Qualia Care Limited

St Marys Nursing 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?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 1 and 2 May 2018 and the first day was unannounced. This was the first inspection of this service registered with a new provider (owner) in April 2017. St Mary's Nursing Home (St Mary's) under the previous provider was known as Alexian Brothers Care Centre.

St Mary's is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. St Mary's is registered to provide accommodation and care to up to 74 people across three floors. On the day of the inspection there were 59 people using the service.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported in their role by an operations support manager and the operations manager.

We found four breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014 in relation to safe care and treatment, need for consent, person centred care and good governance. You can see what action we told the provider to take at the back of the full version of the report.

During our inspection, we found the atmosphere at St Mary's was calm. People were well presented, settled and looked happy to be living here. We saw that families and visitors could visit as they wished and, on the whole, they were satisfied with how their loved ones were cared for at the home. Staff including the registered manager knew people and understood their needs.

People, their relatives and visitors told us St Mary's was a safe environment and that staff knew what to do to help ensure people living there were safe. There were clear processes in place to record and report incidents and the home was well maintained and visibly clean and free from malodours. However we found examples where people were not always kept safe. We found the home's management of medicines needed to be strengthened and personal evacuation plans were not in place for everyone living at the service. These examples were evidence of a breach of the regulations relating to the safe care and treatment of people living at St Mary's.

The service did not always follow the principles of Mental Capacity Act as required by law. We found not all care records contained the required documentation or signed consent forms. This was a breach of the regulation relating to need for consent and meant people were potentially receiving care or support where consent had not been obtained in the right way.

Recruitment processes were inconsistent and needed to be strengthened. We found not all pre-employment checks had been carried out such as gaps in employment history that had not been investigated at

interview. This information helps to ensure staff employed are fit for the role. We made a recommendation that the provider ensure the current recruitment process consistently addressed all aspects of pre-employment checks and was fit for purpose.

Preadmission assessments were carried out prior to people coming to live at St Mary's; this process helped to ensure the home was able to provide the care and support required. We found examples where care and support was not always responsive to the person's individual needs. Some care records were incomplete or contained information that was not current. This meant staff did not always have appropriate information to guide them in providing support. This evidence was a breach of the regulation relating to person centred care.

There was a clear procedure in place for managing concerns and complaints, both written and verbal. We found not all verbal concerns raised were documented; this was not in line with the provider's policy and meant the provider and registered manager did not have a thorough oversight of concerns and possible themes for improvement.

There was also a system of internal quality checks carried out by the registered manager and supported by visits and audits from the provider. We found governance processes needed to be more robust and quality monitored to help ensure people received safe and effective care and support. We found evidence in this regard to support a breach of the regulation related to good governance.

People and their relatives expressed no concerns regarding the number of staff on duty. We found staffing levels to be sufficient to attend to people's needs in a safe and unrushed manner.

Newly recruited staff received an induction and mandatory training before working unsupervised. These were recorded within the service's training matrix but we saw no record of staff induction in any of the staff files we looked at nor were there any training certificates to verify what training actually took place. Staff confirmed training on offer had improved and that they had received recent training in areas such as moving and handling. The registered manager told us they would request certificates from their previous training provider but to the time of writing this report we had not received further information.

Records we looked at and conversations we had with staff indicated they received regular supervisions and had annual appraisals. Staff told us they felt supported by management and their peers. These interventions helped to ensure staff had appropriate professional support to carry out their roles in an effective way.

Care records demonstrated that people living at St Mary's had good access to medical attention and healthcare professionals such as GPs and district nurses when required. People and their relatives confirmed this was the case. This meant people's healthcare needs were being met in line with their individual needs and in a proactive way.

There was a suitable choice of nutritious food and drink on offer at St Mary's throughout the day. Meals for the most part took into consideration people's preferences and were prepared according to their specific needs, for example, texture-modified and suitable for diabetics. This helped to maintain people's good health and wellbeing.

