Mr J R Anson & Mrs M A Anson

St Mary's Haven & St Mary's Haven Respite

Inspection report

St Marys Street
Penzance
Cornwall
TR18 2DH

Date of inspection visit:
30 October 2017
02 November 2017

Date of publication:
15 December 2017

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 30 October and 2 November 2017. This was the first rateable inspection for the service since registration in September 2016.

St Mary's Haven & St Mary's Haven Respite is a care home which offers care and support for up to 34 predominantly older people. At the time of the inspection there were 34 people living at the service. Some of these people were living with dementia. The service uses a detached house over two floors with a lift to provide access to the upper floor.

The service did not have a registered manager in post; a new registered manager was due to begin working at the service the week after the inspection took 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.

Medicine administration processes were not robust. For example, Medicine Administration Records (MAR) did not record when creams were applied. We saw instances where a medicine had been hand transcribed onto the MAR. These were not double signed. It is safe practice for one person to witness this being carried out to ensure accuracy. One person's MAR recorded a change in dose of their medicine; there was no apparent authorisation on the records to account for this change. Transdermal patches were not routinely recorded on body maps to demonstrate where they had been placed. This meant it was unclear where patches had been situated when they required rotating to a different place. We saw overstocking of one controlled drug. Regular medicine audits were carried out. However, these had failed to identify the issues we identified.

The service had not employed the use of a needs based staffing tool to assess the number of staff employed to meet people's needs. We observed and rotas evidenced there were adequate numbers of staff available throughout the day to meet people's needs. However, there was some concern about whether there were enough staff available overnight. We have made a recommendation about this.

Care plans recorded risks that had been identified in relation to people's care and these were appropriately managed. People's risk assessments had been regularly updated so staff knew the best way to care for

people taking into account their changing safety needs. A professional who worked with the service told us, "I don't have any concerns."

Staff knew how to recognise and report the signs of abuse and had access to, and understood the service's safeguarding and whistle blowing policies.

Recruitment processes were robust. All appropriate pre-employment checks were completed before new employees began work.

The premises were largely well maintained, clean and free from malodours. Some areas were due for redecoration and management told us about plans to refurbish and extensively develop the service in the New Year.

We walked around the service which was comfortable and personalised to reflect people's individual tastes. People were treated with kindness, compassion and respect.

Systems for monitoring staff induction, training and supervision were not effective.

People had access to a varied and nutritious diet. For people who did not enjoy the style of meals on offer, alternatives were not variable enough to meet their personal preferences.

The management had a clear understanding of the Mental Capacity Act 2005 and how to make sure people who did not have the mental capacity to makes decisions for themselves had their legal rights protected.

Staff were kind and compassionate and treated people with dignity and respect. Staff respected people's wishes and provided care and support in line with those wishes. People were able to make day to day decisions about how and where they spent their time.

People received personalised care and support which was responsive to their changing needs. Staff supported people to take part in social activities of their choice.

People and their families told us if they had a complaint they would be happy to speak with the designated manager and were confident they would be listened to.

Systems for ensuring appropriate quality assurance in areas such as supervision, training and medicines audits were not effective.

The provider had not ensured the privacy and safety of archived personal records.

There was a breach of the regulations found at this inspection. You can see the action we have told the provider to take at the end of this report.

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 safe. Safe medicines management procedures were not consistently followed.

The provider had not staffed the service based on a needs assessment for the people who lived there. We have made a recommendation about this.

The service followed safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective. Systems for monitoring staff induction, training and supervision were not effective.

People had access to a varied and nutritious diet. For people who did not enjoy the style of meals on offer, alternatives were not variable enough to meet their personal preferences.

The management had a clear understanding of the Mental Capacity Act 2005 and how to make sure people who did not have the mental capacity to makes decisions for themselves had their legal rights protected.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate and treated people with dignity and respect.

Staff respected people's wishes and provided care and support in line with those wishes.

People were able to make day to day decisions about how and where they spent their time.

Is the service responsive?

Good

The service was responsive. People received personalised care and support which was responsive to their changing needs.

Staff supported people to take part in social activities of their choice.

People and their families told us if they had a complaint they would be happy to speak with the designated manager and were confident they would be listened to.

Is the service well-led?

Requires Improvement

The service was not well led. Quality assurance systems for monitoring processes such as induction, supervision and training were not effective.

