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# St Ronans Nursing and Residential 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? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

This unannounced inspection took place on the 27 June and 2 July 2018. St Ronans Nursing and Residential Care Home 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.

St Ronans Nursing and Residential Care Home is registered to provide accommodation for up to 46 people. There were 41 people living at the home at the time of the inspection. The home is a large extended property and accommodation is arranged over three floors with bedrooms on all floors. Floors could be accessed by people, staff and visitors via a passenger lift, staircases and stair lifts. The majority of bedrooms were for single occupancy and had ensuite facilities. There was a number of communal areas available to people, including two dining areas, one of which was also used as a cinema room and three lounges. The garden area was accessible and well-maintained with a number of seating areas for people to enjoy.

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

Processes in place to monitor risks to people were not always robust and did not ensure that people received effective care to ensure their safety and wellbeing. Staff were not always provided with consistent and detailed information and guidance about how people's needs should be met to mitigate risks.

There were a number of audits in place to check the quality and safety of the service, however, some of these were not always robust or effective in identifying concerns. Some areas of the home were not clean and some practices did not protect people from the risk of cross infection. The provider had failed to act on the issues in relation to the cleanliness of the home prior to the inspection and the infection control audit had failed to highlight the issues raised by the inspectors. Care file audits had not always identified the inconsistencies within the care files or that capacity assessments and best interest decisions had not been completed or made following the principles of the Mental Capacity Act.

The principles of the Mental Capacity Act 2005 were not being followed as required to ensure people were only cared for with consent; capacity assessments had not always been completed and best interest decisions were not in place for all people that required them.

Information within peoples care files did not always contain detailed, person centred or consistent information about people's needs and care monitoring records had not been put in place or did not always confirm that care had been provided as required to meet people's individual needs.

People felt safe living at St Ronans Nursing and Residential Care Home. Staff knew how to identify, prevent

and report abuse. Safeguarding investigations were thorough and identified learning to help prevent a reoccurrence.

There were enough staff to meet people's needs in a timely way and staff were able to support people in a relaxed and unhurried way.

Arrangements were in place for the safe management of medicines. People received their medicines as prescribed. People had access to health professionals and other specialists if they needed them. Procedures were in place to help ensure that people received consistent support when they moved between services.

People were cared for by staff who were competent and appropriately trained. Appropriate recruitment procedures were in place to help ensure only suitable staff were employed.

People were cared for with dignity and respect and were treated in a kind and caring way by staff. Staff knew people well and encouraged people to remain as independent as possible.

Staff protected people's privacy and dignity and responded promptly when people's needs or preferences changed.

Staff worked in partnership with healthcare professionals to support people at the end of their lives to have a comfortable, dignified and pain-free death.

People had access to a range of activities. They knew how to make a complaint and felt any concerns would be listened to and addressed effectively.

People and their relatives had confidence in the management. There was a clear management structure in place

The service worked in partnership with a number of organisations to provided them with the opportunity to share knowledge and ideas with others to aid the delivery of effective care.

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

At this inspection we found the service to be in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Individual risks to people were not always mitigated.

There were some systems in place to protect people from the risk of infection; however, we found that some areas of the home were not clean and some practices did not protect people from the risk of cross infection.

Staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate pre-employment checks had been completed.

Medicines were managed safely and people were supported to take the medicines as prescribed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Best interest decisions had not always been recorded in accordance with The Mental Capacity Act 2005.

People received care from staff who were competent and suitably trained. However, staff were not always supported appropriately.

People were supported to have enough to eat and drink.

People had access to health professionals and other specialists if they needed them.

Procedures were in place to help ensure that people received consistent support if they were admitted to hospital.

Staff made appropriate use of technology to support people.

### Is the service caring?

**Good**

The service was caring.

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

People's specific communication needs were understood by staff.

Staff understood the importance of respecting people's privacy.

Staff respected people's independence and encouraged people to do things for themselves.

People were supported to maintain friendships and important relationships.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Information within peoples care files did not always contain detailed, person centred or consistent information about people's needs and care monitoring records had not been put in place or did not always confirm that care had been provided as required to meet people's individual needs.

