The Order of St. Augustine of the Mercy of Jesus

St Mary's Care Home

Inspection report

St George's Park
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected St Mary's Care Home on the 5 April 2016. The home provided accommodation in rural East Sussex for sixty older people who required nursing or personal care. The majority of people lived with dementia but people with a learning disability, mental health and complex health needs also lived at the home. The Order of St. Augustine of the Mercy of Jesus provided care with nursing at four locations, three of the homes are based in spacious grounds in St Georges Park and the fourth home is nearby.

The home had a registered manager. A registered manager is a person who has registered with the CQC 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 home is run.

Not all best interest decisions had been made involving people who knew the person well. We saw evidence that best interest decisions had been made in respect of, for example, the supervision of medicine but not all best interest decisions were decision specific. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and how DoLS is assessed and authorised in other settings such as supported living or people's own homes. People can only be deprived of their liberty in order to receive care and treatment when this is in their best interest and legally authorized. Not all applications for DoLS were made. We have therefore identified this as an area that required improvement.

We found that further adaptions and adjustments could be made to ensure that people with living with dementia and those that had physical or sensory disabilities could orientate themselves around the building, fully access all areas and therefore retain their independence. There was a general lack of signs to indicate to people the function of a room or to help them to know if they were approaching a particular communal room, corridor or floor. The garden was locked to people. The registered manager told us that this was to prevent falls in the garden. However, we could not identify risk assessment for people that evaluated the risk of falls in the garden as a particular risk or other, less restrictive options had been considered. We have therefore identified this as an area that required improvement.

People at the home told us that they felt safe. There were safeguarding policies and procedures in place that were followed and staff were fully aware of their responsibilities in reporting safeguarding incidents. The provider had a whistleblowing policy in place and staff told us they knew how to use it if they needed to.

People's needs were assessed and care plans provided staff with guidance about how individual needs were met. Plans we looked at placed the person at the centre of all planning and contained the necessary risk assessments to keep people safe. They were reviewed and amended to ensure they reflected people's changing support needs.

Essential training was up to date for all staff. Staff received training specific to people's care and treatment

needs, including specific health conditions. One member of staff said, "We have lots of training and everything you can think of is included in the programme. The recent training about dementia was very interesting." People told us they felt the staff were well trained and able to meet their needs. The relative of a person commented, "Staff appear to be skilled and well trained."

People were very complimentary about the friendliness and professionalism of the staff. One person said, "The staff look after me very well indeed. This is why I'm doing so well at my age." Staff interacted with people in a warm and friendly manner. A health care professional told us, "The Nurses/Health Care Assistants I observe are kind, gentle and very respectful towards the patients."

People had access to GPs and other health care professionals. Prompt referrals were made to health care professionals. One person told us, "Oh yes, the doctor has just been actually. They get you seen to, you just need to say if you're not feeling well." We sought feedback from health care professionals. They were positive about the home and staff responsiveness, one health care professional said, "Staff are always happy to assist and always refer to other agencies."

People were able to participate in activities of their choice. Activity co-ordinators organised a programme of activities for people that included gentle exercises, arts and crafts, film nights and outside entertainers. They also carried out one-to-one sessions with people. The relative of one person said, "[My Relative] is in bed all the time now. I know they come in at least every two hours and they also give head massages and hand massages and they don't even charge for it. Sister is very attached to [my relative] and comes in to pray with them."

The provider had systems and processes in place to audit and monitor the quality of the service. Issues identified for development were recorded and an action plan put in place. People were supported to remain in regular contact with families and friends. There was open communication between family members and the home. People and their relatives told us they knew how to complain and were confident in doing so.

Staff were positive about the registered manager and the support they provided. The registered manager responded to staff suggestions and requests. A member of staff said, "The manager is a lovely, lovely nurse, very professional, helpful, approachable, treats everyone fairly and both residents and staff can talk to her about any concerns."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

St Mary's Care Home was safe.

Staff were trained in how to protect people from abuse and knew what to do if they suspected it had taken place.

Staffing numbers were sufficient to ensure people received a safe level of care and treatment.