Medicines management systems were not robust. Auditing systems had failed to identify or rectify issues with administration recording and stock control of controlled medicines.

Archived personal care records were not kept securely. The current arrangements for handling confidential personal information did not meet the requirements of the Data Protection Act 1998.This meant people were not assured that their confidential information was adequately protected.

The service understood and complied with their legal obligations, from CQC and other external organisations, and these were consistently followed in a timely way.

St Mary's Haven & St Mary's Haven Respite

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 checked 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 30 October and 2 November 2017.The inspection was carried out by one adult social care inspector and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service. Their area of expertise was in older people's care.

Before the inspection we reviewed information held by CQC about the service such as notifications. A notification is information about important events which the service is required to send to us by law.

We spoke with the provider, operations manager, a registered manager from another service owned by the provider, the hospitality manager and six staff members on duty. We spoke with ten of the people using the service and four relatives. We also received feedback from an external professional during the inspection.

We spent time observing care practices and interactions between staff and people using the service. We looked at care documentation for four people living at St Mary's Haven & St Mary's Haven Respite and medicines records for 20 people, four staff files, training records and other records relating to the management of the service. In addition we checked the building to ensure it was clean and a safe place for people to live.

Requires Improvement

Our findings

Medicine administration processes were not robust. For example, Medicine Administration Records (MAR) did not record when creams were applied. The MAR stated, 'see topical sheet'. Topical application sheets for creams were kept in a separate folder and were not consistently completed and did not follow the directions provided for administration of creams directed on the MAR. We saw instances where a medicine had been hand transcribed onto the MAR. These were not double signed. It is safe practice for one person to witness this being carried out to ensure accuracy. One person's MAR recorded a change in dose of their medicine; there was no apparent authorisation on the records to account for this change. Transdermal patches were not routinely recorded on body maps to demonstrate where they had been placed. This meant it was unclear where patches had been situated when they required rotating to a different place. We saw overstocking of one controlled drug. Regular medicine audits were carried out. However, these had failed to identify the issues we identified.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

A lockable medicine refrigerator was available for medicines which needed to be stored at a low temperature. Records showed the temperature was consistently monitored. Medicines which required stricter controls by law were stored correctly and records kept in line with relevant legislation.

We observed a senior staff member administer people's medicines. When giving people their medicines they explained what the medicine was and ensured it had been swallowed before moving to the next task. All staff with responsibility for administering the medicines had received the appropriate training.

We observed there were sufficient numbers of suitably qualified staff to meet the needs of people who used the service. The provider, who had taken over the running of the service from another provider, did not use a system to regulate the number of care staff required to meet the needs of the people who lived there. Instead the provider had adopted the same staffing numbers used by the previous provider. We saw there were five staff working in the morning from 8 am to 2 pm, this included a senior staff member who took responsibility for medicines administration and four staff member including a senior from 2pm to 8pm. The respite part of the service was staffed by one carer day and night and provided care and support for nine people. People told us they thought that generally there were enough staff to meet people's needs but we also had comments such as, "There are three ladies up here now who need extra care and with only one carer working over here, they can't leave one of them to come to the others here very quickly" and "You can be under pressure at times. Night time is the main concern with only two staff on at night looking after about

25 people and two people need two to one support to get out of bed. There should be a third carer." We spoke with the operations manager about this; they acknowledged there was currently no system in place to determine staffing levels based on need and the current levels were inherited from levels used by the previous service provider.

We recommend the provider monitors staffing levels by using a tool to assess people's needs to ensure sufficient numbers of staff are deployed to meet people's assessed needs.

We observed people who lived at St Mary's Haven & St Mary's Haven Respite were relaxed and happy during the inspection process. People told us they felt safe living at the service, "Oh yes, very, very safe" and "I do feel safe and happy, but I'd rather be in my own home". Relatives told us they felt the service was safe and provided good care and support. Relative s' commented, "Oh yes, I am very confident that [Person's name] is safe. I have never had reason to doubt it" and "I know my [relative] is safe here. I chose this service on recommendation and I pop in unannounced quite regularly. I have never had any reason to have a concern."

Care plans recorded risks that had been identified in relation to people's care and these were appropriately managed. People's risk assessments had been regularly updated so staff knew the best way to care for people taking into account their changing safety needs. A professional who worked with the service told us, "I don't have any concerns."