People and relatives were very complimentary about staff's attitude, their experience and skills. We observed that staff had good interactions with people and their families. Relatives told us staff were very good with and genuinely cared for their family members.

A range of activities were on offer with a weekly schedule displayed on the noticeboards within the home. People told us they had been asked what activities they most enjoyed and this information was used to develop the current schedule. This helped to ensure people were engaged in activities that were meaningful to them. Staff we spoke with told us how they encouraged people to participate in these but respected a person's wishes if they chose not to do so.

People living at St Mary's, their relatives and friends thought the registered manager was very approachable and visible within the home. Daily departmental meetings were held to 'flag up' concerns within and share information about each department. Each staff member got the opportunity to attend and there was a 'question and answer' session at the end to help staff to understand their role and the impact this had on people living at the home.

There were relevant policies and procedures in place and staff meetings, including daily 'flash' meetings, were held; these helped to ensure staff had appropriate guidance to carry out their roles.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Current systems in place did not provide adequate assurances that medicines were safely managed at all times.

Recruitment processes needed to be strengthened in some respects to help ensure staff employed were suitable to the role.

People told us they felt safe within the home and that they had confidence in the staff's ability to care for them safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The home did not consistently work within the legal requirements of the Mental Capacity Act (2005) (MCA). The registered manager had made appropriate applications for Deprivation of Liberty Safeguards (DoLS) to the local authority.

We observed the mealtime experience and staff assisted people when needed. People told us they enjoyed the food and were given plenty of choice.

Is the service caring?

Good

The service was caring.

People, their relatives and visitors were positive about the kindness shown by staff. We observed that staff's approach was friendly and respectful.

People and relatives said staff were thoughtful and understanding and treated them with dignity. Relatives were able to visit their loved ones without restrictions.

Care records were kept securely and only care staff had access to these documents.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People felt the staff were responsive to their needs and they were given choice. We found examples where the service did not maintain information to help ensure person centred care was provided.

There was clear process in place for managing complaints. People felt they would be able to raise an issue if they needed to and some had had occasion to do so. However not all verbal complaints were recorded so there was no evidence in these cases to demonstrate that complaints were responded to appropriately.

There were a range of activities on offer including an onsite hair salon. The chapel was well used by both people using the service, their families and the local community.

Is the service well-led?

Requires Improvement

The service was not always well-led.

While there was a system of regular audits and checks in place, quality assurance systems were not always fit for purpose.

People and their relatives said the management was approachable and visible and that the service was well run. There was ample opportunity for people, their relatives and visitors to provide feedback about the service.

Staff felt well supported. This was achieved through regular supervisions and staff meetings.

St Marys Nursing 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.

The inspection took place on 1 and 2 May 2018 and the first day was unannounced. The inspection team consisted of three adult social care inspectors, 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 uses this type of care service.

Prior to the inspection we looked at information we held about the service such as notifications, safeguarding concerns and whistle blowing information. We also received a provider information return (PIR) from the provider. This form asks the provider to give us some key information about what the service does well and any improvements they plan to make.

Before our site visit, we contacted Manchester local authority's public health and contracts and commissioning teams and also the clinical commissioning group for any information they held about the service. The public health team's infection control audit carried out in October 2017 identified actions which required further attention. The contracts and commissioning team conducted an unannounced monitoring visit in March 2018 and found improvements had been made in staff training and infection control practice at the home. More information about these visits is contained within the report. We also contacted Manchester Healthwatch and checked their website. Healthwatch had not received any feedback about this service to date. Healthwatch is an organisation responsible for ensuring the voice of users of health and care services are heard by those commissioning, delivering and regulating services.

During the inspection we spoke with eight people who used the service and five relatives. We also spoke with 15 members of care staff including senior care staff and nurses, the chef, an activities coordinator, the registered manager and two operation support managers. We observed how people were supported in communal areas and carried out an observation known as a Short Observational Framework for Inspection (SOFI). This is a way of observing care to help us understand the experience of people who cannot easily

express their views to us.

