Homely Care Limited

# St Theresa's Rest Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This inspection took place on 30 June 2016 and 1 July 2016. The inspection was unannounced and was a comprehensive inspection following the providers previous inspection in November 2015 where the service was found to be 'requires improvement' overall and was found to be 'inadequate' in the 'safe' domain.

After the last inspection in November 2015 enforcement action was taken whereby the service was issued with a warning notice to make immediate improvements linked to Regulation 17, good governance. In addition to the warning notice a notice of proposal with positive conditions was served in relation to Regulation 12, safe care and treatment, where the service were required to submit monthly audits in relation to the safe management of medicines. Requirement actions were also required in relation to Regulation 11, need for consent and Regulation 13, safeguarding service users from abuse and improper treatment.

A focused inspection was carried out in January 2016 which looked at the safe management of medicines and was in response to the warning notice that had been issued. The service had made considerable improvements and the service was re-rated as 'requires improvement' in the 'safe' domain.

The providers' response to the notice of proposal was positive and over a five month period the service consistently submitted evidence as per the requirements of the notice of proposal. The notice of proposal was withdrawn in May 2016.

During this inspection on 30 June 2016 and 1 July 2016 we found that the provider had implemented a number of systems and processes which had resulted in the provider no longer being in breach of the regulations which had been identified at the previous inspection in November 2015.

St Theresa's Rest Home provides accommodation and support with personal care for up to 23 people. At the time of our inspection there were 12 people using the service.

A registered manager was in post and was available throughout the inspection process. 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.

We observed people to be happy and smiling as we entered the home and greeted everyone in the morning. People told us that they liked living at the home and felt safe and well supported by the care staff. We saw that people had developed positive relationships with each other as well as with the staff team within the home.

Care staff that we spoke with were aware of safeguarding, the different types of abuse, how to protect people from abuse and ensure their safety within the home. Care staff also knew what 'whistleblowing'

meant and external agencies they would be able to contact to report any concerns. The service had a number of systems in place to protect people which included robust recruitment checks, staff training and individualised risk assessments for each person using the service.

At the previous inspection in November 2015 a number of issues had been identified around the safe management of medicines. A focused inspection in January 2016 found that the service had made significant improvements. During this inspection we found that the service had sustained the improvements that they had made and the service was found to be consistently managing medicines in a safe manner.

The registered manager and care staff had a good level of understanding around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Care staff were able to give examples of ways in which both these pieces of legislation impacted on the care and support that they provided to people, especially where obtaining consent was concerned. The service had submitted DoLS applications for all people where applicable. DoLS are required to be in place to ensure that where an individual is being deprived of their liberty, that this is done in the least restrictive way.

Care staff had the required skills and knowledge necessary to support people with their care needs. Care staff told us they were able to request any additional training from the provider that was required to fulfil their role effectively and this was provided. Examples of how care staff respected people's privacy and dignity were observed as well as given to us when speaking to them. People told us that care staff listened to them and respected their choices and decisions. We observed positive and meaningful interactions between people and care staff.

At the last inspection we identified that there was a lack of documentation available relating to the management of the home. This included documents in respect of staff supervisions, appraisals, staff meetings and handover notes. During this inspection we found that the service had made significant improvements in these areas and appropriate records were being maintained.

A number of systems and processes were in place to monitor and improve the quality of the service. This included a number of detailed medicine audits, care plan audits and a variety of health, safety and environmental checks. Enhanced environmental checks were also being completed in light of the refurbishment and building work that was being completed within the home.

We observed meal times to be a positive experience for all people living at the service. People eagerly awaited their meals and thoroughly enjoyed the food that was provided. We observed people to have access to a variety of drinks and beverages throughout the day. A menu was on display and people were asked their choices on the day. In addition to this, a bespoke and personalised preference sheet was also on display which outlined individual people's likes, dislikes and alternatives that they would prefer.

People and relatives knew who the manager was and felt comfortable in approaching them if they had any concerns or issues that they needed to raise. Care staff told us that they enjoyed working at the service and that their priority and focus was that of the people they supported.