Staff knew how to recognise and report the signs of abuse and had access to, and understood the service's safeguarding and whistle blowing policies. This meant staff were able to access relevant and recent information regarding safeguarding processes easily and quickly. Staff had received updated safeguarding training. Staff said they would have no hesitation in reporting abuse and were confident management would act on their concerns.

Recruitment processes were robust. All appropriate pre-employment checks were completed before new employees began work. For example, disclosure and barring checks were completed and references were followed up.

The premises were largely well maintained, clean and free from malodours. Some areas were due for redecoration and management told us about plans to refurbish and extensively develop the service in the New Year.

Two maintenance workers were employed at the service and they carried out daily checks to help ensure any defects were attended to. Staff told us they reported any faults and these were addressed promptly. There were regular checks to ensure the building was safe. For example, checks on the water supply and electrical appliances were completed regularly.

People had personal emergency evacuation plans in place (PEEPS) to advise any first responders of the level of support they would require to leave the building safely in an emergency. Personal protective equipment (PPE) such as aprons and gloves were available for staff.

Requires Improvement

Our findings

People were cared for by staff who were skilled in delivering care. It was clear from our discussions with staff that they knew people well and understood how to meet their needs. Relatives told us they believed staff to be competent. Comments included, "There's no problem here. People are very well cared for."

Newly employed staff were required to complete an induction which included training in areas identified as necessary for the service such as fire, infection control, health and safety and safeguarding. They also spent time familiarising themselves with the service's policies and procedures and working practices.
The induction included a period of time working alongside more experienced staff getting to know people's needs and how they wanted to be supported. The operations manager told us 20 staff had received induction over the previous 12 months. Staff confirmed they had received an effective induction. Records to substantiate the training undertaken during induction were not available.

The provider told us staff who were new to care would be supported to complete the Care Certificate. This replaced the Common Induction Standards in April 2015 and is designed to help ensure care staff have a wide theoretical knowledge of good working practice within the care sector. One staff member told us they were in the process of completing the Care Certificate. Records to evidence this were not available.

There was a system of training in place to help ensure staff skills were regularly refreshed and updated. Staff confirmed they received regular training and we saw this was reflected on staff training files. Recent training had included First Aid, safeguarding and moving and handling. Staff told us they had enough training to enable them to do their jobs properly.

The training matrix, which evidenced that appropriate training was being provided was not being appropriately monitored. This meant completion dates for refresher training for some staff had fallen behind the required dates for some areas.

The service had a policy and procedure in place to provide staff support through a system of supervision, which were either face to face or group supervision meetings. Staff confirmed they had received supervision in the past but the frequency and monitoring of supervisions had fallen behind over recent months. There was not an effective or up to date system for monitoring when staff required their next supervision. The operations manager acknowledged, "It's just not been kept up to date." Staff comments included, "I can't recall the last time I had supervision other than the group supervision we had a while back" and "I'm not sure when my next supervision is supposed to be, but I do feel supported working here." There was no

current system in place for staff appraisals.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service did not use methods, such as signage, to assist people living with dementia to orientate around the building. Staff commented, "Staff tend to be on hand to support people moving around the house, but there isn't any signage to speak of to orientate people to find their way". We observed staff supporting people to different areas of the building such as the dining room and hairdressers throughout the day.

The service provided meals which were delivered frozen to the service by an external company. People had mixed views regarding the quality and choice of the meals provided to them. Comments included, "The food is really good and I'm a fuss-pot; there's always a choice of 2 meals; plenty of cups of tea or coffee and biscuits and cake". Other people reported they did not enjoy the meals and found them unappetising and 'bland'. One person told us, "I don't like the meals. I don't like the way they do their potatoes and the meat has the effect on me that makes me keep having to go to the toilet. I tried it twice and it happened again and was unwell after it. A lot of food gets wasted, as people don't like it; we had a residents meeting about it, but nothing changed."

The hotel services manager manager told us two people had refused to eat the frozen meals and individual arrangements had been made to accommodate their needs. However, people who chose not to eat the frozen meals told us their choices were limited. Comments included, "They do a special Monday to Sunday menu for me now, but they do the same meals as those on that menu every week, it doesn't change." Staff told us, "if you don't like [frozen food provider name], there really isn't much choice. For the people who've made it clear they don't want it, they'll buy additional food in, but for others it's really just jacket potatoes, soup and sandwiches only on offer."

