Care Quality Commission

Community Of St Mary At The Cross

Henry Nihill House

Inspection report

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Ratings

Overall rating for this service	Good
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?	Requires improvement

Overall summary

We inspected this service on 11 November 2015. The inspection was unannounced. Henry Nihill House is registered to provide accommodation and nursing care for up to thirty people, some of whom have dementia, physical disabilities and mental health needs. The service consists of three units split over two floors. At the time of our inspection there were twenty nine people living at the service.

The service is located in a purpose built block, on two floors with access to a front and back garden area. The service adjoins the Anglican convent owned by the Community of St Mary at the Cross. The service offers accommodation and care to people of all or no faiths.

We previously inspected the service on 21 March 2014 when the service was found to be meeting the regulations.

Henry Nihill House has a registered manager at the service. 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.

Summary of findings

During the inspection there was a calm and pleasant atmosphere. People using the service informed us that they felt safe living at Henry Nihill House.

All the people we talked with confirmed they were treated with dignity and respect, and we observed good quality interactions between staff and people using the service.

Care records including risk assessments and care plans were up to date and detailed. People were supported to maintain good health by the nursing staff at the home and through regular access to community healthcare professionals such as GPs and local hospital services.

People had their medicines managed safely. People received their medicines as prescribed and on time. Nursing staff ensured safe storage and management of medicines.

Staff had been carefully recruited and provided with training to enable them to care effectively for people. Supervision took place regularly and in different formats including observing the giving of care to people who used the service. Staff felt supported and there was always a nurse on duty.

People told us the management was a visible presence within the home. Staff talked positively about their jobs telling us they enjoyed their work and felt valued. The staff we met were caring, kind and compassionate.

Staff knew how to recognise and report any concerns or allegations of abuse and described what action they would take to protect people against harm. Staff told us they felt confident any incidents or allegations would be fully investigated.

We saw there were enough staff to meet people's needs, although we have suggested the registered manager obtains further feedback from people using the service in relation to levels of support for care at night.

People were offered a range of activities to participate in at the home and increasingly community links were being developed. The registered manager has the financial agreement to increase staffing for leisure activities and this will be of benefit to people living at the service.

People's religious needs were actively facilitated by staff, and staff were able to tell us how they responded to people's cultural needs. The home prided itself on good quality end of life care and we saw that staff were able to respond well to the needs of a person receiving palliative care.

We found the premises were clean and tidy. Measures were in place for infection control. There was a record of essential inspections and maintenance carried out. The building was fully accessible and maintained to a good standard.

The registered manager was in the process of further rationalising care records relating to people using the service to ensure they were easy to read, were succinct and up to date.

The home had arrangements in place for quality assurance. Regular audits and checks had been carried out by the registered manager. It was apparent that management support at a senior level within the organisation had not been as available to the service over the last six to nine months. This had impacted on quality assurance and affected the quality of the service.

We found the provider was in breach of the standard relating to the good governance of the service.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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. Medicines were safely administered and stored.

Safeguarding incidents were dealt with appropriately and promptly.

Staff recruitment was effective and all checks were completed prior to people starting work, so staff were safe to work with people living at the service.

There were effective food hygiene and infection control procedures in place.

The premises was suitable for the service and well maintained.

Is the service effective?

Good

The service was effective. The staff were regularly supervised and a training schedule was in place to ensure staff were skilled to do their job.

Staff were knowledgeable about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Food was of a good quality and choice was offered to people living at the service.

Access to health care was good both within the service and through access to community health practitioners.

Is the service caring?

Good

The service was caring. Staff interactions were kind and caring with people living at the service. People were treated with dignity and respect.

End of life care was of a high standard at the service.

The service ensured people had their cultural and spiritual needs attended.

Is the service responsive?

Good

The service was responsive. Nursing requirements relating to skin care was clear, responsive and well documented.

Complaints were dealt with quickly and appropriately.

There was evidence the registered manager was involving service users and their relatives in the running of the home.

Leisure activites were limited, but the provider had committed to do more in this area.

Is the service well-led?

Requires improvement

The service was not always well led. The registered manager showed good leadership and commitment to providing a good service.

Summary of findings

There was a commitment to transparency and openness within the service and focus on learning from mistakes and incidents.

Care documentation had improved in the last year and the registered manager was further rationalising it to make it more effective.

There had been a lack of senior management support and quality assurance audits at the service and this had impacted on people living there.

