Cavendish Healthcare (UK) Ltd

St Josephs

Inspection report

The Croft
Sudbury
CO10 1HR
Tel: 01787 888460
Website: www.anchor.org.uk

Date of inspection visit: 27 July 2015
Date of publication: 11/01/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection took place on 27 July 2015. The previous inspection was completed in July 2013 and the service was all compliant with that legislation.

St Josephs is a care home for 60 older people, some of whom are living with dementia. The unit that accommodates people living with dementia has 27 bedrooms and separate living space. This unit is known as Gainsborough.

The registered manager was present throughout the day. 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.

St Joseph's is a friendly home with a manager that is known and well-liked by everyone. There is a consistent staff team, a core who have been there for some time. People experienced a home that met their physical care and health needs.

There were some good examples of care and support to individuals that we saw and were told about by people, but there was a lack of consistency for all. Staff liked

Summary of findings

where they worked, but were not consistently provided with the training and supervision that they needed. Staffing numbers were not adequate. They did not take into account peoples support needs as well as the numbers of people resident. The impact of this was that people felt their physical care needs were met. Some people had their social and emotional needs met but others did not.

The environment at St Josephs was well maintained and a pleasant setting for people, but we found that due to peoples disability the environment was not suitable for everyone and posed risks to individuals.

The manager was accessible to people but the arrangements in place to listen and learn from peoples experience were not well developed. There were some monitoring and audit systems in place, but these were not thorough or comprehensive. They were not used to drive improvement or for the provider to have clear oversight of how the service was being managed and developed. This was found to be a breach of regulation.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not consistently safe. There were at time insufficient numbers of skilled and experienced staff to meet people's needs.

Staff had a good understanding of how to recognise and report any signs of abuse, and acted appropriately to protect people.

Risk had been identified and managed appropriately. Assessments had been carried out in line with individual need to support and protect people.

People's medicine management was not robust.

Is the service effective?

Requires improvement 

The service was not consistently effective.

Parts of the premises were not suitable for the intended purpose and placed people at risk.

Staff did not receive a consistent thorough induction and ongoing training.

Staff had received appropriate training in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards. Staff displayed a good understanding of the requirements of the act, which had been followed in practice.

People were supported to maintain a healthy diet and had their healthcare needs met.

Is the service caring?

Requires improvement 

The service was not consistently caring.

Positive, caring relationships had been formed between people and staff, but people expressed incidences of isolation and lack of emotional support.

People were involved in decisions about their care and support, but were unable to influence the running of the service and kept as informed as they could be.

People were looked after by staff that treated them with kindness and respect.

People were supported by staff that, respected their dignity and maintained their privacy.

Is the service responsive?

Requires improvement 

The service was inconsistently responsive.

We found pockets of good practice where people had been listened to, involved and had an individualised service that met their needs but this was not consistent.

Summary of findings

Care records were in the main personalised and so met people's individual needs.

Some activities were meaningful and were planned in line with people's interests, but some people said they were unstimulated.

People's complaints were taken seriously. Some concerns were not resolved to the satisfaction of everyone. People's experiences were taken into account to drive improvements to the service.

Is the service well-led?

Requires improvement 

The service was not consistently well-led.

There was an open culture. The management team were friendly, approachable and their roles defined by a clear structure.

St Josephs does not consistently offer a quality service to everyone all the time. There was a lack of comprehensive quality systems in place to drive improvement and raise standards of care.

St Josephs

Detailed findings

Background to this inspection

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

This inspection took place on 27 July 2015 and was unannounced.

The membership of the inspection team consisted of two inspectors and included 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. Our expert-by-experience had expertise in dementia care.

Information was gathered and reviewed before the inspection. This included all the information we held about this provider, including statutory notifications. These are events that the care home is required by law to tell us about.

The methods that were used included talking to nine people using the service, seven of their relatives and friends, speaking with 11 staff, pathway tracking four people using the service, observation of care and the lunchtime experience. We also looked at and reviewed records relating to medicines management, recruitment, training, audits and management of the service.

