Institute of Our Lady of Mercy

St Mary's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 12, 15 and 21 July 2016. The first day was unannounced.

St Mary's Nursing Home is required to have a registered manager and a registered manager was in place. 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 service is registered to provide accommodation and nursing care for up to 35 older people, however the service operates to take up to 32 people. On the first day of our inspection 31 people were using the service.

Risk assessments and care plans were not always in place to ensure people received safe care. Where care plans and risk assessments were in place, they were not always up to date or accurate and not all risks to people's health and safety were identified and reduced. People had access to healthcare services, however people sometimes experienced delays to receiving their treatment.

Staffing arrangements had not been calculated based on meeting the needs of people using the service. Staff were not always deployed in a way so that people received timely support. Staff recruitment practices had not recorded how gaps in staff employment histories had been considered satisfactory.

The proper and safe management of medicines were not followed and therefore risks associated with medicines were not reduced. Records did not support that people received their medicines as prescribed.

Staff training records did not always identify which staff required refresher training in certain areas. Records did not demonstrate staff had or were completing training expected of them by the provider. Not all staff received supervision on an individual basis.

The principles of the Mental Capacity Act 2005 (MCA) were not fully understood and embedded in the service, nor had the principles of the MCA been followed for people's decision making. The service did not assess people effectively for Deprivation of Liberty Safeguards (DoLS) applications.

People felt listened to however we found people were not always invited to contribute to improvements at the service. Staff interactions with people were mixed. We saw some staff always spoke with people as they walked past, however other staff gave no greeting or acknowledgement to people seated in the main hallway.

Audits and systems designed to check on the quality and safety of services people received were not always effective at identifying shortfalls in the quality and safety of services. Records were not complete, accurate, stored securely or completed at the time care was provided. In addition, the provider had not fulfilled its

responsibilities to send statutory notifications about events that they are required to tell us about.

Where people had expressed a preference for a female carer this had not always been respected. People were not always given support when they raised issues of concern. People had opportunities to take part in activities organised by the activities coordinator or to spend time in their own rooms as they chose.

Not all people had the support to eat in a stimulating dining environment and some people fell asleep without eating their meals when they were hot. People's views on the quality of food were mixed with some people commenting on food being cold when it arrived. People's choices for food and drink were respected. Menu options offered a healthy and balanced diet, however not all people ate their meals.

The registered manager was supported by a Deputy manager and a supportive staff team.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspection is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from risks of unsafe care or the risks associated with medicines. Insufficient staff were at times deployed and staffing was not planned to meet people's needs. Recruitment processes in place did not complete all pre-employment checks fully as required.

Is the service effective?

Requires Improvement

The service was not effective.

Training records were not always effective at identifying when staff required refresher training and whether staff were completing training in line with the provider's expectations. People's access to other healthcare services was not always made in a timely manner. The principles of the MCA had not always been applied, and people were not always assessed appropriately in relation to Deprivation of Liberty Safeguards (DoLS) applications. Not all people were supported to dine in a stimulating dining environment. Menu choices offered a balanced and healthy diet, however we saw not all people ate their meals. People's choices for food and drink were respected.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Not all staff greeted or acknowledged people seated in communal areas as they walked past. People felt listened to, however people had not always been involved in opportunities to improve the service.

Is the service responsive?

Requires Improvement

The service was not responsive.

Not all people who expressed a preference for female carers had this respected. Not all people received support when they raised areas of concern. People took part in some activities and had personalised their rooms and other areas of the home.

Is the service well-led?

Inadequate

The service was not well-led.

Systems designed to check on the quality and safety of services people received were not effective. Records were not complete, accurate, stored securely or contemporaneous. The provider had not fulfilled their responsibilities to send statutory notifications about events that they are required to tell us about.

St Mary's 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.

This first day of this inspection was unannounced. The inspection took place on 12, 15 and 21 July 2016. On the 12 July the inspection team included one inspector, one specialist professional nursing advisor and one expert by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of service. On the 15 July the inspection team included two inspectors. On the 21 July the inspection team included one inspector and one specialist professional nursing advisor.