Recruitment records demonstrated there were systems in place to ensure staff were suitable to work within the nursing and care sector.

Medicines were stored appropriately and associated records showed that medicines were ordered, administered and disposed of in line with regulations.

Is the service effective?

Requires Improvement

St Mary's Care Home was not always effective.

The requirements of the Mental Capacity Act 2005 (MCA) were not being met. Capacity assessments were not completed in line with legal requirements. Not all Deprivation of Liberty Safeguard (DoLS) applications were made.

There was a general lack of signs to indicate the function of a room or to navigate around the home. The garden was locked to people.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff were aware of special diets and dietary preferences.

All staff had received effective training to ensure they had the knowledge and skills to meet the needs of people living at the home.

Is the service caring?

Good

St Mary's Care Home was caring.

People were treated with respect and dignity by nursing and care staff.

Staff knew the care and treatment needs of people and provided individual personalised care.

Care and treatment records were safely maintained and people's information was kept confidential.

Is the service responsive?

Good

St Mary's Care Home was responsive.

Staff had a good understanding of people's identified care and treatment needs.

People were supported to take part in a range of activities both individually and in groups. These were organised in line with peoples' preferences.

Care plans were centred on the person and reflected their current needs and preferences.

People and their representatives were confident they would be listened to and any issues they raised would be taken seriously and acted upon.

Is the service well-led?

Good

St Mary's Care Home was well led.

People, their relatives and healthcare professionals spoke positively about the provider and registered manager.

Staff told us they felt supported and could approach the management about any concerns.

The culture of the service was open and friendly.

Systems for quality review were in place and identified areas requiring improvement.

St Mary's Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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 home and to provide a rating for the home under the Care Act 2014.

The inspection was carried out on 5 April 2016 and was unannounced. It was carried out by two inspectors, an expert by experience and specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist adviser brought skills and experience in nursing. Their knowledge complemented the inspection and meant they could concentrate on specialist aspects of care provided by St Mary's Care Home.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. It included information about notifications. Notifications are changes, events or incidents that the home must inform us about.

During the inspection we spent time with people who lived at the home. We spent time in the lounges, dining room and people's own rooms when we were invited to do so. We took time to observe how people and staff interacted.

We spoke with eleven people and five of their relatives. We gained the views of staff and spoke with the registered manager, deputy manager, three nurses and five care workers. We also spoke with staff who worked in housekeeping, laundry, kitchen, administration and maintenance.

We contacted selected stakeholders, including four health and social care professionals, the local authority and the local GP surgery to obtain their views about the care provided. They were happy for us to quote them in our report.

We looked at six care plans and four staff files and staff training records. We looked at records that related to how the home was managed that included quality monitoring documentation, records of medicine

administration and documents relating to the maintenance of the environment.

The last inspection was carried out on 4 September 2014 and no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "You feel safe with every single one of them, there's not a bad one amongst them". Relatives told us they were confident the staff did everything possible to protect people from harm. They told us they could speak with the registered or deputy manager and staff if they were worried about anything and they were confident their concerns would be taken seriously and acted upon. Care staff told us how they kept people safe in the home, one said, "We keep people safe here because we know them well, so we know the people at risk, Staff are around all the time, watching out for things to happen."

People and their relatives all said that they felt safe and free from harm and would speak to staff if they were worried or unhappy about anything. This was borne out in our observations of people who were at ease and comfortable with staff. We saw people conversing and smiling with staff and looking relaxed and happy in their company. Staff were aware of their responsibilities in relation to keeping people safe. Staff were able to describe the need to raise any concerns about the quality of care provided or any wrong doing or suspected wrong doing so appropriate action could be taken. They told us about safeguarding protocols and the potential signs to look for and the different types of abuse that people might be subject to. Records showed that staff had received training, and refresher training, to ensure they understood what was expected of them. Care staff were able to describe the different types of abuse and what action they would take if they suspected any abuse had taken place. One care assistant told us "I have never seen any abuse here but it could be physical, verbal or financial. If I suspected it I would report it to the manager who would investigate it and follow the full procedure. We have the safeguarding telephone number in the care office which we can use". Another member of staff said, "If I saw any poor care I would report it to the nurse in charge, the deputy manager or manager who would investigate it. If you don't report you are as bad as the person doing it."