Care and support was planned proactively and in partnership with the people using the service, their families and healthcare professionals where appropriate.

Staff responded promptly when peoples' needs or preferences changed.

People received appropriate mental and physical stimulation and had access to activities they enjoyed.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death.

People knew how to raise a complaint and the management team had a process in place to deal with any complaints or concerns.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

A number of audits were used to check the quality and safety of the service; however these were not always robust or effective in

identifying concerns.

There was a clear management structure in place and staff understood the roles and responsibilities of each person within the team structure.

People were happy living at St Ronans Nursing and Residential Care Home and had confidence in the management.

There was an open and transparent culture within the home and people and families confirmed they felt able to approach the registered manager at any time.

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

# St Ronans Nursing and Residential Care Home

**Detailed findings**

## Background to this inspection

We carried out this comprehensive 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.

The inspection was prompted, in part, by safeguarding concerns that had been shared with us by a member of the public and healthcare professionals.

This inspection took place on 27 June and 2 July 2018 and was unannounced. It was completed by two inspectors and an expert by experience on the 27 June 2018 and one inspector on 2 July 2018. 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 12 people living at the home and three family members. We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the two directors of the service, the services business manager, the registered manager, the service trainer, two registered nurses, five care staff, a housekeeper, the chef and a life support worker, whose role was to arrange activities and events.

We looked at care plans and associated records for ten people, staff duty records, four staff recruitments records, records of accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in November 2016 when it was rated as 'Good'.

Requires Improvement

# Is the service safe?

## Our findings

People told us and indicated they felt safe. One person said, "I do feel really safe here." Another person told us, "I feel safe and the staff go out of their way to help." However, at the inspection we found that the processes in place to monitor risks to people were not robust and didn't ensure that people received effective care to ensure their safety and wellbeing. For example, although people's care plans contained risk assessment information within them was not always consistent and there was not always guidance to staff about how people's needs should be met to mitigate risks. For instance, where people required their position changing while in bed to prevent pressure sores, some care plans and risk assessments stated 'Ensure repositioned regularly' there was not always guidance for how often 'regularly' should be for that person. Additionally, some people were unable to use a call bell to request support or assistance were being cared for in bed due to their health needs. Detailed information was not in place which highlighted how often these people should be checked and records did not always demonstrate that these people were monitored regularly to ensure their safety and comfort.

Care records did not demonstrate that people's individual needs had been considered when deciding on the frequency of monitoring checks. When this was discussed with the registered manager they told us that people were checked two hourly. However, this was not always supported by records that demonstrated checks had been completed two hourly. This meant that we could not be assured that people received appropriate care to keep them safe.

People were not protected from all risks of infection and some areas of the home were not clean. For example, on the first day of the inspection some people's bedroom floors and communal corridors did not appear to have been hoovered for several days and in one person's room the over the bed table was dirty with dried up, spilt food on the surface. This indicated that it had not been cleaned for several hours. In a communal bathroom we identified clean bedding had been placed on top of the clinical waste bin, posing a risk of cross infection. This bathroom also contained several unnamed, opened toiletries, which appeared to be in use, however staff could not confirm who these belonged to. We also found used unnamed hairbrushes stored in communal bathrooms and cupboards. In the laundry area, we found a basket containing unnamed and half used toiletries, including toothpaste, shower gel, a used hairbrush, an unsheathed razor and an open prescribed topical cream. Shared usage of these items could lead to cross contamination and place people at risk of infection. When this was discussed with the registered manager and business manager they both agreed that all people should have their own toiletries and hairbrushes. They agreed to ensure that these items would be discarded. By the second day of the inspection we saw that appropriate action had been taken which resulted in people being issued with their own named toiletries.

The failure to prevent and control the risk of infection and to ensure risks to the health and safety of people were assessed and mitigated, were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other areas of the home were clean. Protective equipment such as gloves and aprons were provided to staff to minimise the spread of infection and we saw that, when required, these were worn by staff. There was an

infection control policy in place and all staff had received infection control training. The management team encouraged the staff to have an annual flu vaccination to prevent the spread of infection and were aware of their responsibilities should there be an infection outbreak.