As part of this inspection we reviewed relevant information, including notifications sent to us by the provider. Notifications are changes, events or incidents that providers must tell us about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the local authority and health commissioning teams. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

We spoke with six people who used the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We spoke with seven relatives of people who used the service. We spoke with 13 members of staff, including care staff, domestic staff and the registered manager.

We reviewed six people's care records. We reviewed other records relating to the care people received. This included some of the provider's audits on the quality and safety of people's care, staff training, recruitment records, medicines administration records and minutes of internal meetings.

Inadequate

Is the service safe?

Our findings

People were not always protected from risks because assessments of people's needs did not include all relevant potential risks to the person and how to reduce these. We observed two people whose slings were still around their body after they had been assisted to move into chairs. Both people had been assessed as at very high risk of developing pressure sores. The registered manager told us one of these people could be sat in their sling for up to four hours at any one time. In these circumstances, specialist slings can be used that allow the person to remain seated in the sling whilst minimising further risks to any pressure areas. However, these were not specialist slings, therefore there was a risk people's pressure areas could deteriorate further from sitting in slings that had not been assessed as safe for this use. In addition, records showed some other risks to staff had not been reflected on risk assessments. Risks to people were not reduced because people were not receiving appropriate care to their needs.

Another person had been assessed as at high risk of developing pressure ulcer wounds and had sores that at times, required creams and dressings. There was no care plan for staff to follow on how to manage the care of this person's skin. There was no record of the dressing regime staff were required to follow for this person. In addition, there was no regular measurement or recording of this person's pressure ulcer wounds. There was no consistent evaluation of this person's pressure areas to identify effectiveness or any areas requiring different treatments. There was a risk that staff would not identify a deterioration in this person's pressure areas and take appropriate action to prevent and treat any deteriorations. Risks were not reduced as assessments and evaluations of care and treatment were not in place.

Records showed us that medical attention was not sought in a timely way. As a result one person experienced deterioration in their skin condition. For another person, staff had been asked to observe a sore area; however no further observations were recorded. The service could not demonstrate this sore area had been monitored by staff as requested and that no further deterioration had occurred. No care plans were in place to assess, monitor and evaluate the care and treatment given to these people's skin sores.

Other assessments of risks to people's health were not accurate. Daily records showed one person had, 'A choking fit whilst eating lunch and choked on a pea.' This person's care plan did not identify they had any swallowing difficulties and any special dietary needs. However, staff had not assessed this incident to establish if it was an isolated incident or one that could indicate a change in the person's needs. As such, any potential future risks had not been assessed and no decisions taken on how to reduce any potential future risks.

Another person's care plan did not reflect they had now been assessed by external professionals to require food of a pureed consistency. Although a family member confirmed they did receive pureed food their care plan did not reflect this. This was to reduce the risks of choking as the person was having difficulty taking normal consistency foods. Another person who required staff to assist them with mouth care had no guidance contained in their personal care plan to direct staff with this support. Risks were not reduced as assessments and evaluations of care and treatment were not in place.

We found a sling used with a hoist to assist people to move was faulty and unsafe to use. This was because two areas of stitching on the sling had unravelled. Staff confirmed they had used the sling that morning to assist a person with their mobility. Despite staff confirming they had completed a visual check on the sling before use they had not identified the sling was faulty. We discussed this with the registered manager and prompted them to remove the sling so it could no longer be used.

For another person, records showed they had lost over 11% of their body weight in less than one month. A request was made on the weight chart for this to be rechecked. However, at the time of our inspection, one month later, no record had been made to confirm this person's weight had been rechecked or any monitoring of this person's weight was in progress. Another person had lost over 7% of their body weight in under seven weeks. Records did not show these weight losses had prompted any consideration for other assessments to be completed. The registered manager was unable to provide an explanation as to the weight losses and why no further checks had been completed. People's health conditions were not monitored and evaluated to ensure care and treatment was safe and effective.