Henry Nihill House

Detailed findings

Background to this inspection

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

This inspection took place on 11 November 2015 and was unannounced. It was undertaken by two inspectors for adult social care and the inspection team included a specialist nurse advisor and an expert-by-experience with experience of working with older people. 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 service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

We also looked at the 'Enter and View' Report by Barnet Healthwatch undertaken at the service in June 2015. This can be seen at http://www.healthwatchbarnet.co.uk/content/enter-view.

During the inspection we met and spoke with nine people who live at the service and four visiting relatives. We talked with four members of staff, the registered manager and the regional service improvement manager.

We looked at eight care records related to people's individual care needs, six recruitment files and staff training records. We carried out an audit of medicines stocks at the service and looked at records in relation to medicines management.

As part of the inspection we observed the interactions between people and staff, and discussed people's care needs with staff.

We used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We checked fire safety including equipment, testing of the alarm, lighting and the regularity of fire evacuation tests, and information relating to incidents and complaints. We looked at minutes of residents' meetings and staff team meetings. We also looked around the premises and viewed the garden.

Good

Is the service safe?

Our findings

We were told by people using the service, "I have no worries about my care here" and "I do feel safe." Everyone we spoke with told us they felt safe from harm or abuse and were well treated by the staff.

There was evidence of comprehensive risk assessments covering falls, moving and handling, pressure ulcers, and nutrition using the Malnutrition Universal Screening Tool. These assessments were specific to the individual, for example, where a person was required to be hoisted at all times, the risk assessment outlined the type of hoist to be used and the required number of staff. A subsequent conversation with a care worker demonstrated that the guidance in the risk assessment was understood and we were told that it was followed "exactly as written down."

We saw that risk assessments were reviewed monthly, or when there had been a change in a person's condition, in line with the policies and procedures at the service. Care plans were then updated to mitigate the risks.

We noted that one care plan and risk assessment of a person receiving palliative care had not been updated within the last two weeks despite changes in their needs. We discussed this with the registered manager who could evidence changes in care provided to the person, so this had not impacted on the person's experience of care. The registered manager agreed going forward to ensure care plans were updated more frequently when providing care to a person with rapidly changing needs.

We saw the incident log for the last year. The registered manager told us where they had identified themes from these they were raised at staff meetings so staff could learn from the incidents.

Management of medicines was safe. We examined twenty nine medication administration recording (MAR) charts and found them to be appropriately completed, identify known allergies, contain photographs of the residents and have signatures and countersignatures, where medicine had been hand-written rather than printed.

The service utilised the "Multimeds" dosset system. All medicines, other than liquids and controlled medicines were delivered by this process. Controlled medicines are prescription medicines that are subject to legal controls in relation to how they are stored, supplied and prescribed to prevent misuse. There was evidence of routine double signatures for all controlled medicine administrations and checks. We checked the records of three random controlled medicines and found the stock to be correct.

There were processes and records for the safe return of unused medicines to the pharmacy. The medicines were appropriately stored in a locked clinical area and within a secure cabinet. There were two medicines trolleys, one for day and one for night medicines. These were locked when not in use.

We saw temperatures of the room and medication refrigerator were checked and recorded daily and readings for the refrigerator were within range. There were no gaps noted in the records.

We saw that staff were providing care in a calm and relaxed manner. We saw from the rota there were nine staff working from 7.30am to 2.15pm. From 2.15pm to 7.30pm there were seven staff, and there were three staff working overnight. There was always a qualified nurse on duty. Additional staff carried out other duties including food preparation, maintenance and cleaning.

We saw there were adequate staff on duty on the day of our inspection. One care worker told us, "It can get busy, but that is to be expected. Weekend staffing is fine, there is the same amount of staff as there is on during the week." A nurse told us, "I believe we are very well covered for staff. If we need to get other staff in, there is no problem about this."

People living at the service had a variety of views on staffing levels. One person told us there were "loads of staff" and another said, "They listen and take notice." However, one person told us that at night she had to wait longer to be supported with toileting. We discussed this with the registered manager and whilst they are able to check response times to the call system, which were good, they are aware this may not fully reflect people's experience. The registered manager agreed to get the views of all the people living at the service regarding their experience of night time care by including a question in the annual survey that was due to be carried out at the service in January 2016. The registered manager also raised this with the commissioner of the service as a resourcing issue following the inspection.