## 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. Significant improvements to the way in which medicines were managed had been made and sustained over a period of time.

People told us that they felt safe at the home and with the staff who supported. Staff had a clear understanding of what safeguarding was and knew how and who to report any concerns to.

Each person had a detailed care plan which identified people's individual risks and gave guidance on how care staff were to manage, reduce or mitigate those risks.

We observed there to be an appropriate level of care staff supporting people and this was confirmed by people and relatives that we spoke with. Robust and safe recruitment processes were followed to ensure that only suitable care staff were recruited to work with vulnerable people.

### Is the service effective?

Good

The service was effective. The registered manager and care staff demonstrated a good level of understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and what this meant for the people that they supported. We noted that DoLS applications had been submitted to the local authority where applicable.

The service completed mental capacity assessments for people on admission and where the service had identified that people lacked capacity, best interest decision meetings were held and outcomes were recorded.

Care staff told us that they received regular supervision and we saw evidence that these were recorded. Annual appraisals had also been completed for all staff who had been in employment for more than one year.

Records showed and care staff confirmed that they received regular training to support them in their role. Care staff also confirmed that they had received medicine management

training which included an online competency assessment that they were required to complete.

People told us they enjoyed the meals that were provided at the home and were involved in menu planning. We observed that people were supported in a person centred manner with their nutrition and hydration.

## Is the service caring?

Good

The service was caring. We observed that people had developed positive and meaningful relationships not only with each other but also with the care staff that supported them.

Privacy, respect and dignity were of high importance to the care staff that we spoke with especially when delivering care and support. Care staff were able to give a number of examples of how their values and beliefs related to person centred care was delivered through the care and support they provided.

Care plans were person centred, detailed and gave information about people's likes and dislikes and how they wished for their care and support to be provided. Care staff were aware of people's needs and wishes and knew the importance of reading the care plan which gave them important information about the people they supported.

## Is the service responsive?

Good

The service was responsive. People and their relatives were consulted about the care they received and this was reflected within the care plan. Care plans were person specific and detailed their needs and requirements.

Although an activity plan was not on display, people were observed to take part in activities of their choice and were supported to spend the day as they so wished.

The service had not received any complaints since the last inspection. People and relatives that we spoke with felt able and confident in raising any concerns or issues with the registered manager and knew that these would be dealt with appropriately. A complaints policy was on display outside the registered manager's office.

## Is the service well-led?

Good

The service was well-led. People and relatives knew who the registered manager was and spoke positively about them. Care

staff were also positive about the registered manager and the way in which they were supported to carry out their role.

The service had a number of systems and processes in place to enable the registered manager in monitoring and identifying any issues in the provision of care and support. This included a number of audits in the areas of medicines, care plans and the environment.

People and relatives had been asked to complete a quality assurance survey in December 2015. The provider had compiled an analysis of the results so that any trends and patterns could be identified in order to learn and improve care service provision.

# St Theresa's Rest 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.

This inspection took place on 30 June 2016 and 1 July 2016 and was unannounced. The inspection team consisted of one inspector, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used or uses this type of care service.

Before the inspection we looked at information we had about the provider which included notifications about incidents affecting the safety and wellbeing of people using the service. We also looked at the action plan that the provider had sent to us following the last inspection and monthly auditing information that had been requested as part of the notice of proposal that was issued with a list of positive conditions that the provider was required to meet.

During the visit we spoke with five people using the service, two relatives and six staff members which included the registered manager and the health services manager. The provider was also present on the day of the inspection. Some people were unable to communicate with us verbally and so we spent time throughout the day observing interactions between people and the care staff supporting them.

We looked at the care records of six people who used the service. We also looked at the personnel and training files of six care staff Other documents that we looked at relating to people's care included risk assessments, medicines management, staff meeting minutes, handover notes, quality audits and a number of policies and procedures.

Good

# Is the service safe?

## Our findings

People told us that they felt safe at the home and with the care staff that supported them. When asked if people felt safe, comments made included, "Always safe and comfortable here" and "Yes I do indeed. I am a stamp collector and I can keep my albums here." When we asked relatives about whether they felt that their relative was safe they told us, "Yes, [Name of person] seems safe" and "Yes, my relative is safe."