One person expressed behaviour that presented challenges to staff. However there were no risk assessments in place on how risks to the person and staff could be mitigated. Nor were any details provided to staff in a care plan on how to best support this person and how to minimise any behaviour that challenged. Notes showed that staff wanted to discuss a change in their care and treatment, however without any care plan in place on how to best support this person the service could not demonstrate it had considered least restrictive methods of care and treatment. For another person, their risk assessment for violence and aggression did not reflect their behaviour had at times presented challenges to staff, which had included barricading staff in rooms. In addition, not all incidents of behaviour that challenged were recorded on the behaviour monitoring charts. The service could not demonstrate it was managing people's behaviour safely as there were either no care plans or risk assessments in place or risk assessments were not accurate.

One person's care plan stated, 'It is extremely important that [person's] medications are given on time to help with mobility and other symptoms caused by [their health condition].' However a recent entry in the person's daily notes stated, 'Lunchtime medication omitted due to having previous medication late.' The staff member confirmed this was medicine to help the person's health condition and should have been given on time. There was no explanation recorded as to why the first dose was given late, and no record made of any advice obtained from the GP as to whether it was safe to miss the lunchtime dose as staff had done. As it was extremely important that this medicine was given on time the service could not demonstrate they had taken all appropriate actions to endure this person's health condition had not deteriorated through not receiving their medicine on time. This meant they were at risk from not having their health conditions managed safely through the proper and safe administration of medicines.

We observed staff administered medicine for one person from the other person's bottle. This meant the staff member had not checked to ensure the correct medicine had been administered to the correct person. In addition, the staff member poured the medicine straight onto a spoon without first using a measuring pot to ensure the correct amount of medicine was administered. This meant the staff member had not accurately measured out the person's medicine. We reported these medicines errors to the registered manager.

We observed another staff member record medicine had been administered to a person before it had been given. Medicines administration record (MAR) charts should only be signed by staff to confirm a person has taken their medicine. This is because if the person was to refuse their medicine staff would be able to record correctly that the person had refused their medicine. Procedures designed to help ensure the safe management and administration of people's medicines were not being followed.

Medicines were not kept securely. Medicines were left out on tables in the downstairs office and by the side of the medicines trolley in a communal corridor. This included loose tablets as well as tablets contained within blister packs. Medicines were left out for periods of time when no staff were present to directly observe them. This meant that people who were independently mobile and people visiting the home would have access to medicines not stored securely.

We also found prescribed creams, solution for washing wounds and bandages left out on a person's bedside cabinet and not stored securely. In addition, the solution for washing wounds and bandages were prescribed for two other people and not the person whose room we found them in. Staff told us one of the prescribed medicines was for a person who was no longer at the service. This meant medicines, in addition to not being stored securely and therefore accessible to other people, were also not disposed of in line with the service's medication management policy.

Some people required their medicines to be administered as and when they needed them, rather than at specific times of day. Arrangements were not in place to help staff make consistent judgements on when people required this certain type of medicine. Records also showed topical creams were not applied as prescribed. In addition a family member told us the service had not used the correct creams for their relative's skin. For some creams there was no guidance for staff on where to apply the cream. The service could not demonstrate people received their medicine as prescribed.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection one person waited an hour before staff came to assist them. Staff told us the person had experienced delayed support because they were short staffed. Over lunchtime a member of staff told a person, "We're running late with lunch, someone has phoned in sick." They told us there should have been four staff on that shift and instead they had only three. They told us as a lot of people required two staff to assist them with mobilising and this meant they could only assist one person at a time. In addition, a member of the admin team helped to deliver meals to people's rooms at lunchtime. They told us this was because carers were short staffed. The registered manager told us they had not arranged agency staff to cover the staff shortage, they had instead asked the deputy manager to cover the care shift. However, from our observations this had not resulted in people supported in a timely manner.

One person told us they felt that, "On balance staffing levels were adequate." Other people told us they felt staff responded reasonably promptly to the call bell. One family member told us there was, "Certainly not," enough staff to support people safely. They told us of occasions where their relative had still been in bed at midday and where they had been got ready for bedtime in the middle of the afternoon. They told us after speaking with staff they had the impression this was to spread the carers' workload.