Care plans highlighted general health risks such as diabetes. Where risks were identified there were measures in place to reduce the risks as far as possible. People who lived with diabetes had their blood sugar levels checked regularly to ensure it was within their normal range. Guidance for staff to recognise when their blood sugar was either too high or too low was in place for staff to refer to. People who live with diabetes need regular eye checks and foot checks as the disease has potential side effects. These were in place and evidence that risks to their health were mitigated. Risk assessments were reviewed at least once a month or more often if changes were noted.

Risk assessments were completed to manage and reduce risks to individuals as part of their care plan. These were followed to reduce the risk of an incident occurring. Care plans showed each person had been assessed before they moved into the home and any potential risks were identified. Risk assessments included risks associated with visual impairment but also included falls, skin damage, nutritional risks including swallow problems and risk of choking and moving and handling. For example, specially adapted beds were in place for those that were at risk of falls.

Information from the risk assessments were included in a care plan summary. All relevant areas of the care plan were updated when risks changed. Staff were given clear and up-to-date information about how to

reduce risks. For example, if people lost weight, staff took action to ensure food was fortified and offered regularly. We saw that staff weighed certain people who were identified and updated the GP regularly.

Staff were available to respond to people's requests and needs promptly. Individual bedrooms were fitted with call buttons and staff responded in good time to people's call bells. This meant that people did not have to wait for staff to provide assistance.

On the day of our inspection there were 60 people and the staff team included three nurses, 12 care assistants, four housekeeping staff, one chef and a kitchen assistant, two laundry staff, one maintenance man, one activity co-ordinator, one 'front of house' and one volunteer. All staff we spoke with told us there were usually sufficient numbers of suitably trained staff to keep people safe and meet their needs. Comments included, "Staffing levels are generally good. We give the time to residents and are not rushed. When you rush accidents happen so it's never a good idea and I never do it"; "There are usually enough staff. There is a lot to do but when helping someone we take our time and there is no need to rush" and "We have plenty of staff and if we need agency staff we always use those who are familiar with the home and our residents". Observations indicated that staff were busy providing care and treatment but that there were sufficient numbers of staff on duty to meet people's needs safely. People told us staff were busy and didn't always have time to chat if they were responding to another person's care or nursing needs. We were provided with copies of staff rotas, they confirmed staffing levels remained constant and allowed for staff leave and occasional absence though sickness and training. One person said, "Oh yes, they come pretty quickly. They see what you need and if they're busy and it's not urgent they say they'll come back to you and they always do."

Staff had time to speak with people and to check that people across all areas of the home were safe. Staff told us they checked in with people who preferred to spend more time in their bedroom and we saw that no one was left alone for long periods of time. This included discreet observation of staff supporting people who were nursed in bed. People who needed end of life care received additional attention and care. We saw that these people had care to ensure they were not alone for long periods and had someone to meet their needs.

Staff recruitment practices were thorough, people were only supported by staff who had been checked to ensure they were safe and suitable to work with them. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care and support. All potential employees were interviewed by the provider to ensure they were suitable for the role. All new staff were required to undergo a probationary period during which they received regular opportunities for practice supervision.

Nursing and care staff supported people to take their medicines. Storage arrangements for medicines were secure and were in accordance with appropriate guidelines. People we spoke with confirmed they were happy with the way medicines were administered. They told us that it was administered on time and that supplies didn't run out. We observed staff administer medicines to people. Medicine was seen to be administered safely and in line with agreed good practice. Consent for treatment was observed to be obtained prior to administration. Medicines Administration Records (MAR) were up to date, with no gaps or errors, which meant people received the medicines as prescribed. Where people were prescribed when required (PRN) medicines there were protocols for their use.