Care staff that we spoke with knew about the different types of abuse and the actions they would take if abuse was suspected. When asked about safeguarding, care staff told us, "You need to look after the resident. If you see any danger or abuse I would report it to the manager. It's about keeping the residents safe." Another statement made included, "Abuse can be physical, mental or emotional and I would report anything to the manager."

Care staff were able to clearly explain what the term 'whistleblowing' meant and the external agencies they could contact to report any concerns. One staff member told us that whistleblowing was, "Speaking out if you have seen something." Another staff member stated, "If I feel that the management are not taking the right action I should whistle blow and not keep it a secret. I would inform the Care Quality Commission (CQC)."

At the last inspection we had made a recommendation that the safeguarding and whistleblowing policy should contain contact details of the local authority and the CQC so that care staff had the necessary information for them to raise any concerns to an external agency. During this inspection we found that both policies and had been updated to reflect the recommendation.

Care plans detailed all risks associated with people's health and support needs. Generic as well as individualised risks were assessed and guidance and direction was provided to reduce or mitigate risks to ensure people were kept safe from harm. Risk assessments were completed for areas including bed rails, pressure sores, mouth ulcers, aggression and manual handling. Care staff were aware of the risks associated with people's care. One care staff member told us, "Risk assessments give us guidance on how to support people for example when a person is using a walking frame." A senior manager stated, "Risk assessments tell us and give guidance on how to tackle poor hydration or nutrition. If I write a new risk assessment or update a risk assessment I inform the staff."

All accident and incidents were recorded within an accident book and were monitored by the registered manager on a weekly basis. An individual analysis was then completed of all accidents and incidents for each person who had been involved and where two or more accidents or incidents were noted a referral to a health professional was made so that any trends or patterns could be identified in order to reduce or prevent a re-occurrence. The registered manager had also implemented a number of communication methods including daily handover logs and a communication book to ensure that all staff were informed of any significant events that had occurred within the home so that people received the appropriate level of care and monitoring following an accident or incident.

At the previous two inspections in February 2015 and November 2015, medicines management was found to be unsafe within the home. A number of issues had been highlighted which included risks related to medicines were not identified for each person, people's pain relief was not managed appropriately, accurate records for controlled drugs were not kept, appropriate legal processes had not been followed where people were administered medicines covertly and records were not kept where people had been prescribe topical creams. A focused inspection carried out in January 2016 noted significant improvements in the way the service managed medicines.

During this inspection, the pharmacy inspector completed a comprehensive inspection on how the service managed medicines within the home and to look at whether improvements that had been implemented earlier in the year had been sustained. We checked medicines storage, medicines administration record (MAR) charts, and medicines supplies for 13 people. All prescribed medicines were available at the home. All medicines were stored securely in a locked medicines trolley, within a locked room. Staff secured the medicines trolley to the wall of the medicines room when not in use.

The room where medicines were stored was clean. We were told that care workers wore gloves during medicines administration in line with the infection control policy. There was a controlled drug (CD) cabinet attached to the wall of the clinical treatment room that complied with the Misuse of Drugs Regulation 1971. There were no CDs being stored at the home at the time of the inspection.

Staff recorded the current fridge temperature daily. We advised them to obtain a thermometer that was able to read minimum and maximum temperatures as well as current temperatures as per national guidance. However, the lack of minimum and maximum fridge temperatures did not have any impact on people living at the service. Staff also monitored the temperatures of the medicines room. We saw that medicines were stored at the correct temperature to remain effective.

A local pharmacy supplied medicines to the home on a monthly basis. Care staff could access medicines needed urgently from a local pharmacy via prescription from a GP. Most tablets and capsules were dispensed into a monthly monitored dosage system. Care staff checked the pharmacy sent the correct medicines each month. If any discrepancies were identified, they were documented, and the GP and pharmacy were informed so that any problems could be rectified.

