County Healthcare Limited

St Mary's Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 20 and 21 April 2016 and was unannounced.

St Mary's Care Home provides residential care for up to 44 people, some of whom may be living with dementia. Accommodation is on one floor and all rooms, except four, have en-suite facilities. Communal areas include a number of lounges, a dining room, conservatory and extensive gardens. At the time of our inspection, 35 people were living in the home.

The service had 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected this service on 12 and 17 November 2015 where we found that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of four regulations relating to safe care and treatment, meeting nutritional and hydration needs, staffing and good governance.

Following the inspection in November 2015, the service sent us a plan to tell us about the actions they were going to take to meet the above regulations. They told us these actions would be completed immediately.

At this inspection in April 2016, we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to staffing levels, medicines management and governance. You can see what action we told the provider to take at the back of the full version of this report.

Although the service had a system in place to monitor and assess the quality of the service, these had not been effective as they had not fully identified the issues highlighted in this report.

The medicine records contained gaps and inconsistencies and so it was not clear whether people had received their medicines as the prescriber had intended. Medicines for external application were not securely stored meaning these could be accessed which put people at potential risk.

People's individual needs were not always met in a timely manner and people told us there were not enough staff. People sometimes had to wait for assistance. The service had not consistently provided the amount of staff they had assessed as being required to meet people's needs.

Staff did not always promote people's dignity and their independence was not always maintained. However, people had choice in how they spent their day and staff treated them with respect. Staff demonstrated a kind and caring approach when supporting people.

Training had been provided to ensure staff were competent in their roles. Staff told us they received regular support and were encouraged to offer suggestions for improving the quality of the service. However, some staff did not always feel that the service managers listened to them.

People were encouraged to provide feedback on the service and complaints were investigated. However, some people did not feel that their complaints had been listened to appropriately and did not feel confident that it would be addressed effectively. The registered manager had acknowledged this and sought training to improve their skills in this area.

The risks to people, visitors and staff had been identified, assessed and reviewed on a regular basis. Staff understood the processes in place to help protect people from the risk of abuse and knew how to report any concerns they may have. Accidents and incidents had been recorded, fully investigated and actions taken to minimise any future risk of reoccurrence. Recruitment processes were in place to ensure that the risks of employing unsuitable staff were minimised.

People, and where appropriate, their relatives, had been involved in planning the care they received. Care records showed that these were individual to the person and took their views fully into account. Staff demonstrated that they knew the people they supported including their likes, dislikes and preferences.

The principles of the Mental Capacity Act 2005 and associated legislation had been adhered to. The service had assessed people's capacity to make decisions as required and involved others in making best interests decisions where applicable.

People received enough to eat and drink and any specialist diets were catered for. A range of healthcare professionals were available to assist the service in meeting people's health and wellbeing needs and activities were provided.

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 consistently safe.

People did not always receive their medicines as the prescriber had intended.

The service had failed to provide enough staff to consistently provide support to people at the time they needed and requested it.

The service had processes in place to minimise the risks of employing unsuitable staff.

Is the service effective?

Good

The service was effective.

People received enough to eat and drink and their nutritional needs were met.

People received care and support from staff that had been trained in their roles.

The service had adhered to the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not always promoted.

Staff demonstrated a kind and caring approach to the people they supported.

People were involved in the planning of their care and had choice in how they spent their day.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive the care they required at the time they needed it.

People did not always feel confident that any concerns they may raise would be listened to and appropriately addressed.

People's care records were accurate and personal to them.

The service provided a range of activities to aid people's wellbeing.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The system in place to monitor and improve the quality of the service was not effective.

There were regular meetings held where people could voice their views and opinions. People had mixed views on whether the service listened to their suggestions.

People's views on the quality of the service had been sought.

St Mary's Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 21 April 2016 and was unannounced. The inspection team consisted of one inspector and one inspection manager.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also contacted the local safeguarding team and the local quality assurance team for their views on the service. One healthcare professional was contacted for feedback.

During our inspection we spoke with eight people who used the service and four visiting relatives. We also spoke with the registered manager, one senior care assistant and three care assistants. We also observed the care and support people received.

We viewed the care records for five people and the medicines records for ten people who used the service. We tracked the care that one person received in detail. We also looked at the records relating to the management of the home. These included staff training records, staff recruitment files, health and safety records and records relating to how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in November 2015 the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had not consistently acted upon the risks they had identified to people who used the service.

