County Healthcare Limited

St Mary's Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 27 September 2017 and 2 October 2017 and was unannounced.

St Mary's Care Home provides residential care for up to 44 people, some of whom may be living with dementia. At the time of this inspection there were 34 people living in the home.

Accommodation is over one floor and the home has a number of communal areas available to those living there as well as an accessible garden.

Whilst there was a manager registered with the Care Quality Commission (CQC) to manage this service at the time of this inspection, they were no longer working at the home. 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. There was also no deputy manager in post at the time of this inspection and, on our first inspection visit, a senior care assistant was managing the home. An interim manager was in situ at our second inspection visit.

We last inspected this service in February 2017 where we found the provider had failed to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the February 2017 inspection, we found three breaches to the regulations. These breaches related to safe care and treatment, the need for consent and good governance.

We served requirement notices in relation to the need for consent and good governance. The provider sent us a plan to tell us about the actions they were going to take to rectify these breaches. They told us these would be completed by May 2017. In response to the breach to safe care and treatment, we took enforcement action against the provider in order to help drive improvement. We imposed conditions on their registration in relation to the management of medicines. This meant the provider had to submit records to the CQC, on a monthly basis, to demonstrate they were taking actions to rectify and improve medicines management. These had been submitted as required.

At this inspection, carried out in September and October 2017, we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service continued to be in breach of safe care and treatment and good governance. In addition, the service had failed to safeguard people from abuse and improper treatment, to employ fit and proper persons and notify the CQC of reportable events that affect people's safety.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The provider had failed to have effective systems in place to ensure a consistently caring, effective and safe service had been delivered. This failure had been evident since the provider first breached regulations to the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in September 2014. The provider has been consistently non-compliant since this date and continues to be so.

On our first inspection visit, there was no management team in place to manage the day to day running of the service. The provider had placed the responsibility of this onto a senior care assistant who was also expected to work their normal role. This had put strain on the service particularly as the home was also working with less staff than the provider deemed appropriate to provide a service. At our second inspection visit, an interim manager was in place.

Full information and checks had not been sought on all employed staff in order for the provider to fully assess their suitability to work with those that used the service. This had put those who lived at the service at risk. Furthermore, the provider had failed to fully assess, analyse, manage and mitigate the individual risks to those living at St Mary's Care Home. This had put them, and others, at risk of harm.

Incidents that had affected the safety of those using the service had not been reported to the local authority safeguarding team. The provider had also failed to report them to the CQC as required by law. This meant people were not fully protected and we could not be sure all preventable actions had been taken.

Care plans were not consistently accurate nor did they contain enough information in order for people to receive the care and treatment they needed. Whilst permanent staff knew the needs, preferences and likes of those that used the service, the service was using agency staff to fill gaps in the rotas. Not having enough accurate written information in relation to people's needs put them at risk of not receiving the care they required.

Staff worked well as a team and the culture had improved. However, staff did not feel supported by the provider and were disheartened by the service's unstable management history. They told us they were not consulted in relation to changes. Staff had, however, received training in order for them to meet the needs of those people who used the service.

Staff demonstrated a caring and kind approach and offered people choice. However, people's dignity was not always maintained. Confidentiality was compromised at times.

Most people's nutritional needs were met and they told us they enjoyed the food served. However, improvements were required in relation to the dining experience. We saw that dirty crockery remained in the dining room all morning and that information wasn't readily available to people in regards to the food available.

People had mixed opinions in relation to the amount of stimulation and activities they received. Whilst most people enjoyed them, some felt there weren't enough and that they lacked the opportunity to get out away from the home.

Access to a variety of healthcare professionals was available to people and we saw that prompt and appropriate referrals had been made as required. A GP delivered a weekly visit to the service and also provided treatment as required.

The risks associated with the building and environment had been identified and managed. Regular maintenance and servicing had taken place on equipment and checks were carried out as a preventative measure.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. Improvements were identified in the service's adherence to the MCA and people's human rights were respected.