Care staff kept records of stock levels for all medicines on the MAR charts and this was updated daily. The 'date of opening' was recorded on all oral liquid medicines and eye drops. All unwanted medicines were returned to the pharmacy for disposal at the end of each month and records of these were being maintained.

Only trained care staff, who had undertaken the competency assessment as part of the medicines training and passed, were allowed to administer medicines. The registered manager told us that all staff involved in medicines administration would have their competencies assessed three times a year.

MAR charts were used to record the administration of medicines and creams. Individualised topical MAR charts were used to enable care staff to identify where topical preparations needed to be applied. We looked at 13 MAR charts during this inspection. The MAR charts were computer generated by the pharmacy that supplied the medicines. A recent picture of each person was stored with each MAR chart. This assisted staff in identifying the correct resident. Records documented information about people's allergies. There were no missed doses seen on the current MAR charts. This provided a level of assurance that people were receiving their medicines safely, consistently and as prescribed.

We saw that there were systems in place for managing 'when required' (PRN) medicines. For example, care staff used the 'Abbey Pain Scale' to help them to decide when to administer 'when required' pain relieving medicines. Where a variable dose of a medicine had been prescribed (e.g. one or two tablets), care staff recorded the actual number of dose units administered to the person on each occasion.

Care staff took the correct steps to enable them to administer medicines covertly to people that needed this. When medicines are given covertly, it means that medicines, essential to the person's well-being are hidden in food or drink without the knowledge of the person. The GP, a pharmacist and the next of kin for each resident were contacted before medicines were given covertly and this was recorded within the person's care plan.

Care staff and the registered manager conducted daily, weekly and monthly medicines audits. An external pharmacist conducted a medicines audit once a year. The audits looked at supply, levels of support, storage, basic hygiene and housekeeping, administration, recording of medicines, disposal of medicines, CDs, non-prescribed medicines, advice and training, monitoring, policy and procedures and communication. Completion of these audits highlighted areas for improvement. We saw evidence that systems had improved because of these audits. Care staff knew how to report medicines incidents, and we saw actions that were taken because of medicines incident reports.

During the inspection we found that a urine sample had been stored in the fridge used to store medicines. We highlighted this to the registered manager and care staff who informed us that this sample had been placed in the medicines fridge in error and that they would be more vigilant to ensure that this does not happen again in the future.

We looked at five staff files and saw that the service had safe and effective systems in place to manage staff recruitment. The files contained the necessary documentation including references, proof of identity, criminal records checks and confirmation that the staff member was eligible to work in the UK.

On the day of the inspection we observed there to be sufficient staff available to meet people's needs. People we spoke to confirmed that they felt there was enough staff to meet their needs. When people were asked about staffing levels comments included, "Yes definitely" and "Yes I do. I find it is a very nice home actually." The service assessed people's level of needs on admission and we saw evidence that these were reviewed on a monthly basis. The service then determined the number of staff required based on people's assessed needs. Care staff we spoke with also confirmed that there was enough staff available within the home.

We looked at maintenance records for the home which included annual, monthly and weekly fire checks, call bell checks, monthly water temperature checks and equipment checks. At the time of this the home was undergoing major refurbishment works and so in addition to the checks that were already being completed, the provider had completed a risk assessment and was carrying out daily assessments of building works to ensure people and staff were safe. During the inspection we observed that the provider had ensured that all building work taking place within the home had minimum impact on the people living at the home. There was minimal noise and disruption and the areas where people spent their time were clean and dust free.

At the last inspection in November 2015 we found that the service was not keeping daily cleaning schedules which confirmed the areas that were to be cleaned on a daily basis and whether this had been completed. During this inspection we found that daily cleaning schedules were being completed and these were checked by the registered manager. In addition to this we also saw improvements had been made after feedback from the last inspection whereby all opened food items stored within the kitchen fridge had been

labelled with the date of opening.

Good

# Is the service effective?

## Our findings

People told us that they were supported by care staff who were well aware of the care that they required and understood how the care and support was to be delivered. We asked a number of people about whether they believed staff knew what they were doing when helping them. Responses we received included, "Yes they do, more than I do" and "Yes, if not I tell them."