Following our inspection in November 2015, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us these actions would be completed immediately. At this inspection carried out in April 2016, we found that the service had made improvements around managing the risks associated with people who used the service. However, concerns were found in how the service managed people's medicines.

We could not be sure that people had consistently received their medicines as the prescriber had intended. We looked at the medicines administration record (MAR) charts for ten people. We found that five showed gaps in the records. We identified that one of these five people had not received all of their medicines on eleven days out of twenty. The MAR charts showed these had been refused by the person. However, no action had been taken to alert the prescriber to this or to gain medical advice. For another person, two separate MAR charts were being used for the same medicine. For four out of the ten medicines records we viewed, there was no complete identification sheet in place to identify the person, their allergies or their GP information. This could cause confusion in administrating the medicines and heighten the risk of an error occurring.

In some areas of the home, creams prescribed for external application were not securely stored. These medicines could have been accessed by people who used the service, some of whom were living with dementia. This placed them at risk of harm. The service had charts in place to record when creams had been administered. When we looked at the chart for one person we saw that the two creams prescribed for external application had not been consistently applied. The chart showed that one of the two creams was not available however the records did not contain information on what action had been taken.

We saw that staff authorised to handle and administer people's medicines had received training. When we observed staff administering medicines we found that they followed safe practices. However, it was observed that the staff member was interrupted whilst administering medicines.

These concerns meant the provider was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we brought our concerns to the attention of the registered manager on the first day of our inspection, they took some action to address these. On the second day of our inspection we saw that the service had responded to some of the concerns identified.

We looked at the records relating to the risks associated with five people who used the service. We saw that risks to people had been identified, assessed, managed and regularly reviewed. For example, the service had

identified people who were at risk of not eating and drinking enough, whose skin was at risk of deterioration and the risks associated with specific health conditions. Healthcare professionals had been referred to as required and records were in place that gave staff detailed information on the risk, the level of risk and actions required to reduce those risks.

The service had assessed the risks associated with the building, environment and working practices and an up to date and accurate emergency plan was in place. This gave staff relevant guidance to support people to keep safe in the event of an adverse incident such as a fire. The risk assessments were accurate and had been reviewed.

We concluded that the service had processes in place to reduce the likelihood of harm to people, staff and visitors as hazards had been identified and mitigated both at an individual and service level.

People's needs were not consistently met in a timely manner. One person who used the service said, "Staff always come but I sometimes have to wait". This person told us how uncomfortable they became when they had to wait for assistance to use the toilet. When we asked this person if there were enough staff to meet their needs they told us, "I get up whenever someone comes". They explained that the time they rose varied and was dependent on when the staff had time to assist them. Another person said, "There are not enough staff here" while a third person said they did not see staff on a regular basis.

Out of the four visiting relatives we spoke with, two told us there were not enough staff to meet their family member's needs. One told us their family member was sometimes still in their night clothes in the afternoon. They went on to explain that their family member required prompting to get dressed and that staff didn't have time to do this.

Two of the staff members we spoke with told us there were not enough staff to meet people's needs and that call bells were not consistently answered in a timely manner. One said call bells "Could be answered more quickly". This staff member told us that, due to the home being short staffed, people were not always repositioned as required to maintain good skin condition or left in bed. Another staff member told us that people were not assisted with a bath as regularly as they should as there were not enough staff. They told us that staff were able to provide basic care but nothing more.

When we discussed the staffing levels with the registered manager they told us they used a dependency tool to assess the number of staff required to meet people's needs. They told us that each morning there should be seven care staff on shift. In addition, another staff member covered a five hour period in the morning when people needed the most assistance. In the afternoon there should be six staff members with an additional person between the times of 5pm and 10pm.

We looked at the staff rotas for the eleven days immediately before, and at the time of, our inspection. We found that, out of those eleven days, six did not have the amount of staff working that the registered manager told us there should be. On five of these days no staff member had worked the five hour period in the morning when people needed the most assistance. On one of these days, the service had provided six staff when the manager told us there should be eight.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had recruitment processes in place to minimise the risk of employing unsuitable staff. For example, the service had undertaken a police check for each employee and gained two references. The staff

we spoke with confirmed these were in place prior to them starting in post.
The service had systems in place to appropriately manage any concerns people may have and protect people from abuse. The staff we spoke with told us they would report any concerns that indicated a person may be being abused. We saw records that demonstrated the service had reported concerns to the local safeguarding team and taken action as appropriate.