One member of staff told us there were not enough staff available to stay with people and support them to eat their meals in the dining room. Another member of staff told us staff numbers were not always planned so that people's requests to go to the toilet could be met during meals. Other care staff we spoke with told us people experienced interruptions to their care as they were frequently required to assist other people. We discussed with the registered manager how they planned their staff numbers. Although the registered manager referred to a staffing dependency tool this was not personalised to reflect the individual needs of the people at the service. For example, the registered manager told us 20 people would require the assistance of two carers to assist them to mobilise. There was nothing to show how staff were able to provide this assistance at busy times. For example, when people wanted to get up, go to bed, or during the midday meal, when many people would require staff to assist them, within a similar time frame, with their

personal care and mobilising. Nor was the registered manager able to demonstrate that staff deployed had the right mix of competence, skills, qualifications and experience to meet people's needs. People's needs and preferences were not considered when staffing deployment was planned. Therefore insufficient numbers of staff were deployed to meet people's needs and preferences.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed records of an investigation where an accident had occurred. The investigation and action plan did not demonstrate all reasonable actions had been identified to reduce the risk of a similar accident re-occurring. In addition, the investigation had not identified that a safeguarding referral was appropriate.

One person told us they felt, "Quite safe," and another person told us they had been worried over a noise on their window at night and staff had helped to reassure them they were safe. Although staff we spoke with demonstrated they understood how to identify any potential safeguarding concerns the training matrix did not reflect all staff had completed safeguarding training. Out of the staff listed on the staff training matrix only half were recorded as having completed safeguarding training within the last three years. The service was not able to demonstrate it was keeping staff skills up to date in this area.

Staff recruitment files showed that staff employed at the service had been subject to pre-employment checks. However, where there were gaps in people's employment history the registered manager had not recorded how they had assured themselves of a satisfactory explanation. This meant that there was a risk people may have been employed who were not suitable to work with people that used the service, as the provider had not assured themselves of their previous working history.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us they had applied for one DoLS authorisation for a person living at the service.

We found the process to record decisions in line with the MCA where people lacked the capacity to consent to their care and treatment was not followed. For example, when an external health professional offered a further reassessment of medicines, staff recorded in the notes, '[Name of person] is not well enough to attend an [out patients appointment] or consent to any other treatment.' When staff make assessments of a person's mental capacity, they have to have 'reasonable belief' they are acting in the person's best interests. They also have to take 'reasonable steps' to establish the person lacks capacity to make a decision and establish that the decision is in the person's best interests. We saw no evidence that these decision making stages had been considered and recorded. Another person who lacked capacity to make decisions around their care and treatment had been given a vaccination without any best interest decision making recorded. Staff we spoke with did not demonstrate a basic understanding of the MCA or DoLS. Therefore the provider could not provide assurances that care and treatment was being provided in line with the principles of the MCA and that the decisions staff had taken were in the best interests of the people involved.

The registered manager was not able to demonstrate a confident knowledge of the MCA and DoLS and told us they were not clear on how to apply the MCA to people's care plans. At the time of our inspection one person had been identified by the registered manager as requiring an application for a DoLS assessment. Daily notes showed that another person stated to staff that they were being, "Locked in the dungeon.' We also observed another person had a lap belt fastened on their specialised chair when sitting in a communal area. Neither of these situations had prompted staff to consider whether an application was needed for an assessment of a Deprivation of Liberty Safeguard authorisation for these two other people. This meant people's rights were not being upheld, and restrictions in care were not assessed to establish if they were lawful and proportionate.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another person often refused their care and treatment. An external health professional recommended the person attend a diabetic foot clinic. We found staff explained to the person their wound may get painful and infected if it was not treated. However staff then recorded the person 'appeared' to understand and refuse

the treatment. The level of care and treatment this person refused had the potential to have a detrimental effect on their health. Staff had not assured themselves the person fully understood the impact of their refusal of treatment.

The registered manager and staff member with responsibility for training showed us a training matrix for when staff had completed training. It also indicated when staff training was in progress. The training matrix identified priority areas for training and we were told these were repeated every three years, or for training such as first aid we were told staff attended annual refresher training. However the staff member with responsibility for training was unable to confirm which staff required this refresher training in first aid.