Improvements were also identified in relation to medicines management and administration although further development is still required.

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.

The individual risks to people had not been fully assessed, managed or recorded.

Incidents that had put people at risk of harm had not been reported and recorded as required.

Improvements had been made in relation to how the service managed and administered people's medicines although further improvement is still required.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements had been made in the service's adherence to the Mental Capacity Act 2005 (MCA). However, the service needs to further demonstrate that full support has been given to people when making decisions.

Staff had been trained and received an induction when they first started in post. However, they told us that they did not consistently feel supported by the management team.

People's nutritional needs were mostly met and they had choice in what they had to eat and drink. However, further improvements are required to enhance the dining experience for people.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always support people to maintain their dignity and confidentiality was compromised at times.

The service could not demonstrate that they had given those people that used the service the opportunity to regularly and formally review the service they received.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Although permanent staff knew the people who used the service well, care plans did not consistently contain enough information in order for people to receive a person centred service.

People had mixed opinions on the provision of activities. Some felt there were not enough and did not give them the opportunity to get out into the community.

The service had a complaints policy in place however the majority of those people we spoke with told us they had not had cause to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

The service has been consistently non-compliant with the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 since September 2014.

The system the provider had in place to assess, monitor and improve the service had failed to ensure an effective, compassionate and safe service had been delivered since September 2014.

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. 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 September and 2 October 2017 and was unannounced. Two inspectors, one medicines inspector and an expert by experience carried out the first day of inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of inspection was carried out by one inspector.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us since our last inspection carried out in February 2017. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also contacted the local authority safeguarding team, the local authority quality assurance team and five healthcare professionals for their views on the service.

During our inspection we spoke with eight people who used the service, five relatives and one healthcare professional. We also spoke with the interim manager, a covering deputy manager, the resident experience regional manager, regional manager, administrator, two senior care assistants, two care assistants and one cook. We observed care and support being provided to the people who used the service on both days.

We viewed the care records for 11 people who used the service and a number of medicine administration records and associated documents. We also looked at records in relation to the management of the home. These included risk assessments, staff recruitment documents, staff training records, quality monitoring information and maintenance records.

Requires Improvement

Is the service safe?

Our findings

At our inspection carried out in February 2017, we found that the service had failed to consistently identify, record or mitigate the risks to people who used the service. In addition, the service had failed to mitigate the risks associated with medicines administration and management. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service has consistently been in breach of Regulation 12 since November 2015 following the completion of three comprehensive inspections. At this inspection, carried out in September and October 2017, we found that the necessary improvements had not been made in all areas and that the provider is in breach of this regulation for a fourth consecutive time.

The risks to people, and others, had not been fully assessed, mitigated or managed which had put people at risk of harm. During our first inspection visit, a person who used the service, and a staff member, were hurt following the escalating behaviour of another person who used the service. The potential risks associated with this person's mental health and associated behaviour had been identified by the service but not fully mitigated. For example, following this incident, the service had not taken all actions required in order to mitigate the continuing risk of harm until we raised this as a concern. Whilst we saw that the service then increased the direct supervision this person received, we could not be confident that, had we not raised this as a concern, the service would have taken this action. Furthermore we saw that this level of supervision had not been continuously provided to the person between our inspection visits even though the risk level remained the same.

In addition, the person's care plan gave staff little information on how they could support the person in relation to their mental health and therefore mitigate the risk of behaviour that may challenge or cause harm. Whilst professional intervention had been sought, the care plan had not been updated following this incident or with the recommendations made by professionals.

A number of people we spoke with who used the service told us they felt frightened as this person entered their rooms. One person told us they felt, 'Terrified' of this person. One staff member also raised concerns and told us there were not enough staff to adequately and safely manage the needs of this person.

For another person who had experienced high levels of distress and anger, this had resulted in four incidents over a three week period that had put themselves, and others, at risk of severe harm. These incidents had not been reported as per policy within the organisation and senior managers were not aware of their occurrence. Nor had these incidents been reported to the local authority safeguarding team. No reviews had taken place after each incident and the risk had not been assessed or mitigated to help protect people from harm. The person's care plan was blank and gave staff no guidance in respect of the associated needs and how to support the person.