Requires improvement

Is the service safe?

Our findings

Most people didn't think there were sufficient staff. One person said, "They wash and feed you, and keep you going, but there are too many residents and not enough staff. Sometimes when they have taken a while to answer the call bell they say 'We can't be everywhere, you are not the only resident.' I know that and I am sorry about it, but sometimes I get desperate for the toilet and am in danger of wetting myself. My heart goes out to them, they are so busy". Another person said, "They could do with more staff, I normally have to wait". A visitor said, "They could do with more staff. I sometimes come in and they are all busy, I see no-one around. It is generally worse just after lunch when they all seem to be preoccupied".

One person believed they knew why this had changed. They told us, "I am not unhappy here, but since moving in six years ago, people's needs have changed - when I came most people were reasonably mobile and independent, we all had a social life and went out, now most of the residents are requiring a different sort of care and there is a different mix".

Three people told us it was difficult to get staff attention from the main lounge area and therefore they needed to 'shout' to attract attention. But people said they had call bells in rooms that were generally answered in good time. We observed call bells answered in a timely manner. We found that one person, who was confined to their bed, did not have a call bell to summon staff. They said, "I have never had any way I can call for care staff. I can't do anything about it; I just have to wait for them to come to me". We saw that when a senior member of staff who needed to speak to the visiting GP, who had arrived to hold consultations with several people, staff struggled to continue to provide people with adequate support and attention that they required. One person was being supported to eat. They were left during the time the GP visited. The member of staff returned to support them to eat a cold meal which they then did not then want. A person who lived in the main part of the home told us of a similar experience. They preferred to have their meal in their room (they need assistance) although carers try to persuade them to go down to the dining room, but they told us, "The carers sometimes get distracted halfway through feeding me and dash off, saying 'back in a minute' but of course the food is getting cold while I am waiting, so I prefer them to assist me in my room''.

Three staff informed us that there had been times when they felt there were not sufficient numbers of staff working in the part of the home where care was provided to people with dementia related needs. Two staff told us this had been "stressful" and was "difficult for us to give support to everybody when it was required". They said they had raised this matter with their line manager.

During our inspection we noted that there was one less member of staff working than was shown on the staffing roster. We discussed this and the deployment of staff and staffing numbers with the manager who explained the system they used to determine the numbers of staff required was a ratio to the numbers of people living at the home. The manager informed us that they also considered whether people's needs changed and additional staff were required to meet people's needs. They told us they relied on care staff and senior care staff to inform them of this. We found that there were inadequate systems in place to determine staffing numbers and there were at times a detrimental impact upon people due to insufficient staff being available.

This was a breach of the Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

People told us that medicine was always received on time, including medicine for pain management, if required. We observed staff ask people if they required pain relief during the lunchtime medicine round. People said that the medicine they were taking was what they had been used to for some time, and so they were aware of what it was for and didn't need to be told each time.

Staff were safely managing and administering prescribed medicine to people. We found that stocks of medicines, including controlled drugs, held by the home were accurate and appropriate records had been maintained for receiving, for safely administering, storing and the return of any unused medicines. Suitable arrangements were in place for the frequent disposal and return of unwanted medicines. We observed medicines being administered to people and saw that the medication administration Record

Requires improvement

Is the service safe?

(MAR) charts were suitable and accurately recorded. We saw that people were given clear information and the opportunity to decide whether they wanted their prescribed, 'as and when required' medicines.

There was a procedure for any covert administration of medicine to ensure that people were safely administered their medicines should this be necessary. Several arrangements that had been made to support people to manage their own medicine and that these were managed in a safe manner. We also found that people's choices to take homeopathic remedies was supported and had been recorded in their medication records.