We looked at records relating to the service, including six people's care records and daily record notes, medication administration records (MARs), five staff recruitment files and training records, health and safety records and audits held by the service.

Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were managed across the home. We found some aspects of good practice. However we found there were areas in which medicines were not always managed safely. For example, staff did not always check a person's records (for example, hospital discharge letters or the home's record of visits by GPs) when new supplies of medicine were received. As a result, we found two people had been given the wrong medicine for five days before a medicines check identified the error. The registered manager explained and records showed the supplying pharmacy had labelled the medication incorrectly. We saw the home contacted the GP who assessed that no significant harm had come to either person. Following our inspection visit the registered manager sent us a revised procedure for checking in medicines and assured us that this procedure was displayed on all floors and that all staff had been verbally informed.

Staff checked stocks of medicines each night so that any errors could be investigated by a manager the next morning. However we found that staff did not always check medicines records carefully or report discrepancies in the amount of stock to the registered manager as discussed in the above example. This meant that the home's medicine audit systems were ineffective and did not sufficiently protect people from the risk of harm.

The registered manager and operations support manager also told us the provider had changed pharmacy supplier and that the new supplier would be in place by the end of May 2018. The new pharmacy supplier had arranged to deliver face to face training before the changeover to all staff with responsibility for ordering and administering medication. This would help to ensure people were kept safe from harm because there were no or few pharmacy errors made when dispensing their medicines.

We saw the medicines trolley was left unlocked and unattended during the medicine round, putting people at risk of harm. We also saw that medicine trolleys though kept inside the locked clinic room were left unlocked when not in use. While not a legal requirement, this practice is not in line with national best practice guidelines and we recommend the provider and registered manager review and risk assess this practice to demonstrate and provide assurances that this is safe.

We looked at the medication administration records (MARs) belonging to nine people living in the home. There were no gaps in the records and (with one exception) and protocols were kept with the MAR if a person was prescribed any medicines to be taken only 'when required'. The protocols contained extra guidelines to help staff give 'when required' medicines in a safe and effective way. Two people were prescribed a short course of medicine to treat an infection and these medicines were being given correctly.

Medicines were stored at the right temperatures. Controlled drugs (medicines subject to stricter legal controls because they are liable to misuse) were stored in the way required by law. In most cases, we found thickening powders were stored safely; these are prescribed for people with swallowing difficulties. However, on two of the units we found containers of thickening powder that were not labelled with the person's name or instructions for use. People may choke if drinks are not thickened to the right consistency. We brought this the registered manager's attention who removed them and said they would investigate the

matter. Up to the time of writing this report we did not receive any information regarding this investigation.

Staff had access to medicines training. According to the home's records, three members of staff (out of 61) responsible for administering medicines had not been assessed to check they knew how to handle and administer medicines safely. We raised this with the registered manager during our preliminary feedback at the end of the inspection. They told us they would follow up on this and ensure all staff administering medicines had their medication competency assessed.

With the exception of two people admitted in March 2018 and early April 2018, we found all other persons living at St Mary's had personal emergency evacuation plans (PEEPS) in place that were up to date. PEEPs described the level of assistance and equipment people would need to evacuate the building in an emergency. We asked the registered manager to address these exceptions as a matter of urgency; this was done during the course of our inspection.

The above concerns relating to medication management and PEEPs constituted a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at five staff recruitment files and saw that there was a safe system of recruitment was in place. Each file included a completed application form, references and proof of identity. We saw checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with vulnerable people and informs the service provider of any criminal convictions noted against the applicant. However we saw in two files there were gaps in the staff member's employment history, which had not been investigated at interview. In two other files we saw no record of a health questionnaire for these staff members. While the impact of these inconsistencies was low due to other checks carried out they compromised the recruitment process.

We recommend the provider ensures the current recruitment process consistently addressed all aspects of pre-employment checks and was fit for purpose.