There was a safeguarding adults policy in place at the service and we viewed safeguarding records for the last

Good

Is the service safe?

year. There was evidence the service had acted appropriately and had liaised with the local authority and made notifications to the Care Quality Commission as required.

Staff were able to give examples of the type of abuse that can occur, and were able to describe the process for identifying and reporting concerns. One care worker said, "I observe that a resident may be a bit withdrawn. I give them time to discuss something with me, and if it is of concern, I immediately raise it with a nurse."

Staff understood how to whistle-blow and told us that there were frequent reminders in meetings about this. We noticed there were many signs up around the building, informing staff about whistle-blowing and how to do it.

Thorough recruitment checks were carried out before staff started working with people. We looked at staff records and saw there was a safe and effective recruitment process in place. We saw completed application forms which included references to their previous health and social care experience, their qualifications, their employment history and explanations for any breaks in employment. Each record had two employment references. Records had health declarations and in-date Disclosure and Barring Service certificates [DBS]. Staff we spoke with told us they were not allowed to work until their DBS had come through. This meant staff were considered safe to work with people who used the service.

All records relating to nurses included their up to date PIN number which confirmed their professional registration with the Nursing and Midwifery Council [NMC].

We were shown a separate file which contained all agency staff records and included the profiles of agency nurses and care workers. The file also contained an agency worker checklist, an introduction to people using the service and staff, the location, and reading of care plans. The registered manager told us they limit the use of agency nurses as they prefer to have staff in charge who are familiar with the service. To ensure agency staff were easily able to access information about people living at the service a care plan was placed in each room.

The service was clean and we saw staff cleaning it throughout the day. Infection control measures were in place.

The Food Standards Agency had awarded the kitchen the highest rating of five stars in July 2014 for food hygiene. We saw that food was stored safely by being labelled and sealed in fridges.

There was a Maintenance and Health and Safety log book kept on each floor. Staff wrote in items which needed repair or replacement. For example, we saw how a door closure battery was logged as needing replacement, and this was subsequently signed as done by the maintenance worker two days later. In another entry, where bed rails were thought to be faulty, their repair was logged as done the next day.

Good

Is the service effective?

Our findings

Staff told us they received regular supervision, the frequency of which had recently been increased to once a month. We saw from the training matrix that staff were supervised monthly or two monthly. The notes we saw had a set agenda, including a review of training done. Notes were signed and dated by both supervisor and supervisee.

Staff told us how "supervision is useful, I am able to talk about my work and the challenges I face." A nurse told us, "I get clinical supervision from the manager. This is a good time for me to discuss my professional development and to reflect on my professional needs."

The registered manager told us, "Training is a work in progress as it had been a bit neglected as a result of the various changes in management over the past year." She also told us how "we have prioritised the essential training such as safeguarding, mental capacity and manual handling."

The training matrix evidenced this fact, as staff were either up to date in these areas,or had training scheduled in for the coming months. The registered manager also told us how all nurses had just completed their new medicines training. We were told there was a training topic identified each month which all staff had to complete, by watching a DVD. This training was then discussed in supervision, "to confirm the learning."

A care worker told us, "Training is good, I believe I am confident in my skills as a result." Another member of staff told us, "Training is marvellous." We were also told by a care worker they had joined the organisation with National Vocational Qualification Level 1 and had since completed Level 2 and 3 in social care.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. The registered manager had made referrals to the local authority with regards to deprivation of liberty safeguards (DoLS) for nine people. Six had been granted authorisation and three people were awaiting assessment. The registered manager was reviewing mental capacity as part of all reviews and planned to submit more requests for authorisation as appropriate.

Staff we spoke with were familiar with the Mental Capacity Act 2005, and the need to obtain consent from those who used the service. A care worker told us, "I speak in a gentle way, explaining what I am about to do and give them time to respond. It is no problem if they want to change their mind." They also told us, "Where possible, I like to show a picture of what I am asking, for example, food choices."

However, we noticed there was inconsistency in obtaining the signature of the person who used the service, or if they were unable to sign that this was documented. The registered manager acknowledged that this was an issue, and something which would be addressed with all staff.

Care records included evidence of multi-disciplinary work with other professionals. There was evidence of responding to risk by referral to appropriate services such as Tissue Viability Service, Speech and Language Therapy (SALT), and palliative care specialists, with amendments noted to care delivery as a result of this specialist input.