Medicine was securely sored but not consistently at the required temperature. We checked the records of the temperature for the room and of the refrigerator where medicines were stored. We found that these had not always been recorded every day, despite an instruction in the medicine storage room to record these twice each day. Most of the temperatures recorded were close to the maximum recommended temperature and some had exceeded 25C, which is above the storage room temperature recommended by NICE (National Institute for Health and Care Excellence). No action had been taken to remedy this. We saw several documents regarding the safe management of medicines including two different policies kept in the room where medicines were stored. The manager explained to us that one of the policies dated 2006 was no longer in use although it had not been removed. The policy dated 2014 did not refer to any guidelines regarding the safe management of medicines that the home should be following or to the temperature management of stored medicines, or to any auditing of the management of medication that the home were carrying out. We concluded that people did get medicine prescribed to them, but that the management arrangements to check medicine management compliance were not robust.

People felt safe. One person said, "Staff do know what they are doing and I feel safe when they are assisting me". Staff had received safeguarding training. Staff were confident they knew how to recognise signs of possible abuse. One member of staff said, "I am aware that any person could act in an abusive manner and I would not hesitate to report any such concern. I would also go straight to the Police if I had to". They told us they would not hesitate to report any concerns or suspicion of abuse to the manager and or management, if this was necessary. They felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. There was a policy in place. We saw evidence that safe recruitment procedure were in place to ensure that people received safe care and treatment from staff who had been suitably checked for their identity, work history and references and for Disclosure and Barring Service checks. This showed the manager took measures to recruit appropriate staff. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service.

Risks to people and the service were appropriately managed. There were procedures in place to ensure fire safety, security of the building and maintenance of equipment and the building. Individual risk assessments highlighted people at risk of skin damage, poor nutrition and support when moving or in some cases falling that may cause injury. These assessments in people records were regularly reviewed. Staff knew who required frequent moving to reduce the likelihood of a pressure ulcer developing. People at risk of skin damage had special mattresses and cushions to maintain their skin integrity. One person said they felt safe whilst being hoisted. One person said, "When they help me to move about, it is done professionally and kindly, all very polite." One person had a plan to prevent them falling from bed. A relative told us that her mother had been given a special low bed in her room and another mattress on the floor so, "If she falls it is only a couple of inches". In addition this person's medicine had also been reviewed as a preventative measure. This intervention was working and falls had been reduced. One person told us about a fall they had some time ago. They had needed hospital treatment. They returned to the home after a few days in hospital and that the relevant professionals had visited regularly. They told us they were much more mobile and able to move around the home, saying that they felt safe in doing so. They said that throughout, "Staff had been marvellous and whilst unable to go out and do her own shopping, they taken care of everything for her".

Requires improvement

Is the service effective?

Our findings

St Josephs was well maintained and the location was picturesque and convenient for the town centre of Sudbury. The building had not been decorated or designed with dementia related care needs as a focus of design. Whilst we noted there were pictures of past events on the corridor walls all around the building, there was limited signage to direct people around the building, limited variety of colour used in the decoration and a repetition of one colour and similar features throughout the building. We had concerns about the top floor of the annexe which was up a fairly steep flight of stairs (there was a gate at the top), although residents on this floor used a lift to access the first and ground floors. One person whose room was in the annexe used a walking frame, but to access the ground floor, they needed wheelchair assistance. The lift from their level came down to ground level behind the garage. They told us, "Staff wheel me through corridors, they are completely full of junk - I wouldn't want to have to try to do that on my own- and then through the garage and across the car park to front door". We made this trip for ourselves and the 'junk area' to which they were referred to was dimly lit and was a holding area for spare mattresses and anything else that was not required at the time. It was very unsightly and a little claustrophobic and not a suitable route for people to safely access through, then outside to gain entrance to the main care home.

We also found a small flight of steps directly in front of a different person's room. This person was sight impaired. They told us that recently, "I got so frustrated and anxious, I went walkabouts, and I then got put in the doghouse, they said it was dangerous, I could fall". In these cases the manager needs to evaluate the risk and suitability of the environment to ensure people's needs can be safely met. The current arrangements are a breach of regulation as these parts of the premises were not suitable for the intended purpose and placed people at risk.