The service held up to date records which evidenced that nursing staff employed at the home were registered with the Nursing and Midwifery Council (NMC). This helped to ensure these staff remained authorised to work as registered nurses.

People, their relatives and friends told us the environment at St. Mary's was safe and that people supported felt safe. One person told us, "I do feel safe and would say something if I didn't." Another person said, "All the staff are really nice and make you feel safe and secure." Relatives told us, "My (relative) is really comfortable here and thinks it is fantastic" and "Without doubt my wife is well looked after."

Staff we spoke with were aware of safeguarding principles and knew what action to take to keep people safe. One staff member said, "All staff have safeguarding training so we are all aware of what to look out for and what to do if we suspect anything that is not right." Staff we spoke with were also aware of the provider's whistleblowing policy. A staff member told us, "If I needed to, I would whistle blow straight away – it would definitely be taken seriously by the managers – they are very good." The registered manager kept a safeguarding file which contained contact details for surrounding local authorities and safeguarding policies and procedures. We saw a record of safeguarding incidents referred to the local authority and the Care Quality Commission. We found the service had taken appropriate action to help ensure people were safeguarded from potential harm.

During our inspection, we found staffing levels were adequate to meet the needs of the people. People we

spoke with felt there were enough staff around and relatives confirmed this. Their comments included: "It is really good that there is always a member of staff around to help" and "Whenever I use the call bell staff are pretty quick to attend." The registered manager told us the service sometimes used agency staff to cover annual leave and sickness absences. They told us, and we saw from staffing records, that they used the two agencies and where possible the same staff. This was confirmed by two agency staff members we spoke with. We found the provider had checks in place to help ensure the agency staff's suitability for their roles. The registered manager told us and we saw they used a dependency tool to determine the number of staff deployed on each floor and levels were based on people's needs. This tool helped to ensure that people were supported according to their needs and when required.

We found accidents and incidents were reported and recorded in line with company policies and procedures. Monthly summaries identified types of incidents, actions taken and lessons learnt and shared with the staff team. This process helped to ensure people were protected from risk and suitable action taken when required. We found however the provider and registered manager could benefit from some further analysis of all incidents/accidents that took place across the home to identify any common themes. We communicated this during our initial feedback.

We looked at the laundry facilities within the home and spoke with two staff members employed specifically to manage the laundry. The laundry was properly equipped and well organised with a clear system in place to keep dirty items separate from the clean ones. We saw that people's clothing was labelled to help ensure clothes were returned to the correct owners. Staff told us and we saw there were few unidentified items. However they told us they or care staff approached people and relatives at different times to ensure people's clothes were returned to them. No one we spoke with raised any concerns regarding lost clothing. We concluded that the service had appropriate systems in place to protect people's dignity in this regard.

We saw a good standard of cleanliness displayed by staff. For example, we observed staff ensuring they washed their hands appropriately and used personal protective equipment (PPE) such as disposable gloves and aprons, which were readily available, when needed.

We found the home was well maintained and kept clean and free from unpleasant odours. Staff responsible for the cleaning told us and we saw the home used the national colour coding scheme for cleaning materials to minimise risk of cross contamination. For example, mops and buckets were colour coded so different ones were used in the people's rooms, bathrooms and laundry areas.

Prior to our inspection, we looked at the last infection control audit carried out in October 2017 by the public health team at Manchester City Council. The service had received an 'amber' rating of 66% and we saw that issues identified had been addressed. This meant that people living at St Mary's were protected from risk of infection because there were effective systems in place to do so.

The premises were secure and access to each floor was via a keypad code. We found all relevant checks and certification regarding building and equipment maintenance were in place. These included servicing and inspection of lifting equipment, water systems, fire safety systems, electrical and gas systems and call bells. The registered manager told us and we saw contingency plans were in place should an evacuation be necessary. We concluded the environment was adequately maintained to help ensure people and staff at the home were in a safe environment.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People told us and we observed that staff always sought their permission before carrying out a task. Relatives and visiting friends we spoke with also confirmed this. However, we found evidence the home did not consistently follow the principles of the MCA to help ensure people were safeguarded appropriately. One staff member told us, "There is some work required around mental capacity assessments. We have done some but more need to be completed."