Accidents and incidents had been recorded and actions taken to minimise the risk of future occurrences. We looked at the accident form for one person who had experienced a recent fall. We saw that appropriate actions had been taken such as informing the GP and updating the person's care plan and falls risk assessment. We saw that an investigation had been undertaken into the cause of the fall which included possible contributing factors such as medicines taken by the person or any equipment used.

Good

Is the service effective?

Our findings

At our last inspection in November 2015 the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the nutritional needs of people with swallowing difficulties were not always being met.

Following our inspection in November 2015, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us these actions would be completed immediately. At this inspection carried out in April 2016, we found that the service had made some improvements. We saw that people received the correct textured food and that the service had liaised with healthcare professionals to support people with their dietary and nutritional needs. Staff demonstrated they knew people's needs around eating and drinking and maintaining health.

People who required specialist diets received this. Accurate and detailed information was available to the catering staff to ensure people's nutritional needs were met. When we spoke with the chef, they were able to tell us the needs of the people living in St Mary's Care Home. They could describe the textures of the different dysphagia diets.

Most people who used the service said the quality of food was satisfactory. One person said, "The food is all right" while another said, "The food is not too bad". All the people we spoke with told us they were offered choice in what they had to eat and drink and that they received plenty of it. We saw that a menu was on display which detailed the choice of food on offer. However, for some people we saw that the mealtime experience wasn't always pleasurable as they had to wait for their meal whilst others on the table had received theirs. One person who required assistance in the dining room did not receive the help they needed at the time required. Whilst the provider was no longer in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 further improvements were still required to ensure people received the assistance they needed in a timely manner.

At our last inspection in November 2015 the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had failed to provide consistent training to staff to ensure they were competent in their roles.

Following our inspection in November 2015, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us these actions would be completed by the end of February 2016. At this inspection carried out in April 2016, we found that the service had made improvements.

Most staff had received the training deemed mandatory by the provider. We saw that additional training had been arranged and that staff were booked to attend.

At our inspection in November 2015 we found that only one staff member had received practical first aid training and not all staff had received training in moving and handling. At this inspection carried out in April

2016, we saw that all except two of the senior staff had received practical first aid training with the outstanding two due to attend shortly. In addition, all staff had undertaken training in moving and handling. The staff we spoke with confirmed they had received an induction and that training had been provided. However, they told us they felt they would benefit from more training in supporting people living with dementia. When we spoke with the chef, they told us that, following the last inspection in November 2015, they had received additional training in meeting people's nutritional needs. We saw that staff's ability to support people who required a thickener to their drink to prevent choking, had been assessed.

The staff we spoke with demonstrated knowledge in relation to providing care and support to people. They told us what actions they would take to protect people from the risk of harm. For example, they could explain the preventative measures they would take to keep people safe from the risk of falls and abuse. During our inspection, we mainly saw that staff demonstrated the skills expected from the training they had received. For example, we saw that a staff member assisted a person to transfer from a wheelchair into a chair. This was done safely and according to best practice. We saw that the staff member communicated with the person throughout the manoeuvre and that it was paced according to the person's ability.

Consequently, the provider was no longer in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staff training.

Staff told us they felt supported and that they had received regular supervision sessions. They told us the registered manager had an 'open door' policy and that they could speak with them when needed. However, we found that some staff did not always promote people's dignity and further improvements were required to ensure staff demonstrated the necessary skills.

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 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 staff we spoke with told us that some people living at St Mary's Care Home lacked the capacity to make decisions about the care and support they received. Staff had variable knowledge of the MCA and how this affected the support they provided. On the majority of occasions we saw staff delivering care, we saw that they supported people to make decisions and asked for their consent before assisting them. For example, supporting people to make a decision about where they wanted to spend their day and what they wanted to eat. However, we did see one staff member assist people out of the dining room without first asking for their consent to do so.

Where people's capacity to make decisions was in doubt, the service had assessed this in accordance with the MCA. These were decision specific and the service had supported people to maximise their ability to make decisions. For example, we saw records that showed the service had assessed a person's capacity to make a particular decision at different times of the day in case this had an impact on their mental ability. Relevant people had been included in making best interests decisions on behalf of people who lacked

capacity and these decisions had been recorded. The service had made appropriate applications to the supervisory body to deprive people of their liberty and these were individual to each person.