The training matrix showed five staff had completed the refresher training in February 2014. This meant that according to the service's understanding this refresher training was now out of date. The training matrix showed several staff with nothing recorded to confirm they had either completed training as expected by the provider, or that it was in progress. We were also shown certificates of staff training that were not reflected on the training matrix. As such the training matrix was not an accurate and up to date assessment of staff skills and training. In addition, admin staff who provided assistance with taking meals to people at busy times had not had any training in basic nutrition and food hygiene. There was therefore a risk that staff involved in these duties were not fully aware of the standards required and the actions to take to reduce risks to people. The provider could not be sure all staff had received training to support the needs of people using the service.

Some staff had received specific training in end of life care, called the gold standard framework. However, when we spoke with staff about their training they were unable to demonstrate an understanding of some of the key areas the training covered. The service were therefore not able to demonstrate staff had competency in the areas they had been trained in. Not all staff deployed were suitably competent, skilled or experienced.

Care staff received individual supervision and were provided with the opportunity to review their performance. However, clinical staff did not receive individual supervision; they had group supervision focussed on a particular theme. We observed some clinical staff practice did not follow the provider's policies and procedures and fell short of their expectations for quality and safety of services. The provider could not demonstrate clinical staff received sufficient support and supervision to carry out their roles and responsibilities effectively as their practice fell below the standards expected by the provider.

In addition, the service had identified one member of staff required further training as they had not followed the provider's guidelines when assisting a person to move, which resulted in an incident. This person did not complete the additional identified training in the timeframe originally set. Nor did records show any consideration of whether this staff member's failure to follow the provider's guidelines would fall within the provider's disciplinary policy. This meant that the staff member was working without the training identified by the provider to meet people's needs. As such, the provider could not be assured that staff deployed in the service had the skills, knowledge and competency to meet people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views on the food. One person told us, "[Staff] are so slow at bringing breakfast, it's cold." Another person told us food was usually hot when it arrived, but it was occasionally cold. We observed other people who had fallen asleep without eating their cooked breakfast or cooked dinner. Another person had several cups of cold tea next to them that had not been drunk. We asked staff about the person asleep with

the cold cooked breakfast. Although staff we spoke with told us this should not happen they were unable to explain what systems were in place to ensure people were able to eat their meals when they were still hot.

Other people told us the food was good and this view was shared by family members. One person told us there was a good choice of food at breakfast and said the food was, "On the whole very good; I have scrambled eggs for breakfast and cranberry juice." They added that they enjoyed their morning coffee. Another person told us the food was, "Perfectly adequate; it's improved."

Some people we spoke with told us their preference to eat in their own rooms was respected. However we saw other people who were not able to tell us their preference of where they liked to eat. One of these people had a care plan that stated they liked to eat their lunch in the dining room. We saw this person was served a hot meal, however this was in their own room and they had fallen asleep and their meal had gone cold. Some people are stimulated to eat more in a social, dining environment. This was not always being offered to people.

We spoke with the chef who had knowledge of people's dietary requirements and how to meet these, including for people who required specialised diets. They told us they planned balanced meals for people and included options of oily fish, protein, vegetables and fruit. Another member of staff gathered people's food preferences to make sure food was prepared to people's liking. Although menu choices were balanced and healthy, people were observed to not always eat their meals and take their drinks and their preferences for where to dine were not always supported. As a result, the provider did not demonstrate all people received a balanced and healthy diet.

Where we observed people assisted by staff with their meals this was done at the person's own pace and they were given the choice of whether to start with their vegetables or their meat. Where people had a soft food diet, we saw each part of the meal was served in a separate plate compartment. Where people could easily spill a drink, we saw drinks were provided in lidded beakers so as to reduce the risk of drinks spilling.

People we spoke with told us they had good access to other health services. They told us a GP called regularly and staff would call the GP if they were unwell. Another person told us an optician visited and had tested their eyesight. We saw a visiting health professional had visited a person on the day of our inspection. Records showed people had appointments with other specialist health professionals involved in their care. However daily notes showed that for some people, they had not always received external health advice in a timeframe that prevented their condition from worsening.