This was a breach of the Regulations 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

People told us that they felt staff knew how to care for them and that they felt confident with staff supporting them. One relative said, "Staff are very human and they do use their common sense here. Overall I am delighted with the care. They have got to know mum well and appreciate her sense of humour".

Staff told us they felt well supported and found managers accessible. They found handover a particularly informative time. There were infrequent staff meetings held, that were not well attended. Supervision sessions were not consistent and frequent for staff. There was not a structure in place to assess the performance of all staff on a regular and systematic manner to. The home did not have a written statement or policy related to staff training. The induction arrangements that we saw in the records for three staff were not sufficient to demonstrate that staff would be subjected to a comprehensive plan to ensure that they were competent to provide safe and effective care to vulnerable people. There was no schedule or structure in place to ensure that new staff would undertake a comprehensive training in specific topics. There were no named subjects to show what essential training would be provided to new care staff at any time and there was not a robust or clear arrangement to assess their competency during the induction period. Staff we spoke with were not aware of what their induction arrangement were, apart from an arrangement to work alongside a colleague for a two week period. They could not inform us of what an induction consisted of or how long it might be, or what training and learning they should receive during, or post induction. The arrangement that we saw was for new staff to have a brief introduction to the home and the building, to the policies and an awareness of how to provide care, rather than training in specific subjects. We saw records that showed that this brief introduction had been provided to all staff and to one member of staff over one day only and to other staff between one to three days. We were advised by staff and by the manager that this was followed by a period when new staff worked alongside a colleague before they worked alone. We found that one recently employed member of staff and who was new to working in care services was within their period of working alongside a colleague, or 'shadowed' and had not yet received any formal training, but had been counted as member of staff in the staffing levels and staff work schedule.

We saw a training matrix that was in place for all staff and the system based on the training topics that had been identified by the manager to the frequency that staff might expect. When we spoke to the manager we found that

Is the service effective?

some training topics should have been repeated for staff, although these had not always been provided for staff to enable them to refresh their skills and knowledge within an agreed time frame. We were therefore not assured that all staff had the skill, knowledge and qualifications to perform the tasks they had been employed to perform.

This was a breach of the Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

People confirmed that consent was sought before any care was undertaken, and in the Gainsborough unit we saw a carer helping a resident to transfer from a chair to a wheelchair and she was giving information to the resident about what was happening and why. A different person told us, "They always ask for my permission before doing anything, and yes, they make me feel dignified and private".

People, when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS is for people who may need their liberty restricted to keep them safe and provides protection for people ensuring their safety and human rights are protected. The MCA is a law about making decisions and what to do when people cannot make decisions for themselves. DoLS applications had been appropriately made. The service was aware of the legal process they were required to follow and sought advice appropriately from the local supervisory body. Care records showed that consent had been sought and choices offered to people. These were recorded in respect of personal care preferences. Staff showed a good understanding of the main principles of the MCA and followed this in practice. Staff were aware of how to support people who lacked capacity to make everyday decisions. Managers knew when to involve others who had the legal responsibility to make decisions on people's behalf. Staff members told us they gave people time and encouraged people to make simple day to day decisions. We saw examples such as meal preferences and how people were spending their day. The MCA states, if a person lacks the mental capacity to make a particular decision, then whoever is making that decision or taking any action on that person's behalf, must do this in the person's best interests. Staff understood this law and provided care in people's best interests. Staff sought people's verbal consent before they engaged in personal care.

People were supported to maintain good health. We spoke to a GP from a surgery with whom most people were registered. They advised us that the home had regularly referred to them any medication queries and had ensured that people were protected from the over administering of medicines and had a good history of working with them to ensure that regular reviews of people's medication had taken place. Everyone also said there was good and regular access to medical professionals, particularly GP's and District Nurses. Care records clearly indicated if anyone had an allergy and what needed to be in place for the individual. Records also showed us that people had access and treatment from dentists, speech and language therapists, physios, opticians and chiropodists.