People had access to a variety of healthcare professionals and records showed that people saw these as required. On the day of our inspection we saw that a GP was in attendance and provided treatment to a number of people who used the service. One visiting healthcare professional told us that staff had been accommodating and that the person they were there to treat appeared well cared for. They told us staff were prepared for their visit and had everything available that was required to provide treatment. They said, "It was a positive visit".

Requires Improvement

Is the service caring?

Our findings

The people we spoke with told us that staff knew them well. However, some told us they didn't always feel listened to as staff were so busy. One person said, "Staff don't have much time". Another told us, "They're so busy". From the staff we spoke with and from what we saw during the inspection, staff demonstrated they knew the people they supported.

People told us their dignity and privacy was maintained and promoted. One person told us the staff were, "Very respectful" towards them. One person we spoke with gave an example of requiring assistance with personal care through the night. They told us staff always assisted them in a kindly manner and made them feel as comfortable as possible.

However, during our inspection we saw some examples of staff supporting people in a way that did not promote their dignity. For example, we heard a staff member asking one person about their personal care. This was not done in a discreet manner and compromised the person's dignity. On another occasion we observed that a person did not get the assistance they required at lunchtime. One person who used the service had been transferred to another setting without all of their personal belongings or communication equipment.

Throughout our inspection we saw that staff delivered personal care behind closed doors. However, one visiting healthcare professional told us about an incident where they were assisting one person with personal care in their bedroom. They told us that a member of staff knocked on the person's door and, before waiting for an answer, walked straight in. We also observed this happening once during our inspection. This practice did not promote people's dignity.

Improvements were required to ensure that people's dignity is maintained at all times

Most of the people we spoke with told us staff were kind and caring. One person who used the service said, "Staff are very kind". They went on to say that staff had always been polite and caring towards them. Another person said, "Everybody is very good to me". A third person told us, "Staff are really nice – polite and respectful". The relatives we spoke with agreed. When speaking about the staff, one told us, "They have so much patience". Another visiting relative said, "The care is good and the staff are lovely".

We saw examples of where staff demonstrated a kind, caring and compassionate approach to the people they supported. We saw that staff interacted in a warm and cheerful way. For example, we saw one staff member assisting a person from a wheelchair into an armchair. This was done at the person's own pace and we saw that the staff member explained what was happening. They gave encouragement to the person they were supporting so they felt safe and reassured. On another occasion, we saw that staff were laughing and giggling with a person whilst they all danced together.

The majority of people we spoke with told us they had been involved in the planning of their care. All except one of the relatives we spoke with said they had been involved as required. We saw that quotes from the

people who used the service were contained within their care plans which demonstrated they had been consulted.

We saw that staff took practical action to relieve people's distress. A staff member quickly noticed that a person had become upset. They intervened promptly and offered reassurance. We saw that the staff member sat with the person, gave them a cuddle and talked them through their feelings. We saw that they offered an explanation to what had recently occurred in the person's life to help them better understand their current feelings.

Most people we spoke with told us they had choice in their day to day living. One person told us they were aware of the activities the home provided but that their choice not to get involved was respected. We saw that staff offered people choice in where and how they spent their day. For example, we saw that the service had arranged for a quiz to take place on the morning of our inspection. However, there was a programme on the television to celebrate a special royal occasion and people were offered the choice to watch this instead if they so wished. We saw that people were offered choice in what food they ate and the care they received.

The relatives we spoke with told us they could visit their family members anytime they wished without restrictions. One visiting relative told us they came numerous times a week and was made to feel welcome. They told us that throughout their many visits to the home, they had only ever heard staff interact with the people they supported in a warm, respectful and kind manner.

Requires Improvement

Is the service responsive?

Our findings

There was a mixed response when we asked the people who used the service, and their visiting relatives, about whether they felt their care needs were being met by the service. One person told us that they felt their needs were being met but that this wasn't always completed in a timely manner. Another person who used the service told us, "It could be better" and went on to explain that they felt this was due to not enough staff. One visiting relative said, "[Relative] is quite happy here and I have no complaints". While another said, ""Staff don't have time to spend with people". A third visiting relative told us their family member was often in bed whenever they visited no matter what the time. They said, "There's not enough staff".

