good and practical environment, with lots of places to go". The garden was laid out in a series of interconnected areas designed in different styles, including a meadow area, a sensory area and an area with artificial grass which was accessible all year. All of the garden areas were accessible to people and risks had been managed effectively. For example, cushioned flooring to patio and seating areas to minimise injuries from falls. Inside the home the corridors had a variety of pictures and tactile wall hangings to provide a visually stimulating environment. Each unit was decorated slightly differently to engender team ownership and encourage movement around the home. Doors were painted a different colour to make them visible and toilets and bathrooms had a visual image on them to help people know where they were.

Requires Improvement

Is the service caring?

Our findings

Whilst interactions between care staff and people were often caring, patient and good natured, some were not. We were told about and observed some occasions when interactions between staff and people were not positive for the person concerned. Examples included a relative who told us "Some just say hello. Just hello, they don't stop to talk to her". Another relative said "I did say something. [Name of relative] was in the toilet and she was shouting and calling for her husband because they were cleaning her. She panicked because she didn't know what was happening. They didn't explain what was happening. She was frustrated and scared".

At lunch time a person beckoned us over and told us they would like to go to the toilet, we informed a staff member who was nearby who said the person would have to wait until after lunch. We saw a member of staff who tried to put glasses on another person without explanation. The staff member did not speak to the person who protested, looked angry, moved his head around and wouldn't allow the staff member to put the glasses on him. A few minutes later another member of staff approached the person showing him the glasses and asked if they wanted to wear them. The person allowed the staff member to put on the glasses. This showed that with the right approach the person was able to accept support.

Relatives told us that when they had observed staff acting in an uncaring way they had spoken with the registered manager and were happy with the way this was dealt with. One relative said "I complained to [name of registered manager], they handled it perfectly. The staff member was not kind to my husband. Another relative told us "I saw a carer speak to a resident in a way that was abrupt, intolerant. I spoke to [name of registered manager] and we both said together 'That's not Vecta, that's not the Vecta way. I think he [registered manager] spoke to the member of staff".

Other interactions were positive and showed staff knew each person well. Staff were quick to comfort a person who was upset and to reassure another person who was upset and anxious. A member of staff assisted a person to eat, kneeling at their side. The staff member was called away, they [staff member] apologised to the person for this. The person told the staff member when they'd had enough and was then offered a drink. When staff were talking with people they would sit, bend or kneel down to be at face level with the person which facilitated better communication. Staff spoke with people while they were providing care and support in ways that were respectful. This was often accompanied by friendly banter which both the person and staff seemed to enjoy.

One person told us "Everyone is nice". A relative said "Some go above and beyond. They get to know the patients and really care for them. It's not just a job for them". Another relative told us "I know they [staff] would go out of their way for my mother". Other comments from relatives included "They are affectionate, they will cuddle a resident. On their terms, the resident's terms", and "They are so caring". An external health professional said "Staff are caring it seems very calm when you walk around". Despite the complex needs of the people living at Vecta House there was a peaceful calm atmosphere.

Although visitors were happy that their relatives living at Vecta House were safe they expressed concern

about people's property. One visitor said "Things go missing from his room. His glasses go missing. I tell him to keep it shut, all safe, but he doesn't understand. It wasn't locked yesterday, the TV remote went missing". Another visitor told us "Her glasses kept going missing, they get left around. At a hundred pounds a pop I soon had enough. I got her off the shelf reading glasses". A third visitor also expressed their concerns saying "Clothing goes missing. Sometimes other people's things are in here. I feel bad for them. Small things can be distressing. There's a lock on the door, but it's not always kept shut. They've put a sign on the door saying I said to keep it locked. I didn't tell them to put that. I don't like that". The registered manager told relatives were advised not to leave valuables with people however day to day items such as glasses and clothing are essential for people and expensive to replace. At handover we heard staff being requested to look for a missing item.

Staff understood people's individual needs. Staff spoke fondly of the people they cared for demonstrating good knowledge of people as individuals and what their likes and dislikes were. We also observed staff supporting people gently when moving around by holding their hands and offering reassurance and guidance. They encouraged people to move at their own pace and offered them choices, such as where to sit in the lounges and dining room. A member of staff brought a person into one of the living rooms and said 'Where would you like to go' The person pointed out where they would like to sit and the staff member brought them a drink and cake. The staff member was very friendly and joked with the person, who responded, describing the staff member as "nice and kind". Many of the staff we spoke with had worked at Vecta House for, at a minimum, several years and some for much longer. This meant staff and people had had the opportunity to get to know one another.