Requires Improvement

Is the service caring?

Our findings

Although people using the service told us they felt listened to and valued, and that they attended a residents' forum, the service had not always involved people to express their views. For example, the registered manager had set up an improvement group to look at how the service was run. However people using the service were not included in this and the registered manager was unable to explain why. In addition, staff told us some people spent time in different areas of the building at different times of day. However, staff were unable to explain how they understood this was based on people's choices.

People were mostly positive about the staff that supported them. One person told us, "I'm quite settled; staff and carers are very good. I get on with all of them." Another person told us, "Most of [the carers] are very kind." Family members' comments included, "Some carers are excellent; first rate," "Very nice people, a very friendly crew," and, "I get on with all the staff, they are very approachable, very friendly, very helpful." However, another family member told us how some staff would leave their relative's room untidy.

We observed that most people were supported to maintain their appearance. However, whilst most people had been assisted to keep their clothes fresh after their midday meal, we found one person had spent the afternoon in a top that had been stained with food. Some staff we spoke with told us people had to wait for assistance with personal care. People were not always supported to maintain their dignity in a timely way.

People told us staff treated them with respect and knocked on their doors before entering. Two people we spoke with told us staff respected their wishes to spend time in their own rooms. One person who liked to be in their own room told us, "I'm happy; I don't want company." Staff spoke with warmth for the people they cared for. One staff member told us, "We love our people."

During our inspection we saw a range of staff interactions with people. Whilst staff were heard to speak with people with respect and courtesy, not all staff acknowledged people who were sat in the main hallway. This meant that for periods of time people were sat with staff walking past them who offered no acknowledgement or offered no greeting to them.

Relatives told us they were free to visit when they wanted and we saw people had visitors throughout the day. We saw that some relatives spoke with staff to ask questions about their relatives care and treatment and we saw that staff provided responses to these questions. Relatives were given opportunities to contribute their views about the care and treatment of their family members.

Requires Improvement

Is the service responsive?

Our findings

We saw that people expressed their preferences for whether male or female carers supported them. However the service could not always show these preferences were respected. This was because records showed that although staff knew one person preferred female carers, because they did not refuse or complain, male carers still provided their care. Another person told us they did not like their windows closed at night, however they had been told the windows had to be shut for, "Insurance reasons." People's preferences were not always supported.

Two people told us they were fully involved with their care planning and they were listened to. One family member told us they had contributed to their relative's care plan. They told us they had gone through it with staff and as a result one or two things had now been adjusted. They told us they were, "Working together," with staff. We saw that other family members had also contributed knowledge of their relatives so that staff could understand their life and experiences.

One person told us, "I can have my television on if I want to." Other people told us they liked to read and listen to the radio in their own rooms. We saw families and friends were free to visit people. One person spent some time outside in the gardens with their visitor. Music or the television was available in communal areas and people had daily papers delivered. Staff told us people could access the place of worship on site, or for people with different religious views, a person from their own faith could visit. A new activities coordinator was in post and had spent time supporting some people with arts and crafts. We saw posters that advertised a forthcoming classical guitar concert. People were supported to enjoy a variety of interests.

Staff told us about the recent refurbishment of the hairdressing salon and of the dining room. They told us how people had contributed their views to the colour themes used. In addition we saw people's own art and that of their family members displayed in communal areas of the building. People's own rooms contained pictures and photographs and were personalised to their own taste.

One person told us their food was occasionally cold, however they said, "I don't complain." The registered manager told us if anyone raised a concern they were asked whether they would like to make an official complaint. If the person did not want to make an official complaint then their issue was not recorded as a complaint. We were told no-one had wanted to make an official complaint and therefore no complaints had been recorded since our last inspection. This meant there was no record of complaints or concerns or of any actions taken. There was no system to monitor what issues people raised and therefore the opportunity to learn from people's feedback was not taken in a systematic way.

During our inspection we heard the registered manager receive a telephone call where the person raised a matter of concern. The registered manager was recorded as saying, "I'm sure this didn't happen and I find that very hard to believe." We spoke with the registered manager as we were concerned the person raising the concern may not feel they were believed or that their concern was going to be investigated objectively.

