Calsa Care Limited

# Vicarage Court Care Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Our unannounced inspection took place on 4 June 2018. At our last inspection we identified one breach of regulation relating to safe care and treatment. We found people were not always being supported to transfer in the safest possible way by staff who were competent. At this inspection we observed good practice in this area, and found staff training was up to date.

Vicarage Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Vicarage Court can accommodate up to 80 people, in a single, adapted building which contains units for residential and nursing service users, younger people with disabilities and people living with dementia. At the time of our inspection there were 61 people using the service.

There was a registered manager in post when we inspected 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 told us they felt safe living at Vicarage Court Care Home, which was clean and well-maintained. We saw staff were recruited safely and deployed in sufficient numbers to meet people's needs, although some staff said they would like to have more on each shift to increase the amount of time they had to socialise with people. Medicines were managed safely, and staff and the registered manager had a good understanding of how to report accidents and incidents including concerns about potential abuse. Risks associated with care and support were well managed, although we have made a recommendation about the quality of records on the electronic system.

Staff had the training and support they needed to be effective in their roles, including a formal induction for newly recruited staff. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. We found staff were knowledgeable about people's needs and preferences.

Nutrition and hydration were well managed, and we observed a pleasant mealtime experience on the day of our inspection. Although we received some mixed feedback about meals, we saw the registered manager consulted people on what they wished to see on the menus, and observed people could ask for alternative meals if they wished.

People received support to access health and social care professionals when needed, and there were systems in place to ensure people were supported if they needed to be admitted to hospital. The environment in the Forget-Me-Not dementia support unit required some adaptation in order to improve its

suitability for people living with dementia, however the registered manager and provider had already recognised this and were preparing to act.

We observed people and staff had good relationships, and there was good, caring practice in the home, including ensuring people's rights, privacy and dignity were respected.

There were systems in place to ensure staff had access to information about people's up to date needs and preferences, and the provider was working to involve people more in the processes of reviewing care. Staff were confident in their ability to provide end of life care when needed, however some electronic care plans lacked detail about people's wishes in this area.

There was a varied programme of activities available in the home led by knowledgeable and enthusiastic staff, however people gave very mixed feedback about this and we did not see a high level of activity on the day of our inspection. People told us they would feel confident in raising concerns and complaints, and we saw there were processes in place to ensure these were responded to appropriately.

Feedback about leadership in the home was good, and we saw there was a robust approach to measuring, monitoring and improving quality in the service which took the views, opinions and diverse needs of people and staff into account.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Staff were recruited safely and deployed in sufficient numbers to meet people's needs.

Risks associated with people's care and support were well managed.

Medicines were being managed safely.

### Is the service effective?

Good

The service was effective.

Staff had access to the training and support they needed to remain effective in their roles.

People were offered choice and, where necessary, supported to make decisions in line with legislation.

People's nutrition, hydration and healthcare needs were well managed.

### Is the service caring?

Good

The service was caring.

We observed staff and people had a good rapport, and feedback we received confirmed this was the case.

People's dignity, privacy and rights were respected.

### Is the service responsive?

Requires Improvement

The service was inconsistently responsive.

Care was person-centred, although some detail including that about people's wishes for their end of life care were not documented on the electronic care system.

There was a programme of activities in place, although we

received mixed feedback about this and observed a low level of activities on the day of our inspection.

People knew how to raise concerns and complaints, and we saw processes to manage these appropriately were in place.

## Is the service well-led?

**Requires Improvement**

The service was inconsistently well-led.

There were robust processes in place to manage and improve quality of care delivery, however we found the process of transferring written records to an electronic system required more work.

There was good feedback about leadership in the home, and we saw evidence of high morale amongst staff.

The registered manager had good knowledge of how to respect and meet the needs and rights of people using and working in the service.

# Vicarage Court 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 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.

Our unannounced inspection took place on 4 June 2018. The inspection team consisted of three inspectors, an assistant inspector, a specialist advisor in nursing and an expert-by-experience who had supported someone to use this type of service.

Before the inspection we reviewed all the information we held about the provider, including notifications they had sent to CQC and past inspection history. We also contacted a number of bodies such as the local authority commissioning team, the safeguarding team and Healthwatch to ask if they had any information they wished to share. We did not receive any information of concern from these sources.