The provider had an electronic system in place to record, analyse and assess accidents and incidents which the senior management team had access to. However, we saw that the above incidents had not been

recorded onto the system. This meant they could not be fully assessed in order to prevent future occurrences or harm and that the system had failed to manage and mitigate risk.

For a third person we saw that the care plan did not give consistently accurate information in relation to the type of diet a person required in order to mitigate the risk of choking and aspiration. Aspiration occurs when something, such as a small piece of food, is accidentally inhaled into the lungs causing irritation, damage or infection. When we discussed this with staff and management they were not clear regarding what type of diet the person required in order to mitigate the risks. The service could not produce documents that demonstrated what recommendations the speech and language therapist had made in relation to dietary requirements. When this information was requested and received by the service, during our inspection, it showed that the person required a soft diet. However, during our inspection, we had observed the person having a normal textured diet. Furthermore, on discussion with the cook, they had informed us that the person required a normal diet. This had put the person at an increased risk of choking and aspiration.

These concerns constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the personnel records for three recently employed staff members. This was to assess whether the service had mitigated the risks associated with employing staff not suitable to work with vulnerable older people. For two of these staff members we saw that processes had not been followed in order to mitigate these risks. Whilst one staff member had a completed Disclosure and Barring Service check in place, the provider had failed to request information in relation to the associated barred list. This contains the names of individuals who pose a substantial risk to vulnerable adults. For a second staff member, the service had failed to fully explore the person's full working history including their most recent employment.

Whilst there was no evidence that these staff members posed a risk to those that used the service, the provider had failed to do all that was reasonably practicable to mitigate the associated recruitment risks.

These concerns constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training in safeguarding adults and could explain how to protect, identify and report potential abuse. However, we found a number of incidents that had not been reported to either the service's management or the local authority safeguarding team. The delay in reporting the incidents meant people had not been fully protected and any required preventative measures could not be taken in a timely manner. Therefore, we could not be confident that the provider's procedures for safeguarding people were effective.

These concerns constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our last inspection in February 2017, we took enforcement action against the provider in order to help drive improvement. We imposed conditions on their registration in relation to the management of medicines. This meant the provider had to submit records to the CQC, on a monthly basis, to demonstrate they were taking actions to rectify and improve medicines management. These had been submitted as required.

During this inspection, carried out in September and October 2017, a member of the CQC medicines team looked at how information and records supported the safe handling of medicines. We saw that

improvements had been made and that the service was no longer in breach of this regulation in relation to medicines management. However, further improvements were required in order to ensure the consistently safe management of medicines.
Records did not always confirm that people living in the care home were receiving their medicines as prescribed. Administration of medicines was recorded on medication administration record (MAR) charts which were provided by the pharmacy. There were six omissions in 16 administration records that were examined during our inspection. MAR charts hadn't been signed for the administration of these medicines although they were available and suitable for use. Medicines were not always recorded when they were administered. In one case a morphine based analgesic had been given twice according to the controlled drug Register but it was only recorded on the MAR chart once. Controlled drugs are medicines that require additional controls because of their potential for abuse and are required to be stored safely, securely and records kept of their use. The controlled drug cabinet should only store controlled drugs but we found other medicines stored inside.
Handwritten additions or changes to the MAR charts had been signed and checked by a second member of staff. If there was a choice of how much medicine to give, such as a variable dose of laxative, the records showed what had been administered.

During medicine administration the member of staff was wearing a red tabard which identifies to other people not to interrupt them. However, they were carrying a telephone which caused interruptions and this had the potential to lead to errors.

Medicines were stored in two trolleys which when not in use were stored safely in the treatment room. The temperature of the treatment room and the refrigerator were being monitored and were within the recommended range.