Care plans contained a section relating to communication and gave staff guidance as to how they should communicate with people. Staff described and demonstrated how they had learnt some basic words of two European languages to support people whose first language was not English. Where people had religious or cultural preferences these were known and met. The registered manager was aware of how to contact religious leaders if required.

People's wishes in respect of the gender of staff providing personal care were known and met. Care records included information showing people could choose the gender of the staff member to support them with personal care. This information was known to staff who told us about some people who had a particular preference which they said was always met. Staff described how at night care staff could be 'swapped' between areas of the home for a short time to ensure two female staff were available for one person who had requested this. Staff also respected people's preferences on a day to day basis. One care staff member said "If someone says 'I don't want you', I go away and get someone else [to support the person with personal care], the next day it may be me that they do want".

Staff ensured people's privacy was protected by speaking quietly and keeping doors closed when providing personal care. Relatives stated that staff maintained their loved ones privacy at all times and they had not witnessed any concerns with privacy. We saw when moving and handling equipment was used staff ensured the person's dignity throughout. Staff described how they promoted dignity and privacy, such as ensuring doors were closed and people were covered as far as possible during personal care. One care staff member said "We make sure people are covered and encourage them to do as much as they can". Confidential information, such as care records, was kept securely and only accessed by staff authorised to view them.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. We viewed the care file for one person who had received end of life care. The records showed that staff had provided them with all necessary care to meet their needs at this time. We saw that staff had acted overnight to contact external healthcare professionals to ensure the person received appropriate pain and symptom

management medicines. Discussions with care and nursing staff showed they had an understanding of the care people required at the end of their lives. The home had links with the local hospice and Macmillan nurses whose advice and guidance was sought when required.

Relatives said staff cared for them. We saw visitors were welcomed by staff, greeted by their first name and offered a drink when they arrived. One relative told us how staff had cared for a relative who had become unwell when visiting the home.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they would like more activities to be provided for people. One relative told us "I would like to see more physical activities so people can walk around outdoors, like gardening. Growing tomatoes or flowers or grow the biggest sunflower competition". Another visitor said "I would like to see more for the men like a busy board with switches and locks they could take outdoors and fiddle about with. He'd like to get out more, he gets frustrated. He couldn't do gardening. What he likes is to sit on a bus and to have coffee and cake out". Other visitors identified that it was hard for their relative to take part in group activities saying "I would like them to provide more stimulation for all the residents. Like more 1-1. I would like staff to have the time. Staff are very good, but they are limited by time and other things they have to do". Also "[name of relative] can't get involved. He can't see and he's lost sensation in his hands", and "No, she doesn't take part [in activities] because she can't speak or help herself anymore".

The interests, hobbies and backgrounds of people were recorded in their care plans. Activities coordinators were employed who provided various activities both in groups and individually, adapting these according to the likes and preferences of people on a day to day basis. However, the activities staff also supported other staff when required. For example, on the first day of the inspection in the morning they were providing individual support for a person who was placing themselves at risk as they were unsteady when walking but did not wish to sit down. In the afternoon the activities staff member was supporting a person with a hospital appointment. Whilst both these tasks were important it meant that no other people received activities that day. We identified that the activities staff member had supported twelve hospital appointments in the year to the date of this inspection, approximately once per week. They confirmed that this usually took a whole morning or afternoon. Care staff said that whilst they would like to provide activities they rarely had time to do this. There were also some visiting entertainers for example, musicians and also visits by animals, such as dogs. Vecta House shared an accessible minibus with a nearby home also owned by the provider. This was used to take people for outings when not in use for hospital appointments and staff were available.

We recommend the provider reviews the arrangements for the use of activities staff for other tasks to ensure all people have the opportunity for adequate mental and physical stimulation. We will check on this at the next inspection.