The majority of people were supported to have sufficient to eat and drink and had a balanced nutritious diet. People had jug of water in their rooms, there was water at the lunch table and there were kitchens on the upper floors where relatives and the more mobile residents could make hot drinks. People said there were regular tea and coffee rounds, that biscuits were always available, snacks were produced whenever required and that freshly homemade cakes were always offered around at teatime. We heard staff encouraging people to drink often.

One person had a special diet and said that the kitchen did cater for this, but that they liked to go into town by taxi each week to purchase the things they liked and said, "They are relaxed about me supplementing their menu with other things." They described the food as, "Good, and they give me a varied choice even though I am on a special diet, they always do something different for me."

One person said, "The food is lovely." Another said, "You want a snack? Just ask them and they will get you one." A visitor said, "My wife always seems to enjoy the food."

We observed food served from a hot trolley that looked appetising and well presented, and portion sizes looked good but not overwhelming. People were asked at the lunch table which of the two choices they would like, and the menu was displayed.

The manager told us current residents with diabetes were also living with dementia and so were not in the position to independently manage the condition. We spoke to the chef and they told us they were awaiting training, but in the meantime has researched the condition and had a special cookbook. They were mindful of portion control as well as

Requires improvement

Is the service effective?

managing the intake of sweet things. They made diabetic custard, cakes, jelly, and ensures that diabetic squash and ice cream was available. Afternoon tea had a diabetic cake on offer. The chef had a list in the kitchen of those people on special diets – diabetic/pureed/fortified/soft/allergies as well as special requests. Carers who were giving out the cakes with afternoon tea were able to say who had diabetes. She said "We know the residents well anyway, but this information is always given in handovers."

People's care records highlighted where risks with eating and drinking had been identified for example where there had been weight loss. Staff monitored these people's diets. Where necessary GP advice had been sought and supplements prescribed or fortified diets provided from the kitchen. Appropriate referrals had been made to the speech and language team (SALT) and dietician where needed.

Requires improvement

Is the service caring?

Our findings

We had mixed feedback from people about whether St Josephs provided compassionate, kind care to people. One relative spoke extremely highly of the service and found that it suited their relative saying that communication was very good. We spoke to two people living with dementia. One said. "They are all lovely, it's all very nice." The other said, "If I feel miserable they cheer me up, but I don't often feel miserable here." Both seemed to be in a state of wellbeing, as did other residents on the Gainsborough unit, who were pretty much doing whatever it was they felt like doing. The senior carer on the unit was interacting in a very sympathetic way with residents, making eye contact, and was obviously concerned to attend to their needs.

Virtually all the interactions we saw between staff and residents were polite and friendly, and most of the time, eye contact was made, and information given and permission sought.

One person in the main house said, "If they have the time, they are very good, but everyone is so busy. Professionally they know what they are doing but they don't have time for the niceties. When they get me downstairs and I am settled in a chair in the lounge, no-one thinks to say 'Have you got everything you need?' so sometimes, I find that things like my glasses have been left in my room and then I have to wait to catch someone's attention to go and get them."

One visitor said, "I have found that they cater for people's physical needs very well, but their emotional needs are not addressed." One person gave us an example of this. They told us they were left alone in their room for long periods of time and that the only times carers call in was task orientated. They said, "The carers only come when I call them. I just sit in my chair and I wait and I wait". They told us that recently they had been feeling very alone and getting anxious. "Just recently I have been crying a lot and am very unhappy, but they don't seem to understand." They felt "very isolated, like a prisoner, and because of failing eyesight need help with most things." She said that carers try to persuade her to go to the lounge, but "When I get down there, all I do is just sit there, no-one speaks to me, they seem to think that if you are blind, you haven't got a brain. At least if I am in my room, everything is familiar, there is nothing familiar down in the lounge, and it is often too noisy for me downstairs. They try to get me to do what they think I should do, not what I want to do – I would really like someone to come in and say 'would you like to go to the garden, or what would you like to do?', They just automatically sit me in my chair when I am washed and dressed." We fed this individual case back to the manager on the day of our inspection for them to take action.