It is recommended the provider review the menu options available for people who do not wish to eat from the frozen food menu to ensure sufficient variability of alternative menus are in place to meet people's needs.

Where people had specific dietary requirements due to health concerns such as diabetes or allergies, these were noted in their care plans and on a whiteboard in the kitchen to ensure appropriate planning for these requirements were followed. Weekly ordering of specialist diets such as low salt and pureed meals was carried out.

We observed the lunchtime period and saw it was a relaxed and social occasion. Staff were available to discretely support and offer encouragement to people throughout lunch. This meant they were able to encourage people to eat unobtrusively and without seeming as if they were continually monitoring them. People and staff chatted together in a relaxed and friendly manner.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for DoLS authorisations had been made to the local authority appropriately. Training for the MCA and DoLS was included in the induction process and in the list of training requiring updating regularly. Staff demonstrated an understanding of the principles underpinning the MCA.

Staff demonstrated a good knowledge of people's needs and understood the best way to care and support people as outlined in their care plan. People told us they felt their care and support was provided in a way which met their needs. One person commented, 'There aren't any restrictions, it's wonderful; I can go out when I like with my wife.'

People had access to external healthcare professionals such as dentists, chiropodists and GP's. Care records contained records of any multi-disciplinary notes and any appointments. The operations manager and staff told us they had developed good relationships with local GP's and the district nurse team. A relative told us the GP was always called out if their family member became unwell.

Good

Our findings

Not everyone who used the service was able to communicate their views and experience to us due to their healthcare needs. As well as talking with people we observed care provision to help us understand the experience of people who used the service. We saw staff were patient and kind when interacting with people; staff took time to be sure they understood people's needs and ensured they were at eye level when conversing. Those people we did speak with were complimentary about the care they received. People told us they were 'happy' and had built up 'lovely relationships' with staff saying they were, "as good as gold."

Relatives were also happy with the care provided. Comments included, "I am very grateful for the care and support shown to my [relative]. I think it is good care home." An external professional told us, "This is one of the nicer homes. I find the staff really helpful; very friendly."

People were familiar with all staff as well as the operations manager and provider. People, relatives and staff chatted together and there was laughter and joking throughout the day. Staff told us, "I know everybody here really well, mainly by spending time talking to people."

Some people chose to spend time in a lounge area and it was clear people had developed friendships between themselves and with staff. The provider acknowledged people by name and spent time talking with people. It was a chatty and relaxed atmosphere.

Staff had an understanding of people's needs and used this knowledge to enable people to make their own decisions about their daily lives wherever possible. For example, we saw a care worker take time to ensure a person and their guests were comfortable and had a cup of tea and biscuits of their choice to enjoy. A relative member commented, "The staff are lovely. If you want something staff will go out of their way to get it for you."

People told us they were able to make day to day decisions about how and where they spent their time. We saw people engaged in their own interests such as reading and chatting with friends and happily moving around the building between the dining rooms, lounge and their bedrooms.

People's privacy was respected. Bedrooms were decorated to reflect personal tastes and preferences. People had photographs on display and personal ornaments in their room. Some people had chosen to bring their own furniture into the service. This helped people develop a sense of ownership for their own private spaces. When showing us around the building staff knocked on people's doors and waited for a

response before entering.

People were supported to maintain family relationships. Relatives told us they were able to visit freely whenever they wanted and were always made to feel welcome by staff. One said; "They always ask if we want a cuppa or to stay for lunch. "

Care plans contained information about people's personal histories. This is important as it helps staff gain an understanding of the person and enables them to engage with people more effectively.

The service organised 'residents' meetings to gather the views of people living at the service. We saw minutes of a recent meeting held to encourage discussion about the introduction of the new system of meals. People told us they could talk to staff whenever they wanted if they had any concerns or ideas about how the service was run.

Good

Our findings

People who wished to move into St Mary's Haven & St Mary's Haven Respite first had their needs assessed to help ensure the service was able to meet their needs and expectations. Senior staff would meet with people, and their families if appropriate, to discuss their requirements.