In most cases there was a photograph of people for identification purposes, although in two cases it was missing. The information about people's allergies was conflicting. In four cases people had been recorded as having allergies to medicines including penicillin allergy but this was not recorded on their MAR chart. This could lead to people receiving medicines they are allergic to.

In most cases protocols for the administration of 'as required' medicines were available. These protocols provide guidance as to when it is appropriate to administer medicines that are not required regularly such as laxatives or eye drops. In one case however, one person was prescribed a sedative for agitation but there was no protocol to guide staff to when this would be appropriate.

Medicines that were applied as patches were recorded on charts but the rotation of the patches was not always appropriate. One type of patch needs to be rotated to a different site each week and not applied to the same site for 3 weeks, this was not always happening.

There were records for medicines being applied topically such as creams and ointments and a locked cupboard in people's bathrooms to store their creams. There were some gaps in the administration records.

Medicine incidents were being reported and audits were taking place of medicines administration records. Improvements had been identified over the last four months by the home manager. One audit done by the senior carers was completed on a weekly basis however this did not allow omissions in the records of MAR charts to be actioned immediately.

The people we spoke with who used the service told us they generally felt safe living at St Mary's Care Home although a number told us they currently felt frightened of one person who used the service as described

above.

People varied in their opinion of how quickly staff assisted them or reacted when they used their call bell. However, no one described having to wait for long periods of time and this was witnessed during our two inspection visits. Staff agreed that call bells were being answered in an appropriate amount of time. One staff member attributed this to, "A change in culture." Another told us, "Call bells are seen to as soon as they ring." However, we did observe one person having to wait longer than they wished for assistance out of the dining room following the completion of their breakfast. They told us, "I've been asking to leave all morning." A staff member assisted the person shortly afterwards. Since our last inspection in February 2017, the service had installed a new call bell system which had proved more effective.

The risks relating to the building, environment and equipment had been identified, reviewed and managed. Regular servicing, maintenance and visual checks had taken place and this included in relation to the risk of fire. One person who had recently moved into the home did not have a personal emergency evacuation plan in place and this was raised with the management team.

Requires Improvement

Is the service effective?

Our findings

At our inspection carried out in February 2017, we found that the service had failed to consistently adhere to the Mental Capacity Act 2005 (MCA) This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection in February 2017, an action plan was sent by the provider which detailed how the service would meet their legal requirements. They told us these actions would be completed by 20 May 2017. At this inspection, carried out in September and October 2017, we found that some improvements had been made and that the service was no longer in breach of this regulation. However, further improvements are required in order to evidence complete adherence to the MCA.

The 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 Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's capacity to make specific decisions had been assessed and recorded in accordance with the MCA. However, records did not always demonstrate that the service had fully supported people to make decisions themselves. For example, for one person, we saw that the information provided in regards to the decision to be made was only made available to them in verbal form. Other formats may not have been appropriate however the rationale for this had not been recorded or explored. We also noted that staff only made one attempt at discussing the decision with the person. However, we did see that consideration had been made in relation to the time of day, environment and how the person was feeling in order to give them the best opportunity to contribute to the decision making process. Any decisions made in a person's best interests had been recorded in their care plan and we saw that other professionals had been consulted in relation to these.

Although the rationale for the application was not always clearly recorded, appropriate DoLS had been submitted for consideration. None had been authorised at the time of this inspection.

The people who used the service told us that staff gave them choice and always considered their wishes. They told us that staff asked for their consent before assisting them.

The people we spoke with who used the service told us that they had confidence in the skills and abilities of the permanent staff that supported them. The service was currently using agency staff to fill gaps in the rota

and the people we spoke with told us that these staff were not so good. However, people, and most of their relatives, said the permanent staff demonstrated the attributes required to effectively support them.

One person who used the service said, "They [the service] have got some good staff now who know what they are doing." Another person told us, "I think some of the staff are well trained but the agency staff sometimes are not so good." One relative we spoke with said, "I think the staff we see do know what they are doing which gives us confidence." A healthcare professional told us that the senior staff knew the needs of the people who used the service well and that they had the skills to meet these.