Staff were able to describe how they would respond in an emergency such as a fire and told us they had regular fire training and had taken part in fire drills in the past year. One care assistant told us that as a result

of their last fire drill they had learnt how important it was to be sure the fire was completely extinguished before stopping the use of the fire extinguisher. From the training records we noted that all staff received regular training in first aid. One member of the care staff told us that when they pressed the emergency bell, for example when they found a person had a fall, "Everyone comes running in a flash." We also noted that the response rate of the nursing and care staff was quick when we applied pressure to a sensor mat in a person's room.

Maintenance records showed that regular safety checks were carried out on both the home environment and the equipment to ensure it was all safe. These included nurse call systems, emergency lighting, fire doors, fire alarms and water temperatures. The maintenance person also carried out visual checks of hoists and wheel chairs every month. Any repairs required to the environment or the equipment were addressed locally or referred to an expert for their attention. Staff told us that they reported any faults in the maintenance book in the front office and these were rectified promptly.

Requires Improvement

Is the service effective?

Our findings

People were positive about living at St Mary's Care Home. People told us that they thought staff had the skills to support them. One person told us, "They're very thorough at their job, yes everything's done well." People or their relatives told us they felt well looked after and enjoyed aspects of the home such as the opportunities for social activities and mealtimes. However, we found the home was not effective in all areas.

The Mental Capacity Act 2005 (MCA) provides the legal framework for making particular decisions on behalf of people who lack capacity to do so 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 capacity to take a particular decision, the decisions made on their behalf must be made in their best interests and as least restrictive as possible.

People can only be deprived of their liberty in order to receive care and treatment when this is in their best interest and legally authorized under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager knew their responsibilities under the MCA and DoLS and we saw evidence that appropriate applications for DoLS had been made to the relevant local authorities. Grounds that were deemed as restrictions in people's care included being unable to leave the home independently and the need for constant supervision by staff were necessary to keep them safe. The registered manager told us that although 41DoLS applications had been submitted and three applications had been authorized they recognised that some applications for other people were outstanding. We have therefore identified this as an area that needs improvement.

When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. In care files we saw that capacity assessments had been undertaken by the registered nurses and best interest decisions were clearly recorded. However, we did not see any documented record that the best interest decisions had been made involving people who knew the person well although the deputy manager did tell us that the person's representative was contacted by phone to discuss their action. We saw evidence that best interest decisions had been made in respect of the provision of assistance with activities and the supervision of medicine but the deputy manager told us that not all best interest decisions were decision specific. All care staff we spoke with had an understanding of the requirements of the MCA and all confirmed that they had completed training on the act.

The home was a purpose built three storey home with its own private gardens. The environment was promoted in the provider's literature. However, we found that further adaptions and adjustments could be made to ensure that people with living with dementia and those that had physical or sensory disabilities could orientate themselves around the building, fully access all areas and therefore retain their independence. There was a general lack of signs to indicate to people the function of a room or to help them to know if they were approaching a particular communal room, corridor or floor. For example, as visitors to the home we found it difficult to identify from outside the function of the room that operated as the shop. The garden itself was locked to people. The registered manager told us that this was to prevent falls in the garden. However, we could not identify risk assessment for people that evaluated the risk of falls

in the garden as a particular risk or other, less restrictive options had been considered. We have therefore identified this as an area that needs improvement.

People were supported to make independent decisions about their care and support. For example, we heard staff ask people for their consent before they carried out any care, waited for a response before they started the task and respected their decision. One care assistant told us, "I always gain people's consent before providing care but if they refuse I accept their decision but consult the nurse and go back later." Staff told us that although some people had difficulty in communicating their wishes verbally, they knew them well and were able to understand their preferred methods of communication. Methods of communication were documented in the care plans we looked at in detail. For example, one plan set out, 'To support [named person] understanding, use short simple sentences and use gestures, demonstrations and objects. Give time for them to process information, may need to repeat. Use a calm, relaxed tone of voice, facial expression and body language. Reduce background noise by turning television down'.