Staff had the knowledge and confidence to identify safeguarding concerns and acted to keep people safe. Staff had received training in safeguarding, which helped them identify, report and prevent abuse. Staff told us about how they would safeguard people and actions they would take if they thought someone was experiencing abuse. A staff member said, "Mistreatment of anyone is not okay; if I was concerned about anything I would talk to the manager or take it higher if I needed to." Another staff member told us, "I wouldn't work somewhere that didn't do anything about concerns if I raised them. Here I know that action would be taken if I raised a safeguarding concern." Records showed the registered manager and the business manager had worked effectively with the local safeguarding team to undertake investigations and appropriate action had been taken to protect people from the risk of abuse.

There were safe recruitment procedures in place to ensure that staff were suitable to be employed at the service. Staff recruitment records viewed for four members of staff demonstrated that the management team had operated thorough recruitment checks in line with their policies and procedures to keep people safe. Relevant checks were carried out before a new member of staff started working at the service. These included the completion of Disclosure and Barring Service (DBS) checks, which will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff files included application forms, records of interviews and references.

People and their families had mixed views on the staffing levels in the home. People's comments included, "I am satisfied I get the help and care I need although I am not sure there are enough staff on duty to always cope at busy times" and "If ever I ring the bell the staff come straight away." A family member said, "I think the staff are often really pushed - although they are all really kind." During the inspection we found no evidence of there being insufficient staff levels to meet people's needs and we saw the staffing levels provided an opportunity for staff to interact with people they were supporting in a relaxed and unhurried manner. Staff responded to people's needs promptly. Staff we spoke with felt there were enough staff to provide appropriate care without being rushed in their duties. One staff member said, "There are enough staff to meet people's needs; we have time for people, I love that about working here." Another staff member told us, "I do think there are enough staff, we don't feel rushed and can take our time with the residents." Staff also confirmed that in the past staffing levels had been increased when required and were confident that this would continue if needed.

The registered manager told us that staffing levels were based on the needs of the people using the service. They said that they listened to feedback from people and staff, observed care and monitored the time it took staff to respond to the needs of people to help ensure that the staffing levels were sufficient. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime by existing staff or cover from staff that worked at a partner agency. From viewing the duty rotas and observations, we saw that staffing levels were provided as required. The service also provided ancillary staff including housekeepers, kitchen staff and maintenance staff. This ensured that care staff could focus their time on supporting people and their needs.

Medicines were administered by qualified nurses who had received appropriate training and had their competency checked yearly to ensure that their practice was safe. Staff supporting people to take their medicines did so in a gentle and unhurried way. They explained information about the medicines they were giving in a way the person could understand and sought people's consent. Staff remained with people until they were sure all medicines had been taken.

A medicines profile had been completed for each person. This showed any allergies to medicines, the person's preference in taking their medicines and any special requirements such as taking them before food. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. On viewing the MAR charts no gaps were identified, this indicated that people received their medicine appropriately.

Nurses were aware of how and when to administer medicines to be given on an 'as required' (PRN) basis for pain or to relieve anxiety or agitation. Where people had been prescribed PRN medicines, they had a PRN plan which explained when the medicine should be given. Where people were not able to state they were in pain, a recognised pain assessment tool was in use. This was used to assess and evidence why PRN pain medicine was given, or not, on each occasion.

There were suitable systems in place to ensure that medicines were securely stored, ordered and disposed of correctly and safely. There were also suitable systems in place to ensure other prescribed medicines' such as nutritional supplements and topical creams, were provided safely to people. Care staff were aware of which routine topical creams should be applied for each person.

Environmental risks were managed effectively. Gas and electrical appliances were serviced routinely and fire safety systems were checked regularly. Staff were clear about what to do in the event of a fire, fire alarms were tested weekly and there was an up to date fire risk assessment in place. Each person had a personal emergency evacuation plan detailing the support they would need if the building needed to be evacuated. In addition, reciprocal arrangements had been made to use neighbouring care homes in an emergency and to call in additional staff to support people.