We had not asked the provider to update their Provider Information Return (PIR) in advance of this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the registered manager, the deputy manager, two unit managers, 8 care staff, the activities co-ordinator, 11 people who used the service and 3 visiting relatives. We looked at eight care plans, including supporting documentation relating to areas such as medicines administration, three staff recruitment records, training records and other records relating to the provision of care and general running of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

# Is the service safe?

## Our findings

At our last inspection we rated this key question as 'requires improvement'. We found some concerns with moving and handling practice, and a decision relating to the concealment of medicines in a person's food (often referred to as 'covert' medicines) had not followed a sufficiently robust process. We identified a breach of regulations relating to safe care and treatment, and asked the provider to send an action plan to show how improvements would be made. At this inspection we found the provider's actions had been sufficiently robust, and concluded they were no longer in breach of regulations in this area.

People told us they felt safe living at Vicarage Court. Comments included, "I feel safe and they are kind," "I feel very safe - staff [are] not nasty," and "I am safe, I'm happy here." A relative told us, "I'd recommend it to friends, [name of person] appears very safe."

Staff we spoke with said they had received updated training in moving and handling, and we saw records which showed all senior staff and 94% of care staff had received updated training in this area. One staff member said, "We did observed and practical [training]. We have a theory booklet which we have to answer questions to." Another member of staff said there was very regular observation of their practice. They told us, "[It is] almost every day when we're on the floor in the lounge area." They confirmed senior staff gave feedback to staff about their moving and handling technique where this was required. We observed staff using correct techniques when assisting people to transfer, and saw they gave explanations and reassurance to people when using equipment such as hoists.

We found safer recruitment practices were in place in the home. They included requesting employment references and making checks with the Disclosure and Barring Service (DBS) to ensure prospective employees were not barred from working with vulnerable people. Rotas showed staff were deployed in sufficient numbers to meet people's needs safely, and we saw the registered manager used a system to identify how many staff were needed based on the individual needs of people using the service.

We received some mixed feedback about the levels of staffing in the home. Our formal and informal observations, however, showed a high level of responsiveness and positive interaction.
Staff told us staffing levels enabled them to meet people's needs, however some staff said they would have more time to chat to people if they had an additional person on their shift. We discussed this with the registered manager when we gave feedback at the end of our inspection.

Staff we spoke with had received training in safeguarding, and could describe to us the signs of potential abuse and the action they needed to take to report any concerns. One member of staff explained, "It's making sure that we protect them [people] provide the proper care for the residents, and make sure there's no abuse and no neglect." Staff we spoke with confirmed they understood their responsibility to report concerns about any poor practice they observed.

Care plans we looked at contained assessments of risks associated with aspects of people's care, including those for falls, skin integrity, nutrition, hydration and continence. Although there was some guidance for

staff to follow to show how risks could be minimised, we found there was a variation in the level of detail captured on the electronic care record system. For example, some care plans showed in detail how the person should be supported, and referred to advice received from other health professionals following an appropriate referral. Some care plans lacked detail in this area, however. For example, in one care plan we saw the person was at risk from poor nutritional health, however the guidance for staff lacked information about the person's dietary likes and dislikes which may have assisted staff in encouraging the person to eat. We found staff were knowledgeable about how they minimised risks for individual people, but this knowledge was not always documented. We discussed this with the registered manager, and have made a recommendation which is explained in the 'well-led' section of this report.

Staff we spoke with understood how to record and report and accidents. One member of staff told us, "There are reports for everything. There's forms we fill in and they have to be witnessed by someone." We looked at how the registered manager reviewed and responded to reports of incidents. We saw they conducted further investigation or root cause analysis as required, and recognised when incidents should be reported to other bodies, such as the local authority safeguarding team or the CQC.

People lived in a clean, well-maintained environment which indicated good infection control practices were in place. We saw people had personalised evacuation plans (often known as 'PEEPs') which showed how they could be safely assisted in the event of an occurrence such as a fire. There were regular checks in place to ensure fire safety equipment was in good working order, and staff attended regular fire evacuation drills. We saw staff had access to and used appropriate personal protective equipment (PPE) such as gloves, aprons and hand wash.