We reviewed the care records of five people and found the following examples: care files did not contain mental capacity assessments for personal care or signed consent forms, consent forms signed by relatives and best interest decisions made without evidence of mental capacity assessments having been done. The PIR submitted by the home prior to our inspection visit and registered manager confirmed one person had been admitted to the home under a court of protection order. This order is a legal document from the Court of Protection (a higher court of record under the MCA) that appoints someone to make decisions on a person's behalf due to their loss of mental capacity. We found these transfer documents were not within the person's care file. We asked the registered manager about this and they subsequently told us the paperwork had not been received from the social worker.

In relation to people receiving their medicines covertly (disguised in food and drink), for one person we found no evidence that a meeting had taken place to agree whether or not this decision was in their best interest nor did we see that an assessment of the person's mental capacity to make this decision had been carried out. People have the right to decide whether to take their medicines if they can understand their choices.

The above concerns was evidence of a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as people were potentially receiving care or support where consent had not been obtained in the appropriate way.

We found the provider had made appropriate applications for DoLS for people who required them. At the date of this inspection no authorisations had been received from the local authority. We saw evidence that

the registered manager had contacted the local authority on several occasions requesting an update on the outstanding applications.

Staff were required to complete an induction prior to commencing work. The provider's induction training policy identified initial training and orientation all new staff were expected to undertake. These included values and principles of care, moving and handling, safeguarding and infection control. Staff we spoke with told us they had completed an induction and had undergone training and shadowing prior to working unsupervised. However we saw no documentary evidence to confirm staff had an induction nor were there any training certificates in all of the five staff files we looked at. The registered manager and operations support manager told us they had not received certificates from their previous training provider. They said they would contact this provider to request certificates however at the time of writing this report no further evidence was provided. We saw from training records that staff were enrolled for e-learning as a temporary measure until the new training provider was ready to start. From the training matrix provided by the registered manager, we saw most staff had completed their induction and training considered mandatory by the provider. Staff we spoke with told us about recent training they had in moving and handling and infection control and that fire safety training was scheduled. The registered manager told us they would request contact the previous training provider and explain that certificates were required. But up till the time of writing this report we had not received further information about this.

Staff also told us, and staff records we looked at confirmed, they received regular supervisions and annual appraisals. We found Supervisions also involved the supervisor observing practice of the supervisee and then having a discussion afterwards. Staff told us supervisions and appraisals were used to discuss developmental and training needs and any performance concerns they may have. These practices helped to ensure staff were effective in their role.

People and relatives told us they found staff knew what they were doing and that the people were well looked after. Some of their comments included: "Without doubt, staff are well trained, open and communicative", "Staff have shown that they are willing and able to act with speed and efficiency" and "I must say that staff are really good at communicating updates."

People received a choice of suitable and nutritious food and drink to help meet their health care needs. Their comments included: "The food is tasty and the portions good", "Food is very nice, well presented and easy to eat", "Food is really good here and I am pleased that I am putting weight on again" and "Refreshments are always available if you need something". We found the atmosphere at mealtimes was relaxed and pleasant with good interactions observed between people and staff. We saw that staff supported people who required assistance in an unrushed and empathetic manner and encouraged those who may have been inclined to not eat much. A staff member told us, "Mealtimes take as long as they need to, there is no rush. I will spend the time it needs, especially if I am supporting someone with dementia."