Requires Improvement

# Is the service effective?

## Our findings

People and family members told us they felt the service was effective. A person said, "I am kept clean and comfortable at all times." Another person told us, "I am satisfied I get the help and care I need." A third person said, "The staff try in every way possible to give me the help I need." The service had received a written compliment from a family member which stated, 'We can't fault [relatives] care in anyway. He is happy and settled after every visit. I leave with complete peace of mind, totally confident that [my relative] couldn't be in a better place.' A thank you card recently received from a family member stated, 'I don't know how to express my gratitude and thankfulness in what everyone did for [my relative]. You all truly brought her to life and we, as a family saw another side. She was so happy at St Ronans.'

Some people living at the home had a cognitive impairment and were not able to give valid consent for certain decisions. 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. On the first day of the inspection we found that capacity assessments had not been completed for all people as required. Additionally, robust records of best interest decisions made were not in place to demonstrate why, how, or when the decision had been made, who had been involved in making the decision and what else had been considered. For example, we identified a person who could be resistive to receiving personal care and their care plan stated, 'Restraint should be used where necessary, in the person's best interests.' Although staff may be acting in the person's best interest to provide care this way they had not formally assessed this person's capacity or recorded a best interest decision following the principles as required by the MCA Code of practice. Additionally, some people in the home had bed rails in place; although we found that risk assessments were completed for the use of bedrails, capacity assessments and best interest decisions were not recorded. This meant that the provider had failed to ensure the legal requirements of the MCA had been met for all people using the service and that care was only provided with the consent of the relevant person.

This was discussed with the registered manager on the first day of the inspection. By the second day of the inspection, capacity assessments had been completed for all people, and the registered manager was in the process of ensuring that best interest decisions were made following the legal requirements of the MCA.

The failure to follow the requirements of the Mental Capacity Act 2005 and ensure care and support were only provided with the consent of the relevant person was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (2005). The procedures for this in care homes are called the Deprivation of Liberty Safeguards. The registered manager had applied for authorisations under the safeguards for people where necessary and these were reviewed when required.

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. New staff completed a structured induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff and the completion of essential training. During the induction process, staff also received a number of key documents and policies that were relevant to their role and their own handbooks for reference. New staff completed the Care Certificate and staff were required to complete an annual knowledge check of each of the standards that make up the certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. This helped the provider to ensure that staff understood and worked to expected standards of care. Staff confirmed that they had received an induction when they started work at the service.

People and their families felt that the staff were well trained. A family member said, "The staff are certainly well trained and we know they are often on training courses." Staff completed regular training depending on their role and were given the opportunity to participate in extra training where necessary. For example, the business manager told us that where there had been a language barrier with some staff members, they were supported to receive extra communication techniques training. The training staff had received included safeguarding, diet and nutrition, moving and handling, infection control and end of life care. The service had a dedicated training room and training was delivered via online 'e-learning', practical learning sessions and classroom settings depending on the area of learning. The service trainer showed us examples of lesson plans used for each training session, which included a thorough check of staff understanding. The trainer also used evaluation forms for all staff to complete after a training session to gain feedback which may help to improve future training.

There was a system in place to record the training that staff had completed and to identify when training needed to be repeated. On reviewing this system, we saw that staff had received training as required. All the staff we spoke with felt that they received effective and appropriate training. Staff comments included, "We get loads of training" and "I get the training I need and if I ask for more this will be provided."

Staff told us they felt supported by the management team. There were systems in place which highlighted that staff were to receive a two-monthly face to face supervision and annual appraisals to discuss their performance and development. However, we identified that these were not always completed regularly and some staff had not received a session of face to face supervision for a period of over one year. We discussed this with the business manager who agreed that some people's supervisions were overdue and plans were being actioned to address this. The business manager explained that the training provider had an open diary on their desk so that staff could allocate time with the trainer to discuss any issues or concerns where necessary.

People and their families were complimentary about the food and people were supported to have enough to eat and drink. Drinks and snacks were offered throughout the day and evening. A person said, "The food is very good, we get a choice for breakfast and main course each day, we can also have something different if we like." Comments in the service's annual survey stated, 'I love the mushrooms you do in the morning as a special request' and 'I have asked for something (food) and they got it for me, they are very good.' We observed lunch and saw that people had different meals according to their choice. People were supported to eat independently and where necessary specialist cups, crockery and cutlery were provided. When assistance was required, this was provided by staff in a relaxed and unhurried way.