We found medicines were managed safely, and people who used the service raised no concerns in this area. Medicines administration records (MAR) contained a photograph of the person to aid correct identification, and highlighted any information relating to allergies the person may have. Any special instructions relating to medicine, for example 'to be given before food', were clearly identified. We looked at 12 MARs and found there were no recording errors, and saw any non-administration, for example because the person had refused their medicine, was fully recorded.

We observed a medicines round and saw this was completed in a safe and timely way, with people given time to take medicines at their own pace. One person managed their own medicines, and we saw records showed appropriate risk assessments had been carried out to ensure they were supported to keep their independence in this area in a safe way. Medicines for each person were kept in a locked cabinet in their rooms, and we found stocks matched the administration records, meaning no errors had occurred. Some medicines, known as 'PRN', are prescribed to be given 'as and when', such as those for pain relief. We saw there were clear protocols in place to show staff when these should be given and in what amounts.

We saw all medicines, including those classified as 'controlled drugs', were appropriately and securely stored, with no over-stocking. Bottled medicines were clearly labelled to show when they had been opened, and we saw medicines which needed to be returned were recorded and stored separately for collection by the pharmacy.

Good

# Is the service effective?

## Our findings

At our last inspection we rated this key question as 'requires improvement'. We identified some gaps in the recording of best interest decisions and consent. We did not identify any breaches of regulations. At this inspection we found there had been an improvement in this area, however some electronic care records needed further updates in order to ensure full information had been transferred from the paper records.

We saw new staff completed a formal induction which included classroom and online learning, shadowing more experienced staff through a 'buddy' system, and completion of the Care Certificate by those staff who did not have previous experience of care work. The Care Certificate is an identified set of standards that care staff adhere to in their working lives. All staff received regular updates to key aspects of their learning through regular 'refresher' training in areas such as dementia care, first aid, person-centred care and mental capacity. Nursing and care staff we spoke with demonstrated a good level of knowledge which enabled them to provide effective care.

There were systems in place to enable staff to give and receive feedback on their performance, through supervision and appraisal meetings with their line manager. Staff we spoke with gave varying feedback on the frequency of supervision meetings, but did not express concern that they lacked support when they needed it. Most staff we spoke with said they had had a recent appraisal. One member of staff told us, "We spoke about things that I want to do, training I've completed, my contract. I found it useful." Another member of staff said, "I've had my appraisal in November time. We talked about if there was any training that I needed to do. It was about how I met my goals in my training, if I was doing well, or negative feedback from co-workers."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

Staff had received effective training which had enabled them to understand how the requirements of the MCA and DoLS may impact on their work. One member of staff told us, "You assess someone to see if they have the ability to make their own decisions – if not we'd make it for them in their best interests." Another member of staff said, "DoLS – its keeping them safe if they didn't have one in place, they could walk out of this building at any time. It's in place to keep them safe, for their own safety."

Records showed the provider was identifying clear reasons why a DoLS application should be made, and we saw this happened in a timely manner. The registered manager had an overview of any pending or authorised DoLS which enabled them to manage this process well. They were aware of any conditions which had been attached to any authorisations and their responsibility to ensure these were being met.

Care plans contained information about people's capacity to make specific decisions, and whether the person had a DoLS in place. We saw best interests decisions were made, but some records relating to these had not been added to the electronic care system. We asked to see the paper records relating to one best interest decision to ensure a robust process had been followed, and saw this was the case. Other care plans we looked at contained full and appropriate information to show how the MCA and DoLS processes were correctly followed.

Care plans we looked at indicated that consent had been sought for permission to photograph, allow access to records, and administer medicines, as well as use bed rails if necessary. Where people lacked capacity a family member had signed the consent form.

Staff had a good understanding of the importance of gaining people's consent for any care any support they provided. One member of staff told us, "I have residents who can verbally tell me, if not, it's on their care plan that they don't have capacity. If they show signs of discomfort, I take that as not having their consent."

People gave mixed feedback about the food served at Vicarage Court. Comments included, "Nice food, simple but good," "Good food, I get a choice," "The breakfasts and lunch are good," "The food is not very appetising," "The food is ok, it is just brought to me. I didn't choose it," and "I'm glad I came here, plenty of nice food." A visitor told us their relative needed an adapted diet, and confirmed they received this." We saw the menus were discussed at resident and relative meetings.