Inadequate

Is the service well-led?

Our findings

Prior to our inspection the provider had notified us of a serious injury to a person using the service. During our inspection we looked at how this incident had been investigated. We were concerned that the service had not effectively evaluated and improved their practice from this incident. Therefore learning from incidents to ensure that improvements to the quality and safety of services were not made.

Staff did not record people's care and treatment in a contemporaneous manner. Records we reviewed in the afternoon showed the last time the person had been repositioned was at 5.30am. When we reviewed the same record again on a later day, two additional morning times had been added. These entries were not made in a contemporaneous manner. There was a risk that people would not receive safe and effective care as records used to evaluate their care and treatment could not be relied upon as being accurate.

Written records were not always legible and understandable. In addition, staff did not record the full date when evaluating care plans or updating assessment tools, such as ones used to identify pressure areas or malnutrition risks. People using the service required care and treatment for tissue viability conditions and were at risk of malnutrition. Accurate and complete records of people's care and treatment were not maintained. Despite the registered manager stating care plans and risk assessments were, "Chaotic," and, "A shambles in places," no action had been taken to address the immediate shortfalls in the standards of recording and out of date information. The registered manager had failed to reduce risks to people's health, safety and welfare. The lack of maintaining accurate, complete and contemporaneous records placed people at risk of inappropriate or unsafe care because their well-being could not be monitored effectively.

The registered manager did not ensure staff followed the record keeping policy used at the service. Records of people's care and treatment were not accurate or complete. We found gaps in people's weight charts, care plans and risk assessments. Records were not accurate and up to date, and one person's care plan had not been reviewed for up to seven months. As a result, people's care and treatment was not effectively evaluated to ensure it was safe and effective. The registered manager had failed to ensure records were up to date and accurate. In addition, systems and processes had not been operated effectively to assess, monitor and mitigate risks and to improve the quality and safety of services provided as audits and quality assurance systems had not resulted in improved record keeping.

We reviewed an electrical installation report that gave a rating of 'unsatisfactory' to the electrical installation. We could see further work had been arranged as recommended in the report however there was no up to date electrical installation report to confirm the works were now satisfactory. The registered manager told us there should be a new report stating the electrical installation was satisfactory, however they were not able to locate it. The service's record keeping policy stated records should be, 'up to date and accurate.' Records relating to the management of the regulated activity had not been securely maintained.

In addition, the registered manager did not ensure records were stored securely in line with the record keeping policy in use at the service. This was because people's care plans and daily charts were kept in unlocked filing cabinets, or left out on desks in the upstairs and downstairs offices. We observed staff were

not always present in these offices and records were not secured when staff were not present. The service's record keeping policy stated, 'All files of a confidential nature are stored in a secure manner in a locked filing cabinet and are only accessed by staff who have a need and a right to access them.' This meant people were at risk of not having their rights to privacy and confidentiality upheld by the service. Records were not stored in line with the service's own policy.

Before our inspection the registered manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered manager had reported that care plans, risk assessments and records, such as for people's weight were reviewed and monitored each month. The registered manager did not identify on the PIR care plans and risks assessments were out of date and inaccurate and in need of improvements. Systems and processes were not operated effectively to assess, monitor, improve and reduce risks to people.

We reviewed the audits the registered manager had completed. We found these did not identify shortfalls in the quality and safety of services and identify improvements. For example, the last moving and handling audit stated there were clear moving and handling instructions for every resident. We found this not to be in place. This meant that systems and processes designed to identify risks in the service were not effective and risks to people were not reduced.

In addition an audit reported the service to have, 'fully met' that 'residents only use aids / equipment they have been assessed /measured for. This did not reflect our findings that the provider had not taken into account people at high risk of pressure sores when assessing whether it was safe for them to remain seated in a normal sling. From our findings we found audits were not an accurate assessment of the quality and safety of the service and as such, did not help to identify shortfalls or how to secure improvements. Systems and processes were not operated effectively to ensure the quality and safety of services provided was assessed, monitored, improved and risks were mitigated.