The chef was aware of people's preferences and dietary needs and these were also recorded in people's care records. The chef told us that where people had dietary needs linked to medical conditions; such as diabetes or religion they ensured options suitable for the person were provided. They also told us that they

spoke with people once a month to discuss any changes to people's likes and dislikes to help ensure that they were provided with food they enjoyed. Staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs.

People's nutritional needs were assessed to help identify if they were at risk of malnutrition and if a referral was needed for specialist assessment by a GP, dietician or SALT. Care records showed referrals were made where people had nutritional or swallowing needs and the advice of the SALT was followed. Staff were aware of which people needed soft or pureed food. Food and fluid intake was monitored where this was needed and people's weight was monitored so any action could be taken regarding weight loss or gain.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. One person said, "The medical attention here is excellent; the nursing staff are well trained. I can see the doctor or any other healthcare specialist any time I want to." Wound care was managed effectively. We saw nurses used the correct procedures to assess and manage wounds.

A range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, staff used the Malnutrition Universal Screening Tool (MUST) to help calculate the person's body mass index and identify the need for nutritional support. Other nationally recognised tools were used to assess people's pain levels, risks of developing pressure injuries and to monitor their bowel movements.

There were clear procedures in place to help ensure that people received consistent support when they moved between services. The registered manager told us that new services were provided with up to date information about the person and if required the person would be accompanied by a member of staff.

St Ronans Nursing and Residential Care Home is an older style building set over three floors with bedrooms on all floors. Floors could be accessed by people, staff and visitors via a passenger lift, staircases and stair lifts. The registered manager told us consideration was given to the environment when pre- admission assessments were completed due to the stairs and building lay out. There were assisted bathrooms with equipment to aid people with limited mobility and bedrooms had ensuite toileting facilities. People's rooms were personalised and full of personal possessions, photos and ornaments to reflect people's interests. Some adaptations had been made to the home to meet the needs of people living there. For example, corridors within the home had handrails fitted to provide extra support to people. People were able to choose where they spent their time and there was a number of communal areas available to people, including two dining areas, one of which was also used as a cinema room and three lounges which allowed people the choice and freedom to choose where they wished to spend their time. There was also a bedroom available for family members to stay overnight if the need arose. The garden area was accessible and well-maintained with a number of seating areas for people to enjoy.

The staff made appropriate use of technology to support people and to help ensure that audits and checks on the service were completed in a timely way. The service used a computerised system to document each person's care plan. The business manager also demonstrated how this system aided the management team's auditing process and other management tasks, enabling them to complete audits in line with provider policies. The registered manager told us that equipment was used to help keep people safe, including pressure mats to alert staff when people moved to unsafe positions and pressure relieving mattresses. There was an electronic call bell system in place which allowed people to call for assistance when needed. Wi-Fi had also been installed to allow people or their visitors to connect to the internet and aid communication.

Good

# Is the service caring?

## Our findings

People and their family members were consistently positive about the way staff treated them. People said they were treated with kindness and compassion and that all the staff were kind and caring. When we asked one person if they were alright they responded with, "I'm too well looked after not to be alright." Another person said, "The staff are exceptional; they are so kind." A third person told us, "I am totally dependent on these staff, they give me all the assistance I need with good grace, they are marvellous." A family member said, "My [relative] was cherished from the moment they got here; he loved them [staff] and they loved him." Another family member said, "The staff are unfailingly kind, and I am impressed with them. There is an atmosphere of good humour combined with politeness."

Throughout the inspection we observed positive interactions between staff and people without exception. People were listened to by staff who gave them the time they needed to communicate their views and wishes. Where people had specific communication needs, these were recorded in their care plans and known by staff. One care plan provided information to staff about how to best communicate with a person who found it difficult to be understood. Information in this person's care plan stated that staff were to attempt to 'lip read what [the person] is saying but if unable to gain understanding ask them to write it down. Ensure that pen and paper is always available to them.' This person told us, "Although I have difficulty in speaking, I can still make myself understood. The staff are patient and never hurry me." Throughout the inspection we saw that when communicating with people staff addressed people by their preferred name, knelt to their eye level if needed, spoke clearly and gave people time to respond.