Mealtimes were regarded by people and staff as a social experience, a time to chat and catch up over a shared meal. The dining experience appeared to be positive and the people we sat with over lunch enjoyed their meal and remarked how they liked the food. One person said, "The food is very good generally and the chef takes pride in what he cooks." Another person told us, "You can have whatever you fancy for breakfast, a cooked one every day if you like." They told us they thought there was enough choice and that they liked to sit together and chat at mealtimes. Some people preferred to eat in their room and staff worked hard to make sure their needs, both nutritional and social, were met.

People were provided with a menu on each dining room table. They were asked at the point of service what they would like. People had a choice of main course. Vegetable were served separately so people could decide what and how much they wanted. Condiments were available on the table. One person who lived with dementia was unsure of the choices and was shown the two meals so they could point and choose. Another person didn't want either of the main courses on the menu and was asked what they'd like instead. They chose fish and chips and we saw the request was made to the kitchen and the chef was able to produce the chosen meal.

Some people required special diets and changes to their meal. For example, some people followed a fork mashable diet following guidance set by the Speech and Language Therapist (SALT). The menu was reviewed at mealtimes for these people but everyone was given the opportunity to seek alternatives where they did not want the main option. We saw that staff had a good awareness of who required additional support with their meal. Staff were aware of the importance of good hydration and we observed people with additional needs were supported to access a range of hot and cold drinks. One member of staff explained, "We know people well. One person won't drink from a cup but when we put their fluids in a small glass they take them most of the time."

Staff undertook a range of training to enable them to effectively support people living at the home. Essential training included infection control, moving and handling and fire training. Additional training was undertaken that reflected the needs of people, for example living with dementia. One member of staff said, "The training is really good. We have lots of it and everything you can think of is included in the training programme. The recent training about dementia was very interesting."
In addition, staff were provided with the opportunity to undertake training relevant to their roles. For example, one care assistant told us how they were given the chance to undertake the Gold Standards Framework training programme to support people as they neared the end of life and would be receiving their award at a ceremony in Birmingham shortly. They said, "It has made such a difference to the care we give and we have just achieved 'commend' status. If you want to do something you work for the best result."

Staff spoke positively about the training they undertook. Comments on the training included, "The training here is very good. It is interesting and well conducted by the very good trainer. I am looking forward to doing advanced first aid training next year," and "The training is really well done and you learn a lot. The recent virtual reality dementia training was absolutely fantastic. It opened my eyes and mind and as a result I changed my practice and now speak to people with dementia slowly and clearly." Registered nurse's training was recorded and was valid with renewal dates. Nurse's medicine competency assessment took place at their induction and was subject to regular competency assessment.

New staff completed an induction and underwent a probationary period during which time their practice was monitored and supported. We looked at the records of a staff member's probationary period. This covered all aspects of the new employee's role and had agreed actions in place. Staff told us they felt well supported through the supervision process. One staff member told us, "My last supervision in January was quite useful. We discussed my weaknesses and strong points, any concerns I had and ways to improve and I fed back what I thought." All staff told us they felt well supported in their roles and could approach senior and nursing staff if they needed advice. People and their relatives told us they felt the staff were well trained and able to meet their needs, one relative said, "Staff appear to be skilled and well trained". A healthcare professional commented "Staff are well trained and there is a good level of knowledge about the residents."

People's healthcare needs were met. People were registered with a GP and they were available to visit the home four days per week. Specialist healthcare professionals appointments were arranged to help people stay healthy. The home worked in close partnership with other agencies to meet people's needs. This was confirmed by a healthcare professional who told us, "Staff are always happy to assist and always refer to other agencies." Changes to people's health status were identified and referrals were made in a timely manner to appropriate agencies. Referrals were seen, for example, to the outreach dementia team, the GP and the district nursing team. Each person's care plan contained a separate record of input from outside professionals and the outcome of their intervention.

We observed a staff handover between shifts. Staff arriving for the shift were provided with a clear overview of how people had spent their morning by the senior nurse on duty. It included feedback of what activities people had participated in and included an assessment of their demeanour and any specific health concerns. For example, it was confirmed that a person had seen the GP and apprised staff of the outcome of the visit. Staff used the hand over time constructively to brief themselves of developments and plan their shift together.