The registered manager had failed to ensure medicines were stored securely. They told us the medicines trolleys were not large enough to store the blistered medicine packs inside. Nor had they identified medicines had been left out in a person's bedroom. This meant the registered manager had not identified areas for improvement in safety or taken steps to reduce risks to people.

The registered manager had failed to ensure staff were planned and deployed to meet people's needs. This was because the registered manager had not taken into account people's individual needs and preferences when planning staffing. Nor had they considered how to make improvements when staff raised the issue of service users asking to use the bed pan during meal times, particularly breakfast. The registered manager's response had been to check if night staff could get service users ready before they finished their shift at 7.45am. This approach did not demonstrate improvements to the quality of services offered were being considered in response to this feedback.

The systems in place were ineffective as we found care plans and risk assessments had not been updated to reflect changes to people's needs. Nor had any care plan audits identified that information on people's needs was not current and accurate.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition, the provider had not always fulfilled its responsibilities to send statutory notifications to the

Commission. Notifications are changes, events or incidents that providers must tell us about. Following our inspection we were made aware by the local authority that the service had made a safeguarding referral for a person using the service. The service had not notified us of a potential incident of abuse as they are required to do so.

The registered manager told us all equipment was serviced and all slings were presented for inspection when equipment, such as hoists were serviced. Despite this, we found a sling that was worn and unsafe and still in use at the service. We asked the registered manager for the maintenance records for the slings in use at the service. We were shown records for nine slings. We were not assured, based on the levels of need people had in the service that all slings had been included on the maintenance record.

During our inspection of June 2013 we identified a breach in regulation because the service had not recorded thorough and full checks on gaps in prospective applicants' employment histories. The service confirmed at a subsequent inspection in September 2013 all future recruitment checks would include information as to the reasons for any gaps in employment histories. We looked at three recruitment files and found no satisfactory written explanation of the gaps in people's employment. The registered manager told us she had discussed this with the applicants at the time and was satisfied they had either been studying or working at an agency, however this explanation had not been recorded. From the information we reviewed we could not be assured that gaps in people's employment histories had been fully accounted for. We were concerned as the provider had previously been given a compliance action in respect of this breach of regulation previously. The provider had not evaluated and improved their practice despite it being brought to their attention previously.

St Mary's Nursing Home is required to have a registered manager. St Mary's had a manager in post since 29 January 2015 and the manager became a registered manager with the Care Quality Commission on 23 February 2016. We asked the registered manager on how they gathered the views of people, families, staff and other professionals and used these views in the development of the service. The registered manager told us they did not know whether this was done, however they thought the head office completed some type of survey. They sent us the results of a survey of people's views. However, as the registered manager did not know about the results of this survey and no action plan was supplied to address the areas of improvement identified by people, the service could not demonstrate people's views were being used in the development of the service.

Staff and people using the service had received other opportunities to discuss issues, but we did not see evidence that their contributions resulted in changes for them. Staff had given their feedback on where services could improve however they were unsure of what had changed as a result. The management and leadership at the service had not taken effective action to ensure the service was developed and improved by the people using it, their families and staff.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided in line with the 2005 Act. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed to meet people's needs. Persons employed by the service did not always receive appropriate support, training, supervision and appraisal to enable them to carry out their duties they were employed to perform. Regulation 18 (1) (2) (a) (b)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users did not receive care and treatment provided in a safe way. Risks to the health and safety of service users were not always assessed and not all actions that were reasonably practicable were taken to mitigate any such risks. The proper and safe management of medicines was not always followed. Regulation 12 (1) (2) (a) (b) (e) (g)

The enforcement action we took:

We issued a warning notice against the registered manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The quality and safety of services provided were not assessed, monitored and improved and risks relating to the health, safety and welfare of service users and others were not assessed, monitored and mitigated. Records were not accurate, complete or contemporaneous. Feedback from service users and other relevant persons had not been used for the purposes of continually evaluating and improve both practices in processing information and the service. Regulation 17 (1)(2)(a)(b)(c)(d)(ii)(e)

The enforcement action we took:

We issued a warning notice against the registered manager