We reviewed the wound records of two people, encompassing pressure ulcers and leg ulcers. The nursing response was appropriate. In addition, body mapping was completed, a wound was photographed and dated and a wound care plan was developed with the involvement and support of a Tissue Viability Nurse. Effective nutrition is important to promote healthy skin and provide protein for tissue repair, and it was evident that nutrition was considered and dietetic support secured.

We saw the service was successful managing pressure ulcers and achieving improvement in most instances.

Good

Is the service effective?

The GP visited weekly and people living at the service told us they saw the doctor as required. They also said they saw the optician and chiropodist as they needed.

People told us, "I like the food, it's very good" and "Food nine out of ten." During lunch we noted that staff brought food to the tables for people but didn't routinely say what was on the plate. Whilst this would not be necessary for people who are fully mentally alert, for people with dementia or for people who need food to be pureed, it was important as it can enhance the experience of eating. We spoke with the registered manager and they agreed to talk with staff about this. The registered manager also agreed to develop a pictorial drinks menu alongside the existing pictorial food menu to aid communication.

All nursing care files included nutrition assessments and associated eating and drinking care plans. There was evidence of the use of dietary supplements. There was routine assessment of choking risks and referrals to SALT and dieticians in response to assessed difficulties.

Monthly weights were recorded and incorporated into the Malnutrition Universal Screening Tool (MUST). These were routinely recorded for the files that were reviewed. There was evidence of someone being provided with Percutaneous Endoscopic Gastrostomy (PEG), in response to a choking assessment and SALT referral.

We observed staff offering choices of drinks to people during the day. We examined three fluid intake charts, which showed good levels of hydration recorded. There were entries indicating that drinks had been offered but refused. The three people, whose fluid intake charts were viewed, appeared well hydrated. However, none of the records of fluid intake that we examined had the daily intake totalled. Where daily totals were not used, confidence is lost that the service is routinely assessing intake. We were reassured that, on totalling the records, the intake was good. We spoke with the registered manager regarding this and that there were very few entries for drinks taken after 17:30hrs each day, which was likely to be an issue of recording not hydration. The registered manager agreed to talk with staff about this.

The building was fully accessible and maintained to a good standard. The corridors were wide so creating a spacious environment to move around in. Bedrooms were large with ensuite facilities, usually a wet room with a shower and toilet facilities.

There was a plan for upgrading specific internal areas of the building. Parts of the flooring had been upgraded on the ground floor and the remaining area was booked for completion.

Good

Is the service caring?

Our findings

We spoke with a person who told us, "I would rather live here than anywhere else. The staff are really kind here." Other people said, "The staff are quite nice" , "They are kind and patient. On the whole they are very attentive. They help me when I need help" and "The staff are very caring"

We saw that the staff team were thoughtful and promoted positive caring relationships between people using the service. Throughout the course of our inspection day, we noticed how staff took time to engage with those who used the service, and patiently answered frequently repeated questions. We saw staff stopping what they were doing to speak with people or assist them to another part of the building.

Staff knocked before entering people's bedrooms. We observed how they assisted people to eat in their bedroom. Staff were patient and engaged with the person, giving them time to eat slowly. This was done in a safe way, and the staff member adjusted the person's sitting position as appropriate. A staff member told us, "I think we have a good rapport with people and their families. This helps us to build relationships and helps us all work better together."

People who wished to, had access to regular religious activities, such as mass and visits from a priest or nun. There was a mass held in the specially designated chapel on the day of our inspection. Staff told us that they encouraged people to express their religious needs. People of all faiths were supported in their beliefs. Staff told us how they celebrated different religious and cultural festivals and spoke warmly about valuing sexual diversity. One room that had originally been built as a small chapel was also used as a sensory room and provided a calm and relaxing environment.

The registered manager told us they had links with a local hospice in order to better support anyone who was at the end of their life. She told us, "I would place my end of life care in the hands of any of the staff here. They will sit with a dying person if their family cannot do this. People are not left to die alone in their rooms here."

The registered manager told us they had got a syringe driver up and running within two hours for a person living at the service whose health needs had increased significantly and required palliative care. The service was proud of being able to provide high quality end of life care and the registered manager told us they were developing a good reputation for this. They had recently been asked to admit a young man for the purpose of receiving palliative care, which they were glad to offer.

We saw from the risk assessment for one person receiving palliative care that they had recently asked for gin and tonic to be brought in for them. This was appropriately risk assessed and agreed, and was an example of good quality care being provided at the service.