Staff understood the importance of protecting people's privacy and dignity and people confirmed that staff considered their privacy when providing personal care by closing doors and curtains. A staff member told us, "I would make sure I close the window blinds, shut the door and keep the person covered as much as possible when helping them to wash." During the inspection we observed staff supporting a person in a communal area of the home using a mobility hoist. While doing this, staff ensured the person's dignity was maintained by rearranging their skirt which had risen up during the transfer and offering the person with ongoing reassurance. Care plans contained clear guidance for staff for how they could help to ensure people's privacy and dignity was maintained. For example, 'knock on the door before entering', 'ensure [person's name] is covered appropriately and kept warm' and 'ensure the door is closed and blinds are shut when having personal care.'

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

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. One person told us, "The staff are sensitive to my need for some independence and do everything to respect my position." Comments in care plans highlighted to staff what people could do for themselves and when support may be needed. Comments included, 'Enable [the person] to continue to be

self-caring in as many aspects of their care as possible' and 'Allow [the person] plenty of time to eat their meals, they like to eat at their own pace.' Throughout the inspection we saw staff encouraged people to be independent. For example, specific cutlery and walking aids, such as frames and sticks were provided when required and ongoing encouragement, support and reassure was given to people when needed.

People were supported to maintain friendships and important relationships. Care records included details of their circle of support and identified people who were important to the person. All the families we spoke with confirmed that the registered manager and staff supported their loved ones to maintain their relationships and that when they visited they felt welcome. A written compliment in the service's annual survey sent to family members stated, 'Whenever I visit I always receive a warm welcome from staff. The atmosphere is lovely and very relaxed.' Another stated, 'All [people's] friends and family were struck by the constant friendliness you showed to us in all our visits.'

The provider had a policy that recognised people's diversity and cultural needs and the registered manager told us that they would adapt the care and support provided to meet people's ethnic diversity and human rights. This information was then documented within the person's care plans along with a specific section about how the staff would support people to express their sexuality. A staff member told us, "We have regular visits from the local church but we cater for all religions." The registered manager told us that if a person followed a particular faith that they and the staff lacked knowledge of, they would research this by looking for information on the internet and by speaking to followers of that faith to help ensure that people could be effectively supported.

Requires Improvement

# Is the service responsive?

## Our findings

People told us they received personalised care and support that met their needs. One person said, "They [staff] have a thorough understanding of my needs." A second person told us, "The staff are very good, they know what I need from them."

Each person had a care file which contained individual information about their likes and dislikes and level of support they required. However, we found that some information about their needs was not always detailed, person centred or consistent. For example, two peoples' care file stated, 'Hoist' and 'Hoisting for transfers' Yet it did not provide staff with information about which type of hoist was required to ensure that this was done safely. Furthermore, people were not being provided with their own personal toiletries; this is not a person-centred approach to care and within one person's care file on two occasions they had been referred to by a different name. This was discussed with the registered manager who rectified this issue immediately.

Although staff demonstrated an understanding of people's needs, monitoring records, such as repositioning charts, food and fluid charts and safety monitoring charts were not always kept or completed to an appropriate standard to demonstrate that care had been delivered appropriately. For example, one person had a food and fluid monitoring chart in place which showed that on one day they had only received 100mls of fluids, on another day 530mls of fluids and on a third day 550mls fluids. The recommended fluid intake for adults is 1.5 litres per day. Without effective monitoring of people's fluid intake where required timely interventions and support may not be provided to prevent dehydration.

For other people; some who were at risk of isolation, skin injury or requiring support with eating and drinking there was not always clear or specific guidance provided to staff about how these people's need should be met. This meant we were not assured people always received the correct care to meet their needs and keep them safe in a consistent, person centred and appropriate manner. This was discussed with the registered manager who agreed that they would review all people's care files and update them accordingly.