Relatives we spoke with also confirmed that the care staff were supportive and met the needs of the people using the service. One relative told us, "The care staff are very good to [Name of person] and look after them very well." Another relative stated, "They [care staff] are experts in dementia, [Name of person] seems well looked after."

We looked at the training records for six care staff and we saw evidence that staff had undertaken induction training prior to commencing work with the provider. Each care staff member had an individual training record on file which gave information about the courses that they had completed and the date of completion. Certificates were available within each care staff file which corresponded with the training record. Care staff confirmed that they received regular training. One care staff member stated, "If you need any training, the registered manager will always organise it for you." Another care staff member told us, "I just have to ask for training and it happens."

The provider, at the time of this inspection, was in the process of registering with an external training provider to deliver the care certificate to all new care staff employed by the service. The care certificate is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support.

At the last inspection in November 2015 we found that the service was unable to evidence that care staff had received appropriate medicine administration training and assessed competencies to ensure that care staff were appropriately trained to administer medicines. During this inspection we saw records confirming that all care staff had received training in medicine administration. Following the training each care staff member had to complete an online competency assessment which assessed whether care staff had understood the training they had received. Care staff we spoke with also confirmed the process that had to be completed in relation to medicine administration. The health service manager told us, "I have completed the online competency assessment and both the registered manager and the provider have completed medicine observations with me."

Care staff told us that they were well supported by the registered manager in carrying out their roles effectively. One care staff member told us, "I feel supported, if I have anything to raise I get supported to deal with it." Another care staff member stated, "If you have any questions [Name of registered manager] is always here." All care staff confirmed that they received regular supervision and had received an annual appraisal. Supervision records and completed appraisal forms that we looked at confirmed this. Each care staff had a form on file which gave dates of all supervisions that had been held and also dates of supervision sessions that had been scheduled for the future.

At the previous inspection in November 2015 we found that the service did not have effective systems in place in relation to daily handover and communication methods which may have had an impact on the care people received as care staff could be potentially unaware of serious incidents that had taken place within the home. During this inspection we found that the service had addressed the issues we had highlighted. A communication book was in place which was used on a daily basis to record any significant events or information. All staff members were required to read the book at the beginning of their shift. The communication book also corresponded with the daily handover which recorded information about each person living at the home and concerns or information that had been noted on shift. There was a handover record for the day shift, pm and night shift. Care staff confirmed that they read the handover notes on a daily basis. One care staff told us, "Every morning we have handover and we have handover sheets that we read."

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 application 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. During the last inspection the service was in breach of Regulation 11 and 13 of the Health and Social Care Act 2008 as we found that the service did not have appropriate processes in place which assessed people's capacity and recorded decisions that were in their best interest. This was especially in relation to medicines that had to be administered covertly. We also found that the service had not completed the relevant applications for people living at the service who were potentially being deprived of their liberty for their own safety.

During this inspection we found that the service was meeting the requirements of the MCA and the Deprivation of Liberty Safeguards. Where any person living at the home lacked capacity, we saw evidence that a mental capacity assessment had been completed and a Deprivation of Liberty Safeguard authorisation had been made to the local authority. Where authorisations had been granted, this was documented within the care plan including details of any conditions that had been set. The registered manager held an overview of each person who had been granted an authorisation and the date it was due to expire so that re-authorisation could be requested.

We saw evidence that where a person lacked capacity to make a specific decision, a multi-disciplinary approach had been taken in order to reach a decision which was in the person's best interest. Where a decision to administer covert medicines had been made we saw evidence that the family, GP and pharmacist had been involved in the decision making process. This had been appropriately recorded within the persons care plan. We also saw evidence of best interest decisions that had been made in relation to a person requiring bed rails or a hospital bed.

All staff that we spoke with including the registered manager demonstrated a good level of understanding of the MCA and DoLS and how this impacted on the way in which they supported people with their care needs. One care staff member told us, "MCA and DoLS is where people don't have the capacity to make their own decisions. We try to ask then what they want and try to encourage them but if they refuse we report this to the manager, the family and GP." Another care staff member stated, "The MCA is about someone being able to make decisions and choices for themselves and where they can't it's about getting professionals involved to make a decision in their best interest."