Good

Is the service caring?

Our findings

People were treated with respect. Staff demonstrated kindness and compassion when supporting people and were mindful of privacy and dignity. People were very complimentary about the friendliness and professionalism of the staff. One person said, "The staff look after me very well indeed. This is why I'm doing so well at my age," and another commented, "It's very nice here, they are all so caring and helpful." Many people were living with dementia and we observed one person approach a member of staff to tell then they were looking for their brother. The member of the member of staff in a kind and gentle manner gave eye contact, engaged with them about their concern and reassuringly offered a guiding hand to go and "See if they could find out". The person immediately relaxed. They unfolded their arms and happily went with the member of staff. One member of staff told us, "I hope it shows that we really care and do the best we can for everyone". When we spoke to staff they were able to explain to us what people liked and how they liked to be cared for.

The staff were knowledgeable about the care people needed and when they discussed people and their care needs they did so in a respectful and compassionate way. People or for those living with advanced dementia, those that knew them well, were involved in the development of their care plan and these reflected that their differences were respected. Information about the person's life history was included and used to inform staff of people's interests and hobbies. For example, people were able to express their religious beliefs and staff offered support to people to worship, including attending the providers own chapel in the grounds, if this was what the person wished. The care and nursing staff we spoke with knew people well. They were able to talk about their likes and dislikes, their histories, how they liked to spend their time and their preferences, for example in respect of food and drink. One care assistant told us how one person had enjoyed DIY all their life and built their own home and now made it their job to check the rails in the corridors. Another member of staff reflected on the support one person needed to eat and drink and described how they held any cup of fluid they gave them very tightly but would take drinks when offered in a small glass.

Staff were patient and considerate in their approach. We saw that they interacted with people in a warm and friendly manner and staff were observed to have an excellent rapport with people by, for example, using appropriate humour to create a social atmosphere. A health care professional told us, "The Nurses/Health Care Assistants I observe are kind, gentle and very respectful towards the patients." People appeared to enjoy the interaction with staff and it was apparent staff knew people well; they spent time with people talking about their day, asking how they were and what they were going to do that day. For example, for a person seated in a wheelchair, staff got down to their level to gain eye contact when they talked with them. Staff spent time explaining what was on offer, listened to them and responded to their queries. Staff encouraged people to make choices and people were offered choice, for example in respect of food, drink and where to spend their time. There was a keyworker system in operation and staff told us people were supported by a named keyworker. A key worker is a member of staff who co-ordinated aspects of a person's care and had responsibility for working with them to develop a relationship to help and support them in their day to day lives.

People were encouraged to be as independent as possible. One person enjoyed the responsibility of changing all the menus on the tables in the dining room. A care assistant told us how one person was no longer able to use a knife and fork to eat their meals but managed perfectly well with their fingers, thus maintaining their independence safely. Another member of staff said, "We encourage people to do as much as they can for themselves. We encourage rather than help them so they won't lose their motivation."

People's privacy and dignity was maintained and we noted that people were discreetly supported to go to their rooms whenever there was a need to address a matter of their personal care. One member of staff told us, "We maintain people's privacy and dignity. We always knock and only enter when invited as we respect their bedroom is their own space. We keep people as private as possible when providing personal care and we only discuss their personal issues in a private area and keep that information confidential." A relative told us, "I'm absolutely thrilled with [my relatives] care. They are so patient and kind and treat people with great dignity. [My relative] was always very elegant and they always make sure she is presented in the same way even though she is in bed now" Peoples' right to confidentiality was maintained. Staff undertook regular handover meetings to pass on information to other staff coming on shift, we were able to see that these were conducted in a private office to ensure that people couldn't overhear. Peoples electronic care plans were also stored on a computer that was password protected and written records were stored in locked cabinets to ensure that confidentiality was maintained.

Good

Is the service responsive?