One relative did make negative comments regarding the lack of culturally appropriate food choices. We found the person's care plans recorded these considerations had been noted during the initial assessment and raised these concerns with the registered manager. They told us and we saw evidence that the relatives had agreed to provide recipes but were yet to do so. The registered manager said they would remind the relatives about this.
We found the kitchen staff were knowledgeable about people's dietary needs and that they had an up to date list of people requiring specific diets such as soft or pureed diets or diabetic meals. The home operated a four-week rotating menu which offered a good variety of nutritious food and drink. There was an effective system in place to ensure food stocks were sufficient, and we found the environment was clean and well organised.

From people's care records and what people and their relatives told us we found the service made appropriate referrals to other health care professionals such as GPs. People gave us examples of when staff had contacted the GP or optometrist and relatives told us the service was good at "keeping (them) in the loop". One relative said, "I was really pleased with the speed with which staff reacted and arranged treatment for my Mum's eye problem." We concluded the service had suitable systems in place to help ensure people had access to the right healthcare or medical attention when required.

We looked at the care records for seven people living at the care home. We found initial assessments had been completed prior to admission and these recorded the specifics of care and support required. This helped to ensure the service was able to meet the person's assessed needs. Initial assessments were used to develop person centred care plans for each identified need and personal outcome, for example, mobility and dexterity, dental needs and diet and weight. People and relatives we spoke with confirmed an assessment had been carried out before the person was offered a place at the home. This process helped to ensure the service was able to support the person according to their needs.

St Mary's is a purpose built care home with three units across three floors: the residential care unit of St Mary's unit (ground floor), and the nursing care units of St Alexious (first floor) and St Joseph's unit (second floor). There are several assisted bath and shower rooms and separate toilets throughout the home. People's bedrooms were homely and personalised with their own items such as family photos and other personal effects. On the ground floor, there is a large activities room and a tea room which is decorated in a reminisce-style. The tea room was used by families when they wished to have meals privately with their relatives, for example, on special occasions like birthdays or anniversaries. Connected to the care home was a small chapel and there was a resident priest who performed mass every day.

Good

Is the service caring?

Our findings

People and their relatives we spoke with told us staff were considerate and caring. They said, "There is a really good friendly atmosphere here", "The carers work really hard; I like them", "My [relative] is really happy here and the staff are good to (them)" and "Staff are really friendly and helpful."
Throughout our inspection, we saw staff interaction with people was respectful yet warm and friendly. For example, we saw staff maintained appropriate physical contact, such as hand holding or placing their arm around someone whilst speaking discreetly with them.

We observed that people engaged well with the registered manager and staff. People chatted easily and engaged in good natured banter with the staff and the registered manager. There was the distinct sense of friendship between people and staff and people appeared comfortable and relaxed in their environment. It was clear that staff knew the people they supported well. Staff told us and we saw care records contained pertinent information such as a detailed personal profile and social history, which helped them to better understand and support people in a person centred way.

People using the service, family members and visitors told us staff were respectful and treated people with dignity and understanding. One visitor told us, "Staff are very kind and always treat my friend with respect." Two relatives said, "Even when [person] is having a tantrum the staff remain calm and supportive" and "I am really pleased with the way the staff treat my [relative]."

At meal times, we saw staff escorted people to the dining room in an unrushed and patient way and that staff were well versed in using hoisting equipment in a thoughtful and kind manner. Staff told us and we saw that they always knocked on people's doors and called their names before entering people's rooms.

We saw that people, where possible, were encouraged to maintain their independence and build their confidence. Throughout our inspection, we observed that staff through their actions helped people to maintain their independence and choice. For example, we saw that one person enjoyed staying in bed to read their morning newspaper. Staff we spoke with displayed an awareness and understanding of how to promote people's independence. One staff member told us, "I would let the person do as much as they can for themselves but they know I am there to help."

Service users and relatives stated that they were kept informed of what was happening in the home. One relative told us, ""I must say that staff are really good at communicating updates." We saw that information was readily available to people and their relatives, in the form of the Statement of Purpose, which set out the aims and objectives of the service and provided a guide to services offered.