Staff told us they had received training and, for a newer staff member, an effective induction. They told us this consisted of a number of shifts shadowing a more experienced staff member, reading care plans and speaking with people who used the service in order to get to know them. They told us the induction they received had prepared them for their role. Records showed that the compliance rate for staff training was high and covered subjects that would help staff meet the needs of those that used the service.

Staff did not always feel supported in their role. At the time of this inspection, the service had, in the previous few days, lost both the deputy manager and registered manager. This had impacted on the support the staff had received and we found, on our first unannounced inspection visit, one senior care assistant managing the home whilst also working their normal shift. This included medicines administration, managing staff and ensuring the health and wellbeing of those that used the service. This had put strain on the senior care assistant's capacity to effectively perform their role.

The people we spoke with who used the service spoke positively about the food served. They told us they enjoyed the taste, that they received choice and that the quantities were right for them. One person said, "The food is very nice here and there is a good choice throughout the week." Another person told us, "The food is very good here and I really enjoy it." A third person told us they had a full English breakfast every day of the week which they, "Really enjoyed."

We observed lunch being served on one of our inspection visits. People had choice in what they wished to eat and drink and we saw that people received the support they needed. For one person, they received dedicated support by a staff member who engaged in cheery conversation throughout.

However, we observed aspects of the dining experience that required improvement. Whilst there was a three week menu on display, there was no indication of what week's menu was currently being served so people could not easily see what was being served that day. In addition, we saw that dirty crockery and cutlery from breakfast, covered in food debris, sat on the dining room tables from our arrival at 9.30am to when staff cleared it away prior to serving lunch at 12.10pm. This did not contribute to a pleasant experience for people not only at lunchtime but should they have wished to use the dining room throughout the morning.

With the exception of one person, we saw that people's nutritional needs were met in regards to specialist diets. For those we looked at, we saw that people's records demonstrated that the risks around their nutritional needs had been managed and met.

People had access to a wide variety of healthcare professionals in order to help them remain healthy and well. Those people we spoke with who used the service told us they saw healthcare professionals as needed such as district nurses, GPs and chiropodist. They told us the service was quick to arrange this. One person who used the service told us, "I know the district nurses come in on a regular basis and I need to see a doctor then that will happen fairly quickly. I can also see the chiropodist when I need my feet doing." One relative we spoke with said, "[Relative] has good access to the doctor and when they needed to see one

recently, they came very quickly."

One healthcare professional who gave us feedback prior to our inspection visits told us that the care of residents had improved under the most recent manager. Another healthcare professional explained that the service was, "Proactive" in providing end of life care and that their recommendations were followed in relation to treatment. This healthcare professional told us staff knew the needs of the people who used the service and made time for their visits in order for the communication of information.

Requires Improvement

Is the service caring?

Our findings

The people who used the service told us that staff assisted them in a caring and polite manner but that they were always busy. One person said, "The staff are caring. Everybody is kind to everybody else. They speak nicely to you but they all seem very busy." Another person told us, "The staff are caring enough but there are not enough of them. They never have time to spend with you. They are polite enough when they speak with you; there is just no time to spare."

The relatives we spoke with agreed that staff were courteous and welcoming. One said, "The staff here are very caring. Nothing is too much trouble for them and they make you feel welcome when you come to visit" Another told us, "There are lovely staff here and all very caring. They are all very polite and are pleasant in their manner and do things with a smile." A third relative agreed that staff were polite and worked to their best ability but that the lack of time they had to interact with their family member concerned them. They explained that this was because the lack of stimulation frustrated their family member.

During our visit we consistently saw that staff were caring and kind in their interactions with the people who used the service. However, we saw examples where staff had not considered the impact of their actions on people's dignity. For example, we saw one person repeatedly slumped over the arm of a chair and, on one occasion, with their glasses hanging off. We saw that staff either walked past the person in this position or were in the same communal area as them but failed to assist them into a more comfortable and dignified position. On another occasion we saw a staff member place a person using a wheelchair directly in front of another person sitting in a lounge chair.