Another person told us that carers don't really chat with them when they do come, "I feel taken for granted but I try not to complain."

We found that people were not consistently involved in making decisions about their care and influential in how the home worked. People said that there used to be residents and relatives meetings but that these had not happened for quite some time. One person said, "I don't get any information about what is going on, so I have to keep asking and then they say to me 'Oh the questions you ask…'." A different person said, "There were residents meetings every now and again, but I don't think we have had one for at least a year or so." One person said they had filled in a satisfaction questionnaire last year and that there was a comments folder in the reception area. We found that both of these had been the case. The manager confirmed that meetings with people who used the service had not been held recently.

Two people we spoke with said they had been involved in care plans and reviews of their care. We could see that care plans were developed with peoples preferences in mind and on occasion relatives had been consulted. We were told of, 'Resident of the day', whereby everything relating to the person was reviewed, including their accommodation.

We observed that people were treated with respect and consideration when they were being given their medicines. We saw that staff spoke to people in a quiet yet direct manner about their medicines, reminded them about their medication when this was necessary and asked whether they wanted to take their medicine. We observed that staff spoke to people in a kind manner and saw some occasions when staff sat with people and gave them their full attention. One person said, "I do need help with the bath, they make it all very dignified and they are very respectful."

Requires improvement

Is the service responsive?

Our findings

We saw some evidence that people's views and wishes had been taken into consideration when decisions were made about where they should be provided with care and treatment. We spoke with one relative who explained how their family member had made a well informed decision to remain at the home rather than move to a different care service when this had been considered by health care professionals. The relative said, "I do not want my relative to move to any other care service but have insisted they remain here as they provide excellent care and are kind and competent. They know my relative very well and this is the best place for them".

Care and support plans documented the support people needed and how they wished it to be provided. We asked to see the assessments that had been made to develop these plans, but the manager was unable to locate them for everyone we requested. We saw evidence that there was regular review of people's needs and plans were updated. We also saw that some plans had gaps in them. For instance there was a sheet entitled, 'My favourite things', but this was not consistently completed for people. Staff said that they knew people well and felt they provided the right care for people to meet their needs. People confirmed that they were able to make choices about their daily living – where to spend their time, when to get up and go to bed, have a bath etc.

We found a mixed experience to people being able to follow their own interests and day time occupation. People said that there were activities they liked including piano playing. We spoke to the activities co-ordinator who told us that there are activities going on each day, including weekends, and we could see the list of what was happening daily on the noticeboard. However, one person said, "I haven't read the notices on the board - to do that, you need to be able to get there and then you need your glasses to read it all." The activities co-ordinator said that people were also told about activities by the carers. One person thought that the activities seem to focus quite a lot on the residents living with dementia. They said, "I understand that people with dementia do need stimulation, but people in the main building need something appropriate too." They said that for most of the time they were 'bored'. A different person said, "There are activities, but I don't really want to go. I am profoundly deaf so that makes things difficult."

One person described how they kept themselves busy with meaningful day time occupation, " I deadhead flowers in the gardens, and take books to the less mobile residents, as well as reading, writing and some of own needlework." On the day we observed a gentle exercise class run by the activities person. The CD player could not be located and therefore this was done in silence and not to music as planned. On person said. "We do the same thing every day, we sit and talk". A different person said, "I watch TV in my room mostly. The activities are no good for me". When asked why the person said, "The thing I enjoyed most was the quiz but they don't seem to have them any more". We found that activities for people who were sensory impaired was limited and that the diverse needs of people were not able to be catered for. This was despite having a person specifically employed in the role of activities who had sought the views of people to determine the activities on offer.