One person who used the service told us they preferred to use their walking frame to mobilise. They told us there were not enough staff available to assist them with this so they ended up using a wheelchair. They told us using a walking frame made them feel better.

During our inspection we saw that people sometimes had to wait for assistance. For example, we saw that one person was waiting for assistance to use the toilet. They told us they had been waiting for some time. On another occasion, a person needed assistance to maintain their dignity. The door to their room was open and their call bell was sounding. We saw that they were at risk of falling. This person did not receive the assistance they required at the time they needed it and their dignity and safety had been compromised.

Staff told us they had enough information to get to know people and their needs. However, they told us they didn't always feel there were enough staff to meet these needs in a timely manner. They told us they found people's care plans useful and that they reflected their individual needs. They told us they had a meeting before every shift to ensure they had the most up to date information on the people they supported. However, one staff member thought that staff would benefit from additional training to better meet the needs of those people living with dementia. This staff member also told us that they did not have time to sit and talk to people.

Improvements were required to ensure people receive the support they require at the time they need it.

The staff we spoke with demonstrated that they knew the people they supported. For example, one staff member was able to identify the nutritional needs of the people that lived at St Mary's Care Home. When we observed lunch being served, we saw that staff understood people's personal preferences around food and drink. For example, one staff member asked for a smaller portion for a person as they knew a larger portion was not to their liking. One person we spoke with who used the service said, "Staff know me well and look after me all right".

We viewed the care records for five people to check that their needs had been identified, assessed and reviewed in a person-centred way. We saw that people's needs had been assessed prior to admission into the service. This was to ensure that the service could safely meet that person's needs and to give them the opportunity to discuss their future plans.

Care plans were accurate and individual to each person. We saw that people had been involved in their care planning and that their views had been taken into consideration. For example, the care plans contained quotes from the people who used the service on the various aspects of their daily life. For example, in order to meet their emotional and psychological needs, one person had said, "I love a cuddle – it makes me happy". During our inspection we saw that staff met this preference. We saw that one person had a care plan in place to meet a specific medical need. We saw that it gave staff information on the support they could provide to assist the person to remain well. Details were available on symptoms to be aware of and what actions to take should the person's health decline. We saw that the person had had input into this care plan and had explained how their medical diagnosis effected them.

From the care plans we viewed we saw that most people's needs had been reviewed on a regular basis and any changes documented. However, we noted that one person's care plan around medicines management was not accurate following a change to their medicines. Care plans need to be updated whenever a change occurs. This is to help ensure that the person receives the correct care and support and that staff have accurate and up to date information to provide the care required.

The service had employed an activities coordinator who was responsible for ensuring people's social and leisure needs were met. An additional activities coordinator had recently been recruited by the service and was waiting to commence in post. A range of activities were provided and, during our visit, we saw that people got involved in these and enjoyed them. We saw that a plan of future activities and events was displayed in the foyer of the home and that copies had been delivered to each person in their room. As people had this information in advance, it enabled them to make choices in how they spent their day.

We saw records that demonstrated the service had investigated and responded to complaints. The people we spoke with told us they knew how to raise a concern however not everyone felt confident that their views would be addressed appropriately. One relative we spoke with told us they had had to make a number of complaints about the same issue. They told us that although the manager listened to their concerns they were not always informed of the outcome and did not feel the concern was being rectified. Another relative told us that when they first approached the registered manager with a complaint, they did not feel listened to and found the registered manager's response defensive. However, the relative told us that, following an investigation into their concern and a meeting with the registered manager, they were happy with the response they received. They told us the registered manager had acknowledged their concern, explained what steps they had taken to address it and acknowledged where the service had failed. We saw records that showed this complaint had been fully recorded and investigated.

When we spoke with the registered manager about how they managed complaints and concerns they acknowledged that they did not always have the skills to appropriately manage these. They told us they had recognised this and had sought training to improve their skills in this area.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in November 2015 the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had failed to implement effective systems that mitigated the risk to people's health, safety and welfare.

Following our inspection in November 2015, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us these actions would be completed immediately. At this inspection carried out in April 2016, the service had made some improvements, however further improvements were required as the systems in place to assess, monitor and improve the quality of the care provided were not effective.