During the inspection we saw that staff responded appropriately when people's needs changed. For example, during the second day of the inspection we saw that staff took appropriate action when a person showed signs of being unwell. Staff contacted the person's doctor and arranged for a visit that day to ensure that appropriate treatment could be provided. Additionally, when a person became upset a member of staff sat with this person, provided them with reassurance and attempted to engage them in a particular activity they enjoyed.

Care and support was planned proactively and in partnership with the people using the service, their families and healthcare professionals where appropriate. The registered manager completed assessments of people before they moved to the home to ensure their needs could be appropriately met. Families told us that they were fully involved in the development and reviews of care plans and kept up to date about changes in their loved ones' wellbeing. A family member said, "At the outset I was consulted about my relative's care plan, I have a copy of it and I am attending an assessment meeting tomorrow." Another family

member told us, "I am always kept updated and involved with [my relative's] care."

Staff promoted choice and respected people's autonomy by empowering them to make as many of their own decisions as possible. We heard people being offered choices throughout the inspection. For example, a person was supported to choose where they wanted to spend their time. Within people's care files there was information about people's abilities to make informed choices. For example, within one care file we read, '[The person] is able to make simple choices' and another stated, 'Encourage [the person] to choose their own clothes.'

People had access to a range of activities and people told us they enjoyed the activities on offer. A person told us, "I enjoy the trips out." Another person said, "The staff take me out in my wheelchair to the Co-Op every week, I love going shopping." A third person told us, "There is always someone to talk to; the staff are always cheerful and happy go lucky. I enjoy the activities, such as cooking classes, and artwork, we are always kept occupied."

The service employed 'life support workers' whose role it was to arrange activities, events and outings for the people living at the home. We saw people were provided with weekly picnics and regular trips to the beach or the local town. They also had the opportunity to go to the pantomime, participate in cake sales and charity events, cooking and craft work. A life support worker spoke with us about an artwork project that people had been involved with and a recent fashion show where people, their families and past residents were invited which was followed by a tea party. Activities included relaxation, hairdressing, one-to-one sessions, sing-along, quiz, throwing hoops, minibus outings, music and movement, book reading, card games, pet therapy, birthday celebrations and spiritual activities. People and their families were kept informed of up and coming events and daily activities directly from the staff, notices displayed throughout the home and the resident newsletter.

The life support worker told us that when people were admitted to the home they would discuss their interests to help activities to be tailored to their likes and interests. People's care plans highlighted their social interests and past hobbies. Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. On viewing the minutes from the recent 'resident and relatives meeting', we saw that discussions had taken place which involved people in making decisions about future activities. Links had also been developed with the local community including supporting people to follow their religious needs, charity events and links with local schools.

People were supported to make choices about their preferences for end of life care and their care files contained information about people's next of kin and end of life details, such as the funeral provider people would want. Where this information had been difficult to obtain the registered manager had sought support from advocates where appropriate or arranged meetings with people's families. A staff member who had also experienced end of life care at the home as a relative told us, "The end of life care was amazing." Staff had received training in end of life care and nursing staff had attended training to enable them to better manage symptoms people may have at the end of their life. They were also aware of how to obtain and administer symptom management medicines should these be required.

There was a complaints procedure in place which was displayed throughout the home. People and family members were also provided with information as to how to complain when they moved to the home. One person said, "I don't have any problem raising a complaint, thank God I have only had to do it on one occasion. I spoke to the manager about the matter concerned, action was taken. If you raise a complaint here I guarantee action will be taken." Another person told us, "I would talk directly to the manager, they are here all the time. I have never had to complain and I don't expect to. I could not ask for anything better." We

looked at records of complaints that had been raised to the service since the last inspection and found complaints were thoroughly investigated and action taken where required. The service also had a concerns log in place, which was used to capture and address concerns before they became a complaint.

Requires Improvement

# Is the service well-led?

## Our findings

People told us and indicated that they felt the service was well-led. One person said, "I am delighted about the way the place is run. The staff are properly supervised;  I think this is a well-managed home." Another person told us, "There is an atmosphere of 'can do' that starts from the top, I think I am lucky to be here, this is a very unique place." A family member said, "I am delighted with the care [my relative] receives here, I think the staff are marvellous and the manager is doing a great job."