Vecta House used the provider's care planning format, which provided a comprehensive system to identify people's individual health and personal care needs and direct staff as to how those needs should be met. Individual care plans were well organised and the guidance and information for staff was generally comprehensive other than information in care plans were people may repeatedly refuse essential personal care. We have addressed this in detail in the effective section of the report. We saw staff followed the care plans. Records of daily care confirmed people had received care in a personalised way in accordance with their care plans, individual needs and wishes. Staff were able to describe the care provided for individual people and were aware of what was important to the person in the way they were cared for. Care files were reviewed at least monthly or if needs changed by the qualified nurses. All staff received a formal handover at the start of each shift. We saw that this provided a range of important information for staff and included

any special instructions for staff.

When people moved to the home, they (and their families where appropriate) were involved in assessing and planning the care and support they needed. One relative said "They [staff] ask, but we leave it up to them". Other relatives confirmed they had read care plans saying "I've read the care plan, but no one's gone through it with me", and "Yes, I've read them". Comments in care plans showed this process was on-going and family members were kept up to date with any changes to their relative's needs. This was also confirmed by relatives we spoke with. Care plans contained lots of individual information about people. People's preferences, likes and dislikes were known, support was provided in accordance with people's wishes and staff used people's preferred names.

People received the personal and nursing care they required in a way that met their preferences. A person told us they were offered showers regularly and that they were happy with the personal care support they received. A visitor told us they were happy with the way their relative's health and personal care needs were met. Staff recorded the personal care they provided to people including if people had declined offered care such as a shower or bath. These records showed people were supported to meet their personal and other care needs. Although there was a list for who should have a bath on a specific day we saw people had received baths at other times. Staff told us the lists were a guide but people could have baths on other days. Care staff told us they had ready access to any equipment such as for repositioning or assisting people to move around the home which they required.

Relatives gave us examples of when staff had responded promptly to questions or concerns. These included for example one relative who said "Things are done there and then. If it's not 'I'll put it on a post-it note and get back to you sometime. I wanted to find out how long [name of person] could stay in her chair. [Name of deputy manager] phoned the company. When a chair was delivered there were no instructions on the use. [Name of deputy manager] said she would give the physio a ring. She's brilliant". Another relative told us "We want to take her [person] out and they've shown us how to use the wheelchair". Another relative told us how staff had responded when their relative was unwell saying "The doctor was called; she [doctor] comes from Newport [local town]. They took her [person] to hospital". Nursing staff described the actions they had taken when a person had been found lying on the floor several days prior to the inspection. This included providing emergency care and contacting external health professionals. However, we were also aware of an event which occurred in December 2016 when staff did not take all necessary action promptly when a person was in need of medical attention resulting in a delay in their receiving treatment. We reviewed the information relating to this with the registered manager who said this had been discussed with all trained nurses at the home. Although the nurses involved were no longer employed at the service the registered manager had responded to ensure the situation should not reoccur.

Relatives were aware of how to raise concerns or complaints and were confident the registered manager would act on their concerns. One relative said "I would complain to the nurse of the section or to [name of the registered manager]". Other relatives also named the registered manager saying "Straight to the manager" and "I would speak out. I know the process. I know [name registered manager] well". The provider had a new 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. The information on how to make a complaint was displayed on a noticeboard within the home, in the 'service users' guide and included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman. The registered manager told us they had received four complaints since our last inspection. We looked at the records of these complaints and saw they had been dealt with in line with the policy and the result of the complaint was fed back to the complainant.

Requires Improvement

Is the service well-led?

Our findings

The provider's quality assurance procedures had failed to identify the areas of concern we found in relation to the failure to follow the provider's policy for the use of restraint which resulted in a breach of a Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have reported on this in the effective section of the report. The medicines audits had failed to note that a person was not receiving medicine for seizures as prescribed which may have led to their experiencing a seizure. We noted that staff were not always recording care or food and drinks at the time this was provided. This related to records for food and fluid intake and hourly checks undertaken on some people. There is a risk that not recording at the time may lead to inaccurate recording. Nursing and care staff had failed to self-monitor their practice such as leaving potentially dangerous fluid thickening powder available to people and not following up on gaps in administration records for insulin.

The failure to operate effective systems and processes to assess and monitor the quality of service and ensure regulations are complied with is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had arranged for a series of audits to be carried out by key members of their team such as the head of housekeeping who carried out regular audits of the laundry, infection control and cleanliness of the home; and the maintenance manager who carried out a system of audits to ensure that safety checks were made in respect of moving and handling equipment, water temperatures and fire safety. Other audits overseen by the registered manager included falls, accidents and incidents, medicine management and care plans. They also carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified an action plan was created and managed through the regular meeting processes. The registered manager held a daily 'stand up' meeting with senior staff to review any concerns or issues with people, staff or the environment.