A member of staff told us how they ensured people had a good diet which supported their nutritional health. They said, "We go round the day before and ask everyone what they would like for their lunch. There's a choice. Everyone is on monthly weights [charts], if we find people aren't maintaining weight or losing weight we refer them to the dietician and put them on weekly observations." Another member of staff demonstrated their knowledge about people's dietary needs and preferences. They said, "One lady only likes tea or water – another lady – she's dairy free. It's all written down in the kitchen and documented in a care plan. She's on a pureed diet too."

We found kitchen staff were knowledgeable about people's needs and preferences, including any adaptations to diet that were needed to ensure care or faith needs were met, and people were not exposed to ingredients they were allergic to. We spoke with the chef who was knowledgeable about people's needs and showed us they were alerted to any changes in people's nutritional health, for example weight loss, and adjusted the person's diet accordingly.

We made observations of people's dining experience during lunch. We saw tables were set with tablecloths, condiments and flowers and observed staff bringing cutlery to the table for each person. People had already chosen their meals, however we saw people were able to ask for an alternative if they wished. We observed people were given drinks and snacks during the day, and saw good monitoring in place for people who were at risk from poor nutrition or hydration.

Staff demonstrated good practice when supporting people who needed assistance to eat their meal. For example, we heard staff describe what was on the plate, asked the person which part of the meal they wanted next and chatted to the person throughout their meal, giving the person encouragement to eat and

checking they were enjoying the food. Where people needed other assistance, for example in cutting up their food, staff did this but then encouraged people to use their cutlery independently.

We saw evidence people received care and support from other health and social care professionals as required. For example, we saw staff called GPs, opticians, speech and language therapists, tissue viability nurses, the falls team and dieticians when needed. People's care and support information was summarised in a file which could accompany them if they were admitted to hospital. This helps health professionals to more effectively treat people.

Although the environment in the Forget-Me-Not unit was calm and pleasant, we found more could be done to make it an area which supported people who may be living with dementia. We raised this with the registered manager, who was able to show us they had identified this as an area for action, had plans in place to drive improvement in people's experience, and we found they had researched best practice in this area. Staff had recently undertaken interactive training in dementia care, and several staff told us this training had given them greater insight into the experience and needs of people living with dementia.

Good

# Is the service caring?

## Our findings

People were positive in their feedback about the staff. One person told us, "Everybody is kind to me, and friendly." Another person said, "They are angels." Visiting relatives also gave feedback about the caring attitudes of staff. One relative said, "They are very friendly." Another relative told us, "[Name of person] is happier than they have been for years."

We saw staff had a genuine caring approach to supporting people, and our formal observations showed staff interactions had a positive impact on people's moods. We saw staff were attentive to people's needs both in communal areas and in their rooms, and regularly chatted with people in ways which showed they knew the person well. We saw staff using appropriate touch and low tones of voice to reassure people who were upset or anxious. One member of staff explained to us what 'caring' should look like. They told us, "By providing the good care, meeting people's needs, being polite and preserving their dignity and respect. [About staff] be a happy person, be polite – have manners." We saw staff referred to people by name, and people preferred a shortened version of their name or a nickname we saw this was documented in their care plans.

When relatives arrived we saw staff greeted them warmly and knew their names. A member of staff said, "We say hello, we greet them [visitors]. Ask if they want anything to drink, we tell them if a resident they're visiting is not well." A relative told us about their experience of the staff when they visited a family member. They said, "They are very caring of us both."

People told us their privacy and dignity was respected. One person said, "They always keep me well covered when they move me."

Staff could describe a number of ways in which they ensured people's privacy and dignity were promoted. One member of staff told us, "You don't shout things – you have a nice one-to-one conversation with them, not in front of everyone." Another staff member said, "I close the doors, if they're in the bedroom. I close the curtains when [the person is] having a shower. I always give people a choice." Other staff told us how the ensured they promoted people's independence. One staff member said, "Say I'm getting someone up on a morning I'll try get them to wash their face. I try getting them to do as much as they can without my help." Our observations showed staff routinely knocked on doors before entering people's rooms, and explained what they were going to do before giving patient and unhurried assistance.