Care staff told us that they always sought consent from people when supporting them with their needs and requirements. One care staff member told us, "Consent doesn't have to be only verbal. Where someone cannot speak, we follow gestures or facial expressions, they can nod, shake their head or smile. They can also hold up their hand to tell you to stop." Another care worker gave an example and stated, "When taking someone to the toilet, you start by asking them and explaining to them what you are going to do." A third person explained, "It's about giving them choice and asking them what they want."

We saw evidence in care plans that where people were able to, they had signed their own care plan, consenting to the care that they received. Where people were unable to sign, relatives had been involved in the care planning process and had signed the care plan.

We observed mealtimes to be an experience that was enjoyed by all. People were very positive about the food and the choices that they were offered. One person stated, "The food is beautiful, never have any complaints." Another person when asked if they enjoyed the food told us, "I do definitely; they make a lot for us." We observed a calm and relaxed atmosphere throughout the mealtime and people ate well and were supported where required.

Menus were set by the registered manager in conjunction with people living at the service. We saw evidence of residents meetings where the registered manager discussed meal options with people. A menu was displayed in the lounge with options and choices for each mealtime. In addition to the menu there was a chart listing each person and their choices in relation to particular food items and portion sizes. For example, if chips were to be served for lunch, for one person it would be noted that as they did not eat chips, this would need to be replaced with an alternative such as mashed potatoes. For some people it was noted that they liked to have both chips and mashed potatoes. This chart was very personalised to each person and made note of their likes and dislikes.

A variety of drinks was available throughout the day and people had access to snacks and biscuits when requested. People's weights were checked and monitored on a monthly basis. Where weight loss or excessive weight gain was noted charts were completed to monitor food and fluid intake as well as appropriate referrals made to help ensure that people's nutritional needs were met. Where people required professional input in relation to dietetic services or the speech and language therapists, we saw records of referrals that had been made. Records and guidance were available where people had been assessed to require specialist assistance with their meals such as a pureed diet or thickening agents to be added to their meal or fluids.

Care records evidenced that people's health and well-being were monitored and people had access to a variety of health care professionals where and when required. When we asked people about seeing the GP or any other health care professions, they told us, "I get to see the GP as I need to" and "The GP comes here to see us." Each care plan contained a GP and health professional visit sheet which recorded details of each visit that took place by the GP, chiropodist or optician.

Good

# Is the service caring?

## Our findings

During the inspection we observed that people had developed positive and caring relationships not only with each other but also with the care staff that supported them. People told us that they were treated with care, compassion and respect. One person told us, "They are very caring to me." Another person commented, "It's a very nice home, we are very happy and we all get on well with each other." Relatives also confirmed and echoed what people had told us. Comments included, "Of course, yes they are caring, absolutely."

During lunchtime we observed personal and caring techniques adopted by care staff when administering medicines. As the carer prepared each medicine they would arrive in front of the person and validate who they were to confirm that the medicine they were offering matched with their records. The approach in which the carer solicited validation from each person as to whom they were was extremely individualised. The conversation would begin by way of a little chat at the beginning before asking who they were. Equally concluding, after ensuring the person had taken their medicine, with a further little chat.

Throughout the course of the inspection we observed care staff treating people with dignity and respect. Care staff clearly understood people's needs and preferences, likes and dislikes and each individual person's mannerisms and special traits. When asked about respect and choice, one care staff told us, "We give one person different books to read as she likes reading. She may not remember what she is reading but we know she enjoys it." People's needs in respect to their religion and beliefs had been recorded and understood.

Care plans that we looked at were detailed and person centred and identified each person's individualised needs, preferences and wishes. Detailed and individualised information included the time when the person wanted to wake up and go to bed, the gender of the care staff that they preferred to be supported by and the things that they liked to do.  Each care plan had a 'day' care plan and a 'night' care plan and gave guidance and information on how the person chose to be supported at different times of the day.