Our findings

People and their relatives told us they were happy with the standard of care provided and that it met individual needs. Staff practices reflected person centred care. One person said, "It's all free and easy, no one is telling you what to do" and another person told us, "I get up and go to bed when I want to, I usually have my supper and then get into my pyjamas and settle down for the evening."

Information about people's health and social needs was used to devise individual care plans. They were written on admission and were reviewed with the person when changes had occurred. People's care plans were personalised to each individual. They contained information to assist staff to provide care in a manner which respected their wishes. Care plans contained information about people's past lives, their best means of communication and their likes and dislikes. For example, one person preferred to eat their meals in the dining room in a social setting, in the company of their friends. The care plan identified their assessed needs and set out the actions needed to support them to achieve this preference. In another example, we saw that one person could become agitated when offered their medicine. Staff gave the person appropriate space if they became distressed and only offered them their medicines after some time.

Every person had a, 'grab and go' file for use if they required admission to hospital. These included their admission sheet, the address and telephone number of the home, the Do Not Attempt Resuscitation (DNAR) documentation if completed, their past medical history and a shortened version of their care plans. The deputy manager told us that the up to date Medication Administration Record (MAR) chart was added at the time of transfer and that feedback from healthcare professionals was that these files were very useful when a hospital admission was necessary.

Care was personalised to the individual and included changes to their health. For example, one person's appetite had reduced and they were identified as at risk from malnutrition. Staff had immediately taken action and consulted the GP. Following discussion, they immediately started fortified food and drinks. We also saw that food and fluid intake was recorded and analysed on a daily basis. Staff were therefore responsive to the changes in this person's care and nursing need and the care that was delivered was reflective of their current needs. We were told that when staff noted people showed signs of diminished appetite it was highlighted to staff on handover and food and fluids were encouraged. We saw a handover during which changes to peoples appetite was noted and discussed.

Activity co-ordinators organised a programme of activities for people that included gentle exercises, arts and crafts, film nights and outside entertainers. They also carried out one-to-one sessions with people. They used this time to reach out to people whose dementia was advanced or those who declined to join in organised group activities. One person said, "I don't have dementia like many of the rest of them and I am quite a private person so I tend to stay in my room as there isn't anyone I can have any meaningful conversation with and I suffer from anxiety." Examples of one-to-one time included simply chatting, going for a walk in the grounds or giving a manicure. The relative of one person said, "[My Relative] is in bed all the time now. I know they come in at least every two hours and they also give head massages and hand massages and they don't even charge for it. Sister is very attached to [my relative] and comes in to pray with

them." An activity co-ordinator was also employed during the evening so that people had meaningful activity throughout their day. An activity co-ordinator we spoke with told us that the activities programme was flexible and depended on the needs of the individual. For example, on the day of our inspection they planned to accompany a person to the nearest town to obtain a passport photograph. Later on they planned to go to the farm within the provider's grounds to see the new-born spring lambs which the farmer had let the home know had been delivered earlier that day. In addition, people could visit the hairdresser who opened their salon in the home for two sessions a week and there was a shop where people could purchase small personal items. One person told us how much they enjoyed sitting at their window with their binoculars looking at the wildlife in the grounds and said, "I love this room and I love to look out at the ducks on the pond and see what they are doing". A member of staff told us, "There's always something going on and the activity staff are always thinking of new ideas".

The provider and registered manager took into account the views of people. There were regular resident meetings and records of the discussion that occurred. A person told us, "Yes, they have them regularly for us and you can bring up anything. I mentioned the food should be served hotter and it's getting better." A relative said, "Have a look at the suggestions box, you can let them know anything you want to." The provider had recently held a 'listening week' during which they were available in the home to meet with people, their relatives and representatives and hear about their experience of care as they provided it. People and their relatives were also given the option to provide written feedback, anonymously if they preferred. They were asked about what they thought were good things about the home but also what they could do better. The information that was captured was collated and the results were shared with people. The registered manager told us that if anything was raised that required a response, it was identified. Feedback consistently identified key themes that included supportive and caring staff, a clean and comfortable environment, good communication that kept people updated, nutritious tasty meals and social activities provided. The provider demonstrated that they were working on the issues that were identified to change. For example, one comment came back that noted the lack of access to the garden. On the day of our visit a team of specialist dementia care consultants together with the provider were surveying the garden to make it accessible to all people in the home. One relative commented, "I think they're hoping to improve. Sister [provider] went to a seminar where they heard about the benefits of residents getting fresh air so I think that's why they're getting the garden done."