There was a complaints procedure in place that people could access. A relative told us they had received an information sheet when her relative first came to the home detailing all the procedures, including complaints. People said they would speak to a senior or the manager if they had any concerns. Most seemed confident that they would be listened to and that the issue would be rectified. One person said, "Yes, they would sort it out if they could." A relative said they had complained that other residents were going their relatives bedroom and so had asked if their door could be kept locked when they were in the lounge, with a key hanging on a hook that they had put up by the door, but said that this had been refused because 'people are entitled to go where they want'. We found no record of this matter in the complaints log. The manager stated that the home gets few complaints. The last one had been received in May 2015 and had been investigated by the local authority who had been satisfied with the outcome for people. We looked at this matter and found that the manager had implemented some changes to try to prevent a similar occurrence in the future from happening.

Requires improvement

Is the service well-led?

Our findings

When asked, staff were not able to tell us about the visions and values of the organisation although they said that a culture of good care was the focus and major aim of the service. Staff supervision was not consistent. Staff did not receive regular supervision. When we spoke with staff they were not all aware of when or how frequently they would receive supervision. We were told by the manager that most staff were unable to attend staff meetings. Combined with the lack of regular supervision of the majority staff this showed that that there were reduced opportunities for team development and regular management communication with all staff. This meant that staff did not have the opportunity to reflect on practice and look at how the service could be improved.

Audit and governance systems were limited The manager had started to develop strategies for monitoring falls prevention and had surveyed people for their views this year, but we did not see a comprehensive reporting system that was effective and drove improvements. We saw evidence that external audits by a pharmacist had been carried out and other weekly and monthly medication checks had been conducted by the home. However these checks had not noticed the temperature of storage for medicines and no remedial action had been taken. In addition the use of redundant policies and procedures had not been noted. We did not find any systematic monitoring of staff training, performance and their competencies. There was no clear system to monitor staff performance at induction level and afterwards. We found that was not a clear approach in place to ensure that people's dependency needs are accounted for when the staffing levels were being planned. On the day we found the roster to be one staff short and another staff member counted in the numbers event though they were still shadowing staff as part of induction. As a result people experienced inconsistent care and support.

An external manager on behalf of the provider had visited the home and completed quality monitoring reports. These had not been systematic or comprehensive. Where matters of improvement had been identified there was not an action plan in place. These visits did not identify the concerns we have with the environment presenting a potential risk to people who lived in the annex. During the inspection we requested information from the manager, but they were not able to find records for us to assess the quality of the service. We concluded that St Josephs does provide some people with a good service some of the time, but does not consistently offer a quality service to everyone all the time. There was a lack of comprehensive quality systems in place to drive improvement.

This was a breach of the Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

People and family members we spoke with had confidence in the management team. One person said, "I know who the manager is. She doesn't come to our rooms but I see her around when I go downstairs. If I had any concerns I would go to her, her door is always open and I am sure that she would listen and try to put things right". Eight staff told us that they felt the home had an open approach to communication and that they could speak to their manager and senior managers at any time should they need to. A staff member said, "There have been very few staff changes here, it is virtually all the same staff since I started. The manager is good and that if there were any problems I would go straight to her and I'm confident of help". A visitor told us, "The management is good. A lot of the staff have been here for a very long time, and to me that says an awful lot". Observations of how staff interacted with each other and the management of the service demonstrated to us that there was a positive culture. There were some links with the local community: holy communion every Friday, church visitors, and the activities co-ordinator was making links with local taxi firms to accommodate more outings.

The home had good external links. We heard from one relative how the home had worked well on several occasions to ensure the best care and treatment was provided for one person through lengthy communications with a local NHS hospital. We spoke with a GP and two district nurses who advised us that the home had created good working relationships with them. Regular communication with a pharmacist had also ensured the home had worked well with a local pharmacy.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were at times insufficient suitably trained, supported and experienced staff deployed to meet peoples needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Some People were at potential risk because the premises (The annex) were not suitable for the intended purposes.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There was a lack of good governance to assess, monitor and improve the safety and quality of the home.**