We observed there were no restrictions on relatives visiting their loved ones. A relative said, "I think it is great that relatives are able to visit whenever they want." We saw that staff made visitors welcomed and most relatives and visitors we spoke with were very complimentary about the service.

We found people's care records and personal information were kept securely in a room accessible only by

staff. This meant people's right to privacy and confidentiality was maintained appropriately by the service.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us the service was responsive to their needs and that their individual care plans were tailored specifically for them. Comments made to us included: "Whenever I use the call bell staff are pretty quick to attend", "They know [person] needs medicine at different times and (staff) ensure [person] gets it when (they) need it" and "Staff are very approachable and they do listen."

Most of the care plans we looked at were detailed and considered people's physical, mental, emotional and social needs and included a personal history, interests and hobbies and religious practices. People's communication needs were identified and recorded. This helped the service respond appropriately to their needs. People and their relatives confirmed they had been involved and contributed, where appropriate, to the care planning and review processes and that people's care plans were regularly reviewed and altered if needed.

However we found examples which demonstrated care and support was not always person centred and responsive. We found care plans for two people were incomplete and did not contain specific guidance relating to their needs regarding safe environment, mobility and nutrition. This meant there was limited information to guide staff. We asked the registered manager the reason for the delay in completing these records given that these people had been admitted over four weeks prior. We were given no specific reason as to why these plans had not been completed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we found there was a clear procedure in place for managing concerns and complaints, this was not always managed according to the provider's policy. We saw that written and some verbal complaints raised were dealt with in line with policy and the complainant received a response which included the outcome of any investigation and/or subsequent action taken.

Most people and relatives told us they had no reason to complain but knew how to do so if they had any concerns. They said, "From experience, I am reassured that if I ask for anything to be done for my (relative) it will if at all possible, be acted upon" and "No complaints, staff do listen to what I want." Two relatives told us they had raised concerns and only one concern had been resolved to the relative's satisfaction. For the other relative, we saw no record of their complaint or what action had been taken to date. We spoke with the registered manager about this. They said the concern had been reported verbally. They explained people and relatives would pop into their office and raise verbal concerns which sometimes were not documented. According to the provider's policy all concerns or complaints, including verbal ones, should be recorded. This meant the registered manager and the provider did not have a thorough oversight of concerns and possible themes for improvement. We also could not be sure that every one's concerns were being managed appropriately.

The service supported people's wellbeing by offering a range of activities and events they enjoyed, including access to the community. The registered manager told us and records we reviewed confirmed that in March 2018 people had been asked for their opinion on what sort of activities they preferred to engage in. This

analysis had been used to inform and improve the home's activity programme. We saw a range of activities were on offer with a weekly schedule displayed on the noticeboards within the home.

During our visit we saw that staff were keen to promote and encourage the importance of hobbies and activities which took place on a daily basis but respected a person's wishes if they chose not to do so. People, relatives and visitors confirmed St Mary's facilitated a variety of activities at the home as well as trips out. Scheduled activities for the week of our inspection included music for health, hand therapy, baking, crafts, a singing group, afternoon tea and bingo. The home had an activity room on the ground floor and people from across the home were escorted down to join in the activities if they wished. Their comments regarding activities from people and relatives included: "We have a good laugh and I like to join in the many activities", "The staff are exceptionally nice and encouraging", "A lot of residents join in together and we have fun" and "I really enjoy the concerts that they put on."

Aside from these activities, people told us staff supported them to engage in an activity or hobby of their choosing. They said, "I like to get outside when the weather is fine and the carers are always willing to help" and "I like to read the papers and books that are available."

The registered manager told us there was a resident hairdresser on site though they were on holiday during our inspection. People's care records we looked at and a compliment from a relative confirmed this service was on offer.