The operations manager was aware of the negative impact people's needs could have on each other and worked to help ensure appropriate care plans were in place to provide the correct level and type of support to people. For example, they had recently arranged for one person to be reassessed regarding a potential move to another service as they recognised the person's level of needs were escalating. This had resulted in a decision to continue the person's placement with additional professional support in place.

Care plans were an accurate and up to date record of people's needs. The records were well organised on an electronic care management system and it was easy to locate the information. They were detailed and contained information about a wide range of areas. For example there were sections on mobility, communication, social needs and night time routines. This meant staff had a complete picture of any issues which might have an impact on people's well-being.

Care plans gave direction and guidance for staff to follow to meet people's needs and wishes. For example, one person's care plan described how staff should assist the person with their personal care including what they were able to do for themselves. The care plans were regularly reviewed to help ensure the information remained up to date and relevant.

People and their relatives, were appropriate, confirmed they were involved in review discussions about care planning. One relative told us, "I'm aware of my [relative's] care plan. I get the information and I'm invited to attend reviews if I want to."

There were systems in place to help ensure staff were kept informed of any changes in people's needs. Daily records were consistently completed and there was a handover between night staff to staff arriving on shift in the mornings and vice versa. Information from daily records was monitored to identify any patterns that might indicate a change in people's well-being and discussed at staff handover meetings.

People had access to a range of activities which were chosen to reflect people's interests and preferences. For example, we were shown examples of knitted blankets and crochet work completed by people. Some male residents had also expressed an interest in carpentry and painting and some bird tables had been

purchased to provide a focus for this activity. Other people had enjoyed planting pots to decorate the outside space.

The service employed an activities co-ordinator and they were able to plan and organise group activities as well as spend one to one time with people. We saw people go off for a 'magical mystery tour' of the local coast on one day in the service mini-bus and heard about another shopping trip attended by people in the same week. People told us they enjoyed the range of activities on offer and in particular the variety and having the opportunity to do things outside of the service. In addition to this the service actively sought visitors from the local community to come into the service.We heard about recent harvest festival celebrations including a visit from a local school choir who joined people at the service to sing songs and share local fruits and produce.

There was a complaints policy in place which outlined the timescales within which people could expect to have any concerns addressed. There were no complaints ongoing at the time of the inspection. We saw one complaint regarding a person's mobile charger being repeatedly unplugged that had been successfully rectified by putting a sign on the charger for it to be kept fully charged. Relatives told us they would approach a member of the management team if they had any worries.

Requires Improvement

Our findings

The service was being managed by the organisation's Operations Manager with input from a registered manager from another of the organisation's services, following the departure of the previous registered manager in September 2017.

The service is required to have a registered manager. 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 operations manager told us a new registered manager had been appointed and was due to begin work at the service the week following the inspection.

Systems for monitoring processes such as induction, supervision and training were not effective. More detail about this will be found under 'Effective'.
Medicines management systems were not robust. Auditing systems had failed to identify or rectify issues with administration recording and stock control of controlled medicines.

A large number of archived personal care records were stored in boxes in an unused part of the building. We observed these were stored in a room which had been left open and could be accessed from outside. We spoke with the operations manager about this who explained they were in the process of dealing with the old records. However, the current arrangements for handling confidential personal information did not meet the requirements of the Data Protection Act 1998.This meant people were not assured that their confidential information was adequately protected.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff said they felt well supported and were able to speak freely about any issues at any time. The operations manager told us they had an open door policy and encouraged staff to air concerns as they arose.

The service had not formally asked families or other professionals who were familiar with the service for their views since being registered. The operations manager told us this was planned and would be carried out once the new registered manager was in post. Relatives told us "I wouldn't have a problem talking to [management] if I needed to. I know that there is a temporary Manager at the moment – [previous registered

manager] left three weeks ago".

Checks were completed on a weekly or monthly basis as appropriate for fire doors and alarms, emergency lighting and Legionella checks. Hoists and slings were regularly serviced to ensure they were fit for purpose.

The service understood and complied with their legal obligations, from CQC or other external organisations, and these were consistently followed in a timely way. For example any notifications that we required were received promptly and contained appropriate information.

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 12 HSCA RA Regulations 2014 Safe care and treatment The management of medicines was not proper and safe.Reg 12 2(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not consistently operating systems and processes to assess, monitor and improve the quality and safety of the services provided to people. Reg 17 2(a)