Although the service completed regular audits to monitor the service delivered, these had failed to consistently identify and address the concerns raised in this report. Although an audit was completed in January 2016 on the quality of care delivered, this had failed to identify that people's needs were not being met due to them having, on occasion, to wait for assistance. When we discussed staffing levels with the registered manager, they told us they used a dependency tool to calculate the number of staff required to meet people's needs. They told us that this was being adhered to. However, senior staff were included in this calculation and we saw that their roles meant that they were often in the office completing documentation. This meant they were not available to answer people's requests for assistance. No system was in place to monitor the deployment of staff and, during our inspection, we did not see any staff member overseeing this.

When we spoke to the registered manager they told us they expected people's call bells to be answered within six minutes. However, staff told us that people often had to wait longer than this for assistance. During our inspection, we saw that people waited for assistance on a number of occasions.

Following our last inspection in November 2015, the registered manager had introduced medicines management audits and these had been completed on a regular basis. We saw that some issues identified at this inspection had been observed on the audit carried out in April 2016. For example, the service had identified that identification cover sheets required improvement. In addition the audit had identified that there were gaps in the records. However, daily medicines management audits carried out by the senior staff had also failed to ensure people received their medicines as the prescriber intended.

We saw that the service had also had a medicines audit completed by an outside pharmacist in January 2016. This reported that some issues had been found including an out of date staff signatory list and gaps in records. The audit had been signed to say actions had been taken to address the issues. When we checked, we saw that the service had updated their staff signatory list. However, our inspection showed that gaps were still present in the medicines records.

The senior management team completed regular audits of the service. On the audit carried out in March 2016 we saw that a senior manager had reported that the registered manager was not reviewing the home's

audits on a regular basis. They reported that the audits carried out did not always provide adequate evidence to support the findings. This demonstrated that the provider had an oversight of the service being delivered. However, we saw no evidence that the issues identified were being addressed.

The service has been in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 since September 2014. Since this date, the Care Quality Commission has carried out three additional inspections. At the inspections carried out in September 2014 and February 2015, the service had not deployed enough staff to meet people's needs. The service was in breach of this Regulation at the November 2015 inspection as staff had not been consistenly trained in their roles. The service needs to ensure that enough suitably qualified, competent, skilled and experienced staff are deployed to safely meet people's needs in a timely manner.

These concerns meant the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in post. They told us they felt supported in their role. We know from the information held about St Mary's Care Home that the service had reported most events as required. However, we noted that one event had not been reported as is required by regulations. We discussed this with the registered manager who apologised for this oversight and completed the relevant documentation immediately following our inspection. They were able to tell us the circumstances surrounding the incident and we were satisfied all appropriate actions had been taken.

Regular audits had been undertaken on the accuracy of people's care plans to meet their needs. These were completed fully and covered all aspects of people's day to day care needs. They had been completed with the person who used the service. The care plans we viewed demonstrated that these audits had been effective.

The provider had sought people's views on the quality of the service in January 2016. This was done through the completion of a quality survey and included the views of people who used the service, their relatives, staff and visiting healthcare professionals. Responses had all been positive.

People who used the service, and their relatives, had the opportunity to discuss the service and make their views known at regular meetings. People told us they were aware that meetings were held and had the choice to attend. Most people we spoke with chose not to attend these meetings however one person who attended regularly told us, "There are not enough staff here. I've brought it up at meetings but nothing gets done". This person felt the service had not listened to their concern. However, one relative disagreed and told us that the registered manager had been, "Brilliant" in listening to them when their family member first came into the home.

Staff told us there were regular meetings where they were given the opportunity to discuss the service, their roles and to keep updated with the changing needs of the people who used the service. Staff agreed that they were encouraged to voice their opinions and suggestions however there was a mixed response on whether they felt the registered manager listened to them. One staff member told us that they had voiced their concern around people's needs not being met due to poor staffing levels but had been told by the registered manager that there were enough staff. Another staff member felt that the registered manager did not have an understanding of other roles within the service as they, "Spend a lot of time in the office and only come out at mealtimes". However, this staff member felt the registered manager did listen to staff and the suggestions they made in relation to the service being delivered.

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 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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe care and treatment The service had failed to do all that was reasonably practicable to mitigate risks associated with medicines administration and management. Regulation 12(1)(2)(a)(b) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (RA) Regulations 2014: Staffing The service had failed to ensure there were enough staff deployed to meet people's needs. Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good governance The service had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17(1) and (2)(a)(b)(f)

The enforcement action we took:

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