One of the main features of the home was its chapel which had a resident priest who held a daily mass. A relative told us, "It is really pleasing that there is a church attached to the home. If my (relative) misses Mass, the priest comes to visit (them)." In a letter of compliment, another relative spoke about "the beautiful chapel" which they attended at Christmas time with their loved one. The chapel was open to the community, which meant that there were opportunities for people within the home and in the community to mix. In recognition that the service operated in a multicultural community, the registered manager told us the chapel, though Roman Catholic, was prepared to facilitate services of different faiths if requested. They had made links with other religious leaders within the community.
We saw the service had received various recent compliments from relatives and health professionals including tissue viability and stroke nurses for the way staff supported people.

People's end of life care was dealt with in a sensitive way. The registered manager told us, and care records confirmed that end of life was discussed, if people wished to, upon admission. These plans were reviewed and updated as required and included decisions around resuscitation (DNR - Do Not Resuscitate). In one person's care records we saw DNR documentation issued when the person was in hospital rather than from the community. We brought this to with the registered manager who told us they would contact the GP to arrange a review of this.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection, there was a registered manager in post. They understood their legal obligations including notifying CQC of any significant incidents. This was evidenced by the appropriate notifications having been sent to the CQC.

There were systems in place to monitor and assess the quality of the service. These helped to ensure people's safety and welfare were maintained and people achieved meaningful outcomes. The registered manager was responsible for a series of internal quality checks which included medication administration, care plans, infection control and accidents and incidents. Additional oversight was provided through corporate audit processes such as monitoring visits from the operation support manager. While we acknowledged there were systems in place to audit and monitor quality these were not effective in addressing concerns identified in the management of medicines, record keeping in relation to consent to care, person-centred information in care plans and complaints. This meant people were at risk of poor quality care because the provider did not provide suitable assurances they effectively monitored the service provided. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with told us the registered manager was approachable and visible within the home. They said, "The home is very well run" and "This is a friendly home where people treat you properly." The registered manager told us they were well supported and also attended monthly home managers meetings to discuss practice across their various homes. The registered manager was told us they were supported in their role by peers and senior colleagues within the wider organisation.

Staff told us they found the registered manager was approachable and fair and that they enjoyed working at St Mary's. Comments included: "The manager is fair. Yes I can talk to (them) anytime" and "I enjoy my work. My colleagues are friendly and the residents are lovely."

There were mechanisms in place to help ensure people and their relatives and visitors could provide feedback about the service and identify any areas for improvement. These included regular residents meetings and an annual survey. We saw the annual survey had been done in March 2018 and the results collated. However the registered manager and provider did not demonstrate how they would use these results to drive improvements within the service.

People and relatives we spoke with confirmed that regular residents meetings took place every couple of months and actions determined at previous meetings had been acted upon. Actions included improvements with laundry and activities survey. Minutes of previous meetings we reviewed confirmed this.

There were appropriate support systems in place to help ensure staff were supported in their roles; these included policies and procedures, regular staff meetings and staff handovers. A handover is the process through which staff coming on shift are updated on what has taken place prior to them starting work. Staff we spoke with also confirmed this. They said, "I feel well supported here and do see the operation managers

regularly" and "We have two operation support managers and we work closely (with them) to check all audits are completed and the service is improving."

We observed there was an open and transparent culture at the care home. The registered manager provided clear leadership which helped to ensure good communication amongst the staff team and support people effectively and responsively. An example of this included daily "Take 10" flash departmental meetings in which representatives from each department highlighted and discussed any concerns. The registered manager also used this forum to ask staff how they think their role has an impact on the service provided to residents of the home and how this aligns with the five key questions the Care Quality Commission ask services when inspected. Key messages from the registered manager were taken back to each department and the registered manager kept records of these flash meetings for staff review if required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Some care plans were not updated which meant staff had limited information to help ensure they provided care and support that was responsive to the person's needs. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	We found instances in which the service did not consistently follow the principles of the Mental Capacity Act such as the lack of signed consent forms, mental capacity assessments and best interest decisions made without an assessment of capacity. Regulation 11

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were not safely managed. Regulation 12

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality monitoring processes did not provide suitable assurances they effectively monitored the service provided.

Regulation 17