We saw evidence people's personal care needs were met, and people and relatives confirmed this. A person said, "I am very nice and clean, and my clothes are nice." A relative told us, "[Name of person] is always fresh and clean." We saw people wore clean, well presented clothing, had their hair styled or combed, and we saw nail care had been attended to. Gentlemen who did not choose to have beards were clean shaven. When we reviewed daily notes in people's care plans we saw personal care delivery such as bathing or showering was recorded.

Requires Improvement

# Is the service responsive?

## Our findings

We observed good, person-centred practice by staff, and found they were knowledgeable about people's preferences and needs. One member of staff told us about how they ensured care was person-centred. They said, "Everyone is different and the care has to be specific to that person. No two people are the same. You can't care for two people in the same way. Everyone has different levels of needs."

There was a handover between shifts to enable senior staff to share observations and updates about changes in people's needs, which enabled the staff to plan for and deliver responsive care. We reviewed the records of handovers for a two week period and saw they were brief and informative, and included any relevant information about underlying conditions which could help staff understand the care people needed. We saw care plans were reviewed regularly, and people's involvement in this area was being promoted though a 'resident of the day' system.

The registered manager was aware of their responsibilities to meet the Accessible Information Standard, which was introduced in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. They told us documents such as care plans or policies and procedures could be made available in accessible formats such as larger print or spoken format if required, and told us about the support one person received which enabled them to contribute to their care plan. A person who used the service told us, "The library comes every 3 weeks and they get me large print books." We saw exploring further ways of supporting people and staff in this way was included on the overall action plan for the service.

Care plans contained information about planning for the care people wished to receive at the end of their lives, however there was some variation in the level of detail that had been captured on the electronic system. For example, in one care plan we saw information about the person having a 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) order in place, however there was little guidance for staff as to the person's wishes, for example whether they wished to be cared for in hospital or at Vicarage Court, and who they may wish to have present. Other care plans we looked at did contain more information, however. Staff we spoke with said people had access to good spiritual and religious support in this area of care planning if they needed it.

We found some information relating to review of care was limited on the electronic care system, and have made a recommendation which is explained in the 'well-led' section of this report.

One member of staff told us about how they would provide care at the end of someone's life. They said, "I provide the best care that I can. It's just being there. A little while ago, there was a person that took a bond to me. It was being there for them, it wasn't about meeting my needs or the job role. It was for them. Comforting them if they were having a bad day – providing anything they wanted. It was easier in that way – they could tell me what they wanted." Nursing staff we spoke with told us about recent experiences of providing end of life care to people. They said they were confident in their ability to support people well at the end of their lives.

People told us about their experiences of activities in the home. Comments included, "I can't sing, but they get people [entertainers] in for us sometimes," "I can find plenty to do, mostly I go to the 'memory class'," and "I watch the TV." Relatives we spoke with also gave feedback about this. One relative said, "They take [person] in the garden if it's nice." Some people, however, told us they did not feel there were often activities they wished to engage in.

Staff told us about the activities people could participate in. One member of staff said, "There are loads of activities. We have a big activity board over there. Tai chi classes, gardening, memory book, where the residents get their own memory book and put their own pictures in it." We asked about how staff supported people who may be at risk of social isolation. One member of staff said, "[We] try to encourage them as much as possible to come out of their rooms – to sit in the lounge or have a conversation can make all the difference." Another member of staff told us, "I'd give them other options, if they wanted to stay in their room – I'd ask if they wanted me to paint their nails or read a book together."

Although there was choice available to people in respect of the activities on offer, we saw no formal activities on the day of our inspection other than a multi-faith religious service. The lack of formal activity was most notable on the Forget-Me-Not unit, where we did not see an alternative activity for anyone who did not wish to attend the service, however our formal observations showed there was a high level of positive interaction with staff, and people we frequently engaged with tasks or activity. This meant people did have some stimulus, and we saw people's moods remained positive throughout these observations

There were systems in place to record any complaints or concerns received, and the action taken to resolve this. We saw this included correspondence with people where necessary. The registered manager carried out analysis of complaints received to enable them to identify and taken action to address any emerging trends in this area. We saw the service also received compliments and thanks from people and their relatives. For example, one person's relative had written to the registered manager and said, 'Thank you for the excellent care provided by all at Vicarage Court, and all your staff. It gives me great comfort to see the way [name of person] is treated.'