There were a number of audits in place to check the quality and safety of the service, however, some of these were not always robust or effective in identifying concerns. For example, the provider's infection control audit; completed six days prior to the inspection had identified the issues in relation to the cleanliness of the home and an action plan had been produced. However, at the time of the inspection the service continued to remain unclean. This completed infection control audit had also failed to identify the risks posed to people as a result of shared toiletries.

Audits had also failed to identify inconsistency and lack of information within care plans, incomplete monitoring charts and that capacity assessments and best interest decisions had not been completed or made following the principles of the Mental Capacity Act. These issues were discussed with the registered manager on the first day of the inspection. The registered manager acknowledged that improvements were required in these areas and agreed to review the auditing processes. By the second day of the inspection we found that work was underway to make the required improvements which included an audit timetable being produced to help ensure that audits were completed regularly.

The lack of robust systems and processes in place to assess, monitor and mitigate the risks associated with people's care and ensure the safety of the services is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other audits in place were effective. We found that there were systems in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures, equipment and fire safety. These demonstrated that action was taken where concerns were noted in a timely manner. We also saw that when incidents, accidents or near misses had occurred these were clearly documented and analysed to see if there were any common themes and if there could be any learning from these events.

There was a clear management structure, which consisted of the directors, a business manager, a registered manager, a deputy manager, nursing staff and care staff. Each had clear roles and responsibilities which were understood by all staff. The staff we spoke with told us they enjoyed working at the home, that there was an open transparent culture and that they felt well supported by the management team. One staff member told us, I feel absolutely supported by the management, they always listen to us [staff] and really care about the people and the staff." Another staff member told us, "I love working here, it's a great place to work; the people, staff and managers are all brilliant." A third staff member said, "The managers treat us well, they treat us as equals and the staff all get on really well together."

Staff told us they received regular staff meetings which kept them updated on the running of the service, enabled them to share ideas to help improve the quality of the care and to discuss any issues or concerns they had. These meetings also provided the management team with the opportunity to reinforce the values of the organisation and their application in practice. The registered manager told us that their vision and values were to provide a safe, happy environment to people; they added, "I want people to have a good life, this is their home."

People were engaged in the running of the service and their feedback was sought through residents' and relative meetings, held every eight weeks and the use of questionnaires which were sent to people, their families, visiting professionals and staff annually. The business manager analysed the responses and produced a summary of the results and we saw where people had made requests, action had been taken to address these. For example, one person said, 'I would like more paints for painting' and this had been arranged'. Another person had commented: 'Be a bit quicker with breakfast' and this had been passed on to the Catering Team. There was also a comments box within the reception area of the home which allowed people to make suggestions or raise issues confidentially if they wished. A person told us, "I am confident that if I raised any suggestion it would be welcome." Another person said, "The manager always asks for my views and opinions on the service to make sure I am happy."

The service worked in partnership with a number of organisations. The business manager of the service sat on the Hampshire Domiciliary Care Providers (HDCP) executive group and was the representative for the Portsmouth area. They were also a member of the Hampshire Care Association (HCA) executive board. HCA represents the views, concerns and interests of its members to commissioners, government and regulatory bodies. They undertook local provider meetings, and liaised with the local authority, the CCG and Skills for Care (SFC). Their active involvement with these organisations provided them with the opportunity to share knowledge and ideas with others to aid the delivery of effective care following up to date guidance and legislation.

St Ronans Nursing and Residential Care Home had up to date and appropriate policies in place to aid the running of the service. These were reviewed and updated annually by the business manager and were made readily available to staff to help ensure that staff were kept up to date and could easily access advice or guidance in a particular area. Duty of candour requirements were being followed; these required staff to act in an open and transparent way when accidents occurred. The manager understood their responsibilities and was aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed prominently in the home and on the providers website.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br>The provider had failed to follow the requirements of the Mental Capacity Act 2005. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br>The provider had failed to prevent and control the risk of infection and to ensure risks to the health and safety of people were assessed and mitigated. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br>The provider failed to ensure that there were robust systems and processes in place to assess, monitor and mitigate the risks associated with people's care and the safety of the service. |