The registered manager was collating information for a bereavement pack to assist friends and relatives once a person had died, illustrating awareness of the need for good support for people in a time of crisis.

People's rooms had personal memorabilia in them and the service had photos, collages and paintings on the wall. The registered manager was keen for people to feel like this was their home. Somebody else told us "..sometimes this feels like home." We saw that people requested daily newspapers and these were left outside their bedroom door early in the morning.

Good

Is the service responsive?

Our findings

The care and support people received was responsive to people's needs. Care records contained a comprehensive pre-admission assessment, which a nurse told us "formed the basis of the person's care plan." On the day of our inspection, a member of staff was visiting a person who was considering moving to the service. The registered manager told us, "Part of this visit is to learn how to use their equipment prior to admission."

Care plans were detailed, person-centred and provided good information for staff to follow. They included guidance about how people's care and support needs should be met and were regularly reviewed. A care worker told us, "We are expected to read people's care plans and are informed by the nurse if there are any changes made to them."

There were appropriately completed Personal Emergency Evacuation Plans within each of the files that we reviewed, and we noted that when people went for hospital appointments the medical staff were asked to complete a brief summary to report the outcome of the visit. This helped the service to keep up to date with the person's needs.

We reviewed the complaints book over the last year. The issue, the action taken and the outcome were recorded appropriately. All the people living at the service knew how to complain and who they could talk to, but no-one had felt the need to do so.

The views of people living at the service and their relatives were gained through regular meetings and annual surveys. We were told "They are interesting" and "I think they are useful" by two people living at the service. In order to evidence the impact of people's involvement the registered manager had put up on the notice board a document which stated 'We asked. You answered. We listened"

This told people what the service had done to respond to issues they had brought up.. An example was, "Can you suggest anything that could improve our care of you." One person had said, "I'd like the use of the garden." The garden had been upgraded to ensure it was safer and with better wheelchair access so people are able to go out unaccompanied in the better weather.

Another example was, "If you could change one thing what would it be?" One person said, "Communication , I feel there could be better communication between staff and relatives re the service user". The service has introduced communication books in all bedrooms to facilitate better communication.

The service operated a key-worker system but although there was some personal information in the folders in people's rooms, care plans did not contain the person's social history. Staff we spoke with could not give us much detail about the background of those whom they were supporting, for example, whether they used to work and their occupation, whether they had children or the area in which they grew up.

Whilst one person told us, "I sometimes chat about my family to the staff", another person said, "I'd like them to be more aware of my life" and a relative told us, "They don't talk about her previous life." This information was of particular importance when supporting people with dementia, as it can often help to engage them in conversation. It is also a vital element of offering personalised care to people. A nurse told us, "This is something we have recognised and are trying to get information from families." This was confirmed by the registered manager.

Whilst there were two staff who facilitated activities at the service, both were part time. They offered keep-fit classes, bingo, massage, craft activities and took one person swimming. There was a regular quiz at the service and we saw on the notice board that in 2016 there was a world food event planned in which each month there would be a different focus on food. On the day of the inspection there was a 1958 WWII drama film on which was quite appropriate as it was Armistice Day, but that was the only activity planned for the day. We saw that there was musical entertainment booked once monthly for November through to February.

There were some activities outside of the service arranged over the summer, some people went to the London Eye, and there was a BBQ in the grounds. There were also planned shopping trips nearer to Xmas. But one person told us, "I would like to have more outings arranged and be able to go out at weekends without having to ask." Another

Good

Is the service responsive?

person told us, “I spend most time in front of the TV. All day nonstop, and I go a lot to chapel.” One relative told us they thought there should be more stimulus for people at the service.

The registered manager told us she was aware of the limited range of activities for the number of people at the service and had secured the funding for an additional part-time activities co-ordinator. This would help to increase people’s opportunities for doing interesting things. There was access to two minibuses and the maintenance staff were appropriately qualified drivers so with additional staff support people could have greater opportunities for leisure.

Requires improvement

Is the service well-led?

Our findings

The registered manager has been in post since early 2015, having previously worked as a nurse within the service. They had been working hard to make improvements to the systems, paperwork and culture within the service, emphasising openness and transparency within the staff team and the service overall. The registered manager's commitment to providing good quality palliative care was evident through the care provided, the good partnership working with associated medical staff and the records we saw at the inspection.