Requires Improvement

# Is the service well-led?

## Our findings

At our last inspection we rated this key question as 'requires improvement.' We found some aspects of quality monitoring were limited, and this activity had failed to identify or address issues with moving and handling practice we observed during that visit. At this inspection we saw audit and quality monitoring activity was more comprehensive, and saw safe moving and handling techniques used in the home. We have rated this key question as 'requires improvement' again as we have made a recommendation about the management of care records, which emerged as an issue during our inspection.

There was a registered manager in post when we inspected. They had become registered after our last inspection and we saw they had put improvements in place in the service. There was now a deputy manager in place, and we saw they and the registered manager worked effectively together and communicated well with both staff and people. In addition there were unit managers for each area of the home. The registered manager told us the provider spent a lot of time at the service, and said they had a supportive and constructive relationship.

We received good feedback from staff about the approachability and quality management of the home. One member of staff told us leadership had improved in the home, and said there were, "New ideas and change." Another staff member told us they thought the registered manager was supportive and said, "I can go to them with anything." We found there was a positive culture promoting good standards of care, and observed staff morale was good.

The home had recently moved to an electronic care records system. During the inspection we found the detail captured in the paper care records had not always been fully incorporated into the electronic versions. Although we found staff were knowledgeable about how to provide personalised care to people, electronic records did not always fully reflect the detail of this. For example, some care plans stated people needed assistance but did not describe what this assistance should be. We concluded there was more work needed to complete the transfer of records to the electronic system, and recommended the provider audit and update electronic care records to ensure they were robust drivers for safe, effective and responsive care.

Staff told us they could voice opinions openly and raise ideas or concerns with the registered manager. There were meetings held where this could happen, for example three 'flash' meetings each week between senior staff to enable information about people's care and other aspects of the operation of the home to be shared quickly and effectively. Full staff meetings were also held, and staff told us they felt able to speak openly. One staff member said, "We talk about everything – anything that needs raising. I say it as it is." We saw there was a plan in place which showed when a variety of meetings would take place, including general staff meetings, unit meetings, night staff meetings and health and safety meetings.

People and their relatives also had opportunities to meet formally with the registered manager. We saw a range of topics were discussed including menus for mealtimes, activities and ideas to improve the overall experience of people living at Vicarage Court. We saw feedback at one meeting suggesting the home should communicate how action had been taken in a more easily accessible way. A 'You said, we did' display had

been suggested, and the registered manager showed us display equipment had recently been received to create this display. Although records showed there was activity in place to give people a voice in running the service, when we spoke with people awareness about this was low. Comments included, "We do have meetings for family but it's only for fund raising," "We have a food forum where we discuss the menu, but nothing changes really," "I have never been asked my opinion," and "I have never done a survey."

There was an annual staff survey, which asked a series of questions such as those related to the effectiveness of training, their understanding of the provider's vision and objectives, and quality of support they received. We saw there was a high level of satisfaction in the responses to this survey.

The registered manager also told us in detail about how they would provide appropriate support to enable people to maintain their relationships, faith and chosen lifestyles. They told us, "We have a very open and inclusive culture, and we have a very open minded provider driving this."

Staff said they thought standards of care in the home were good, and told us they would recommend it to family or friends. Comments about what they thought was good about the home included, "The compassion that all the staff show to the residents. We're here in their home making them as comfortable as they can be," "Making the residents happy, providing the care that they can't do for themselves – seeing that smile on their face and listening to them," and "Just seeing how happy and well-looked after people are. It's like a nurturing nature you have, looking after people to make sure they're well. Everything is on offer that you can give to them." When we asked about what they would like to improve about the home most staff said they would like to have more time to spend chatting with people.

The registered manager had systems in place to ensure quality was monitored and improved in the service. In addition to meetings, surveys and an 'open door' policy, they carried out a number of audits across areas such as medicines management, dignity, maintenance, infection control and nutrition. We saw actions were identified and followed up, with clear indication of who was responsible for taking or contributing to any action and by when it was to be completed. There was also a plan in place to drive future improvements, which we saw had been mapped to the key lines of enquiry used to determine CQC's rating of the service. This meant there was a good understanding of regulatory requirements. The registered manager showed us how they could extract detailed, themed information about various aspects of people's care from the electronic care management system, which assisted in developing the on-going improvement plans for the service, and we saw they used this information to help monitor and drive quality of care offered at the home.