People and their relatives said that they would be very comfortable to raise a complaint or concern and most said that they would raise this with the registered manager, who they knew was available to them. People confirmed they felt comfortable approaching nursing and care staff with any concerns. A person said, "It's very good, excellent. They advise you and always tell you what's going on. I'm very happy here, I've no complaints but if I did I could talk to any of them." A relative told us their experience, "The communication is very good. They even contact you with positive news not just when [my relative] isn't well. They contacted me to let me know they were sitting up and drinking again." A copy of the complaints policy was provided to people when they moved into the home. A complaints record gave details of the complaints received and the outcome for each. Staff told us they weren't aware of any complaints but if people or their relatives expressed any concerns they would tell the nurse in charge who they were confident would take the appropriate action.

Good

Is the service well-led?

Our findings

People and their relatives were complimentary about the home and everyone we spoke with said it was a friendly and welcoming home, where visitors could call in at any time. People, their relatives and staff commented on the leadership the registered manager provided. All staff we spoke with told us that St Mary's Care Home was a good place to work. One staff member said, "I am happy working here. No one day is the same and you never know what challenges you may face but we always have help and I like to think we make a difference." A person said, "The manager is a lovely, lovely nurse, very professional, helpful, approachable, treats everyone fairly and both residents and staff can talk to her about any concerns."

The provider's culture and values were embedded through the staff probationary period and ongoing training in the everyday nursing and care practice in the home. All staff; nursing, care and ancillary we spoke with understood the vision of the home and were continuously striving to improve. Staff spoke positively of how they all worked together as a team. They said they had regular staff meetings and the provider and registered manager listened to any suggestions for improvement they made. For example, a care assistant told us the registered manager had adopted their idea to have a single member of staff identified to complete people's food and fluid charts at meal times. This had replaced a previous system where each carer had done their own recording. The system change had been reviewed and was seen to work. Staff commented on the team, one said, "We work very well together as a team," and another told us, "Team work is usually top notch and everyone communicates well".

A staff member described the strengths of the home in the following way, "In this home we strive to give good care, the staff are well trained and we work well as a team. Management does its best to keep staffing levels high and doing the Gold Standards Framework has benefitted everyone and promoted end of life care". A relative said, "There is a nice atmosphere here. The staff and management are nice and caring and concentrate on the residents. There is a good standard of cleaning and the maintenance man is on to any job straight away." A relative told us, "The best thing about the home is its surroundings and you can't fault the quality of care which is provided by a dedicated team of carers".

Quality assurance systems were in place. The provider had systems and processes in place to monitor the quality of the service. Audits were undertaken internally by the registered manager. The provider was a regular visitor to the home and managers from the providers other locations visited each other's locations to bring a fresh perspective to the practice within each home. This demonstrated an openness to share best practice and to improve the care and treatment for people. Audits were robust and focused on standards. They showed how the provider monitored the quality of the service and picked up areas that needed improvement. Care plan audits identified that people's specific health needs were accurately reflected in in care documentation. For example, improvements had been made to updating peoples care plans. The registered manager used the audits to identify issues and worked through them to further improve the care and treatment people received.

The registered manager was aware of their reporting responsibilities to the Care Quality Commission about incidents such as safeguarding issues and had sent in notification to CQC as appropriate. The registered

manager explained how they met their CQC registration requirements. They explained the process for submitting statutory notifications to the CQC to ensure that they were sent in a timely manner. This meant we had the most up to date information available about incidents that had occurred. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered manager was able to describe unintentional and unexpected scenarios that may lead to a person experiencing harm and was confident about the steps to be taken, including producing a written notification. They were able to demonstrate the steps they would take including providing support, truthful information and an apology if things had gone wrong.