The service had a philosophy based on the values of both organisations, St John of God (the employer) and St Mary of the Cross (commissioner of the service) of compassion, hospitality, respect, justice and trust. The service aimed to provide an environment that people could consider their home.

It was evident that considerable changes had been made to the care planning and recording processes over the last year. Some older records were retained in the files, enabling a comparison of the revised documentation to be made. This showed a clearer and more structured current approach. The registered manager was rationalising the paperwork to minimise duplication, making the records easier for care staff to read and record in.

There was involvement by staff. Views were gained and information was shared through regular staff meetings. It was clear from our discussions with staff that morale and motivation was high. One care worker we spoke with said, "I am very happy with how things are going now. The managers are very approachable and are always around." Another told us, "There have been many changes recently but I think they are going in the right direction. We all want the best for the people here."

Staff told us they felt confident they were listened to. One said, "We have a staff meeting each month and things get changed. For example, a simple thing like getting a new phone which we can walk around with was sorted out within days of it being requested."

The registered manager made clear that all staff were important in providing good care to people living at the service. For example, at a recent staff meeting involving maintenance as well as care staff the key lines of enquiry the CQC inspect on, safe, effective, caring, responsive and well led, were discussed so staff knew what was important from a regulatory point of view.

The registered manager had recently increased the regularity of supervision and had delegated the supervision of care staff to nurses. One element was to observe staff carrying out tasks which provided information for discussion during supervision and training requirements. This practical style of mentoring can be a helpful tool in improving practice.

There was evidence that essential services such as gas, electricity, and portable equipment testing had been professionally checked within the last twelve months. Fire drills were carried out regularly as was water testing, and infection control audits regularly took place. This evidenced systems were in place by the registered manager to ensure the safety of people in the service.

There was a comprehensive list of policies and procedures so staff knew what was expected of them.

It was evident from our inspection the registered manager provided good leadership to the staff at the service; was aware of areas that needed improvement or continuous development and had an action plan to make the necessary changes.

One example of this was to get specific training for nursing staff on the Mental Capacity Act 2005 (MCA) by the Law Society and to provide pocket size cards with the five key principles of the MCA so they had easy prompts when considering issues of consent in relation to people living at the service. Another example was that following an incident at the service that occurred in 2014, the registered manager had ensured care staff now had to sign to confirm they had read the latest care plan for a person they were caring for.

However we also noted that registered manager needed additional support to ensure the improvements identified through audits were followed through. We noted that care plans were audited, but actions recommended as a result of that audit were not always followed through.

For example, an audit in September noted that the care plan review needed to be updated, the resuscitation form had to be signed and manual handling notes needed to be rewritten. None of these actions were taken by the time of

Requires improvement

Is the service well-led?

our inspection, two months later. We drew this to the attention of the registered manager, who agreed that there needed to be more robust oversight of follow-up actions from audits, and was introducing a monthly care and support review form for completion by staff.

We also found from talking with one person who lived at the service and by checking through their file there was a discrepancy between two documents relating to whether they needed pureed food or not. As a result of this confusion sometimes the person was getting pureed food and other times not. We drew this to the attention of the registered manager and she immediately spoke with staff regarding this, updated the file accordingly and ensured the person was no longer receiving a pureed diet.

Whilst the leadership offered by the registered manager was good, there had been resourcing issues within the senior management support offered by the St John of God organisation (the employing organisation). This had impacted on the level of quality assurance and support offered by senior managers to the registered manager and the service. An example of this was the delay in writing of two internal investigative reports into incidents at the service and the monthly quality audits that should be taking place had only occurred once in the last five months since May 2015.

One example of the impact of lack of audits and follow up of actions by senior management was it had been noted by one member of staff in the senior management audit in March 2015 that there can on occasion be an issue with the level of staff cover at night. This was again noted during the inspection. Since the inspection the registered manager had now taken forward discussions with the commissioner regarding the resourcing of night care and was planning to get more views of people at the service in the new year regarding their experience. However, had senior management audits and follow up been taking place more regularly this may have been addressed earlier.

This was a breach of regulation 17(1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the Service Improvement Manager who told us that the senior management resourcing issues within the organisation are being addressed. Such action would result in the level of support to the service and quality audits being increased over time.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The provider did not ensure there were systems or processes in place to assess, monitor and mitigate the risks to the health, safety and welfare of the people living at the service. Regulation 17(1)(2)(a)(b).