The registered manager reviewed all accidents and incident and where people had fallen, the person's risk assessment was reviewed and staff considered additional measures that could be taken to protect the person. These incidents were logged onto an electronic system, which allowed analysis of accidents on an individual basis, across the home or across other homes owned by the provider. For example, an analysis of falls at the home identified an increase in falls during the early evening shift. As a result of the analysis an additional member of staff was allocated to that shift, which has had a positive impact in reducing the number of falls.

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. 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. The provider also sought formal feedback about the home through the use of a nationally recognised independent market research organisation. This was completed on an annual basis and the results were fed back to the provider and were available on-line for people, their families and interested parties to access. A comprehensive report and analysis of the feedback was provided to the registered

manager. We saw copies of the analysis feedback for Vecta House, which was positive and consistent with the previous year's results. The registered manager told us that if concerns were identified they would develop an action plan, which would be monitored by the provider through the regional director.

The provider had an extensive range of policies and procedures which had been adapted to the home and service provided. We saw these were available for staff in the nurse's offices. Staff referred to these at one point during the inspection showing they were familiar with the procedures file. However, the policy they referred to was found to be out of date. The registered manager confirmed the medicines policy had been reviewed and updated but a copy of the new version had not been provided to nursing staff. They immediately arranged to print copies for the three units and stated they would check that any other policies which had been reviewed were replaced. We were told any new policies were reviewed internally by the registered manager before being put in place to ensure they reflected the way the home was working.

There were systems in place to monitor the quality, safety and the maintenance of the buildings and equipment. The regional director carried out a regular detailed inspection of the home. Where areas of concern were identified the registered manager prepared an action plan and this formed part of the discussions during their regular management meetings. External specialists were contracted to carry out safety checks for legionella, gas and fire safety equipment.

There was a clear management structure, which consisted of the regional director, the registered manager, deputy manager, heads of units, nursing staff and senior care staff. Staff were confident in their role and understood the part each played in delivering the provider's vision of high quality care. The management team encouraged staff and people to raise issues of concern with them, which they acted upon.

The registered manager had an open door policy for the people, families and staff which enabled and encouraged open communication. Relatives were able to name the registered manager and other senior staff members. One relative said "'I'd air things with [name of registered manager]. He's approachable. There have been things I've questioned and he explains why things happen as they do or he's solved things. He's excellent. Top class. Very approachable". Another relative said "They [management team] are quick to address things and to solve things". External health professionals also felt Vecta House was well led. For example, one told us "I think it is well led, I have had positive feedback from all of my colleagues about the home".

The registered manager told us they kept up to date with current best practice via the provider's specialist teams, such as for dementia, who would also visit the home and provide training for staff. The registered manager had been regularly undertaking nursing shifts including weekends and nights due to a shortage of registered nurses. They reflected that, although this impacted on their management time it had given them the opportunity to work closely with staff and further understand the needs of people. The registered manager was aware of key strengths and areas for improvement, in respect of the home. On the first day of the inspection we identified areas which could improve the service; by the second day of the inspection the registered manager had taken action to investigate or address these for example, ensuring fluid thickening powder was stored safely.

Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. One staff member told us "We also have regular meetings. The 'stand up' meetings, heads of department meetings,

health & safety meetings, kitchen staff meetings, night staff meetings and general meetings. They are useful for sharing information and understanding what is happening in the home".

We observed positive, open interactions between the registered manager, staff, people and relatives who appeared comfortable discussing issues in an open and informal way. Records showed that notifications about significant events were reported to CQC as required. A duty of candour policy had been developed, and was being followed, to help ensure staff acted in an open and honest way when accidents occurred. The rating from their previous inspection was displayed on their website and in the foyer of the home. 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.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure that all medicines were administered as prescribed. Regulation 12 (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person has failed to ensure the assessment of people's needs and their capacity to consent when restraint was used. Regulation 13 (4)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person has failed to operate effective systems and processes to assess and monitor the quality of service and ensure regulations are complied with. Regulation 17(1)(2)(a)(c)