Although the service was not currently supporting anyone who was lesbian, gay, bi-sexual or transgender, care staff we spoke with told us that the support a person would receive would not be dependent on their sexual orientation but would be in line with their personal needs, requirements and wishes. One care staff member told us, "I would support them normally. I would support them as a person not by their sexuality. Another care staff member explained, "I would read their care plan and support them how they want. They just need our support and that's why I am here."

Care staff were clear on how they viewed person centred care and the importance it held for the people living at the service. One staff member told us, "Everyone has their own individuality, we ask each person what they want and whatever they want they get it." A second care staff member stated, "We make sure we give them the best care possible. Individually they all need different types of care and by reading the care plan we find out about the person and the care they require." A third staff member told us, "They are here for support. We are supporting the person, they come first. People should be first priority."

People told us that they were involved in making decisions about the care they received and that staff always supported them in the way in which they wanted to be supported. When we asked people about this they responded by telling us, "Yes, if there are any problems I would tell them" and "Yes, I do and I find that important." People also told us that they were treated with dignity and respect and that their privacy was maintained at all times. One person told us, "Oh yes, when you are in your room, it is your room. You can do what you want."

Privacy, respect and dignity was of high importance to the care staff that we spoke with especially when delivering care and support. Care staff were able to give a number of examples of how their values and beliefs about person centred care was reflected through how they supported people. One care staff member explained, "I draw the curtains and close the door when supporting a person. I put myself in their situation and imagine how I would feel." Another care staff member told us, "All personal care should be provided in the person's own room. I always knock on the door before I go in."

Good

# Is the service responsive?

## Our findings

People living at the home and their relatives were happy with the care and support that they received and felt confident and able to raise any concerns or issues that they had. When we asked people if they had any complaints, one person told us, "No, if there was a problem I would address it." Another person said, "I have never complained, never a need to thanks be to god." Relatives told us, "I can approach [Name of registered manager] if I have any complaints" and "I have nothing negative to say."

The service had not received any complaints since the last inspection in November 2015. The registered manager operated an 'open door' policy where people and relatives were able to approach them at any time. A complaints policy was displayed on the registered manager's office door which gave clear guidance to people and relatives on how to lodge a complaint and the processes that would be followed. The registered manager also kept a record of all compliments that the service received. We saw a sample of compliments which were very positive. Comments included, "The best way to describe St Theresa's is to say I would be happy to live there myself" and "I would recommend this home to others as my sister is getting the best of care."

Care plans were person centred and reflective of the needs and requirements of each person living at the home. Relatives confirmed that they were always involved in the care planning process and that they were always consulted with all aspects of the persons care and health needs. One relative told us, "Yes, they do involve me when reviewing their [person] care. They call me before they do anything and tell me about what they are planning to do and what do I think." Another relative stated, "Communication is very very good. If anything is wrong or if the GP is called they inform me straight away."

Care plans were reviewed on a monthly basis or as and when required if there was any significant change. We saw evidence of where a person was able to take part in the review they were asked to sign their review paperwork confirming what discussions had taken place and any if any changes had been made. Alternatively, relatives had been involved in the review process and had signed paperwork to confirm their involvement.

Each person living at the home had an allocated key worker. The key worker role involved paying specific attention to a person's personal care needs, ensuring they had sufficient personal clothing and toiletries, communicating with the family on day to day matters, arranging monthly reviews and updating their care plan. One care staff member told us, "As a key worker I carry out their monthly review, make sure their room is tidy and their clothes are in good condition." Another care staff member stated, "As a key worker I read the care plan and get to know the person."

Each person had a life history document within their care plan which gave important information about the person's life, their experiences and interests so that all staff had a greater understanding of the person as an individual. Care staff told us that they were aware of this document and always made a point of reading it to gain a greater understanding of the person they were supporting. The health service manager told us, "We always ask the next of kin and family and collect information from them about a person. We then ask all staff

to read it."

The service kept a 'Resident's Activity Folder' which contained a log of all activities delivered within the home. Care staff were required to complete this every time an activity took place. We saw entries of a number of activities which included movement to music, hand massage, discussions, talking quiz games, art and craft, monthly praise and worship and ball games. When we asked people about activities, responses we received included, "They are quite good. We do catching the ball, singing sometimes and we do little exercise every day" and "There are lots of activities inside and outside."

Activities were not planned or set as part of a fixed time table. We observed daily activities taking place across the whole day which responded to the needs and wants of the people during the day. People could choose to participate or not at a time that suited them and an activity that they chose. We saw that this method was productive. There was delight, laughter and hand waving of communication from around the room as people observed the various activities as they occurred, whether they did colouring-in, reading, quiz participation, knitting or participating in nail varnishing, or simply being chatted too. Everyone's needs were recognised and responded to as each person wanted them to be.

We observed a quiz session during the afternoon of the inspection. This activity was illuminating as the questions were stimulating in so much as it kept the active participation of each person who were mostly answering with the right answer. The nature of the questions were historical in relation to people's lives and covered, politics, films, history and geography from an era before their dementia impacted on them. Thought had gone into the questions to be asked and people that participated were engaged throughout the activity.

Monthly residents meetings were held and feedback from people living at the home was encouraged. Discussions and outcomes from each meeting were recorded and included topics such as outings, the environment, mealtimes and menus, expression of views and feedback about the care people received.

Good

# Is the service well-led?

## Our findings

People and relatives knew who the registered manager was and were confident and comfortable in approaching them whenever they had a concern or complaint. When we asked people if they knew the registered manager they told us, "Yes [Name of registered manager]. She comes round and speaks to us. If there are problems it is very easy to talk to her" and "[Name of registered manager] is the manager and she is of course easy to talk to." Relatives comments included, "[Name of registered manager] is very forthright and very confident. She is great with my dad."

Care staff were highly complementary of the registered manager and told us that she was always available when they needed her to be. We observed the registered manager to be visible around the home, communicating and interacting with each person living at the home and supporting them where required. Care staff told us, "I have been here one year and it's been good" and "It's nice in here, there is a nice atmosphere."

At the last inspection in November 2015 the service was not meeting the regulations in relation to the effective management of the service especially in relation to the management oversight of medicines. During this inspection we found that service had made considerable improvements whereby the registered manager and the provider had clear oversight of the management of the home and where issues were identified these were actioned. The service had a number of quality assurance systems in place to monitor and review the performance of the service and included identifying areas where improvements were required. These included daily, weekly, monthly and annual medicine audits, environmental audits, care plan audits and health and safety checks.

At the time of the inspection, significant refurbishment and modernisation of the home was taking place. The provider ensured that they were present at the home to oversee the building work that was being completed to ensure that there was minimal impact on the people living at the home. The provider completed daily environmental, health and safety checks to ensure people's safety.

Staff meetings were held on a monthly basis and minutes of these meetings were seen confirming this. Agenda items included infection control, choice for residents, residents care needs and improvements. The registered manager also held ad-hoc staff meetings as and when required where significant updates, issues or concerns had been identified which need to be discussed with the staff team. Care staff confirmed that these meetings took place every month and made comments such as, "We talk about residents and what they need, any staff problems. The registered manager listens to us if we want to make any suggestions or if we have any concerns."
After the last inspection in November 2015, the registered manager also introduced three monthly medication management meetings to discuss updates, concerns and issues relating to the management and administration of medicines.

People and relatives were asked to complete an annual quality assurance satisfaction survey in December 2015. At that time the home had 15 people living at the home. 15 surveys were sent and all 15 completed

surveys were received. Where people living at the home were unable to complete the survey, the questionnaire was sent to their relative. Relatives that we spoke with confirmed that they had recently received a questionnaire and had completed it. One relative told us, "We did have a questionnaire about quality suggestions for improvements and I feel I would be listened to and I would be more than comfortable in making suggestions."

The registered manager compiled an analysis of the responses that were received to allow for trends and patterns to be noted and for improvements to be made where required. Responses were very positive and included comments such as, "The accommodation and décor and general atmosphere is excellent. The home is run like a proper home and not like an institution" and "The staff are excellent, very caring and nothing is too much trouble for them."