When we arrived for our first inspection visit we saw that people who used the service were clustered together in the foyer area. This appeared to be in order to have their medicines administered to them or waiting for assistance to enter the dining room for breakfast. Whatever the cause, we saw that people were cramped and placed in front of each other in their wheelchairs or specialist chairs and that it was not dignified for them.

When we spoke with staff they demonstrated that they understood the needs and wishes of the people they supported. The people who used the service, when we discussed this with them, confirmed that staff understood how to support them in the way they liked. One staff member told us how best to support a person when they became distressed or upset. A person who used the service told us, "Staff know what I like and what I don't like." Another said, "Staff know how I like things done. I have nothing to complain about; I am happy with what I get."

We saw that care and support was delivered discreetly and that people's privacy was maintained. For example, we saw that care was delivered behind closed doors and there were areas for people to go if they required some privacy. We saw that consultations with a healthcare professional were undertaken in private. However, whilst a central staff desk in a communal area made staff more approachable and accessible, this did compromise people's confidentiality. For example, we witnessed a number of occasions where people's care plans were left open and unattended on the top of this desk. Whilst we saw no staff

discussing personal issues relating to the care and support people needed in communal areas, we did see a staff member discuss a person's needs on the telephone in a communal area. We raised the concerns we had around maintaining people's confidentiality with the management team at the time of our inspection.

The people we spoke with who used the service told us that staff involved them in the care and support they received on a day to day basis. However, they were not able to tell us of a time when they had formally reviewed this with the service. One person who used the service told us, "Nobody has asked me what I think about the care I get." Furthermore, the care plans we viewed did not consistently show that people had been involved in the planning of the support they received. For example, care plans were not signed by those they referred to nor did they record how the information had been collated and agreed upon. Whilst people were consulted on a day to day basis, we could not be confident that people had the opportunity to regularly and formally review the service they received.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with who used the service told us they were happy with the service they received and that it met their needs. They told us staff knew their likes, wishes and needs well. One person who used the service said, "Staff always try to make sure I get what I want." Another told us, "I think they [staff] do know what I like and what I don't like and try to make sure that is what I get." Of the five relatives we spoke with, all except one agreed that their family member received the care and support they needed.

We viewed the care and support records for 11 people who used the service. This was to see whether the service had identified, assessed and reviewed people's needs in a person centred manner. We also looked to see whether care plans contained enough information for staff to deliver an individual, effective and safe service to those living in St Mary's Care Home. Care plans should build a history of the care, support and treatment people receive and we checked to see whether this was in place.

The care plans we viewed were variable in the information they contained although most were accurate, individual to people and had been regularly reviewed. Some, however, lacked information to meet people's needs and contained little person centred information. However, on discussion with permanent staff, it was clear they knew people, their needs, likes and preferences well.

For one person who had been admitted a few weeks prior to our inspection, we saw that their care plan contained little information and, in some areas, no information at all in relation to their needs. However, when we discussed this person with the staff that provided care and support, they had an understanding of the person's needs and the way in which support was required. An assessment of their needs had been undertaken prior to them moving into the home and this was available to staff. However, at the time of this inspection, the service was relying heavily on agency staff. Not having written information in relation to the needs and preferences of people posed a risk that they would not receive appropriate care and support, particularly when agency staff were in use. For two further people their care plans contained no information in relation to a specific healthcare need. We brought this to the attention of the management team. On our second inspection visit, we saw that care plans were in place in relation to these three people and their specific needs.

For another person, their care plan and associated records did not allow us to track what care and treatment they had received following periods of illness that had resulted in hospital admissions. The person's care plan did not clearly and accurately record when the hospital admissions had occurred, for what reason, what the recommendations had been and the required changes to the care and support needed. Not all hospital discharge information could be produced which meant we could not be sure the person was receiving the appropriate care and support. This was discussed with the service at the time of our inspection who told us they would seek the required information and make changes to the care plan as necessary.

Out of the five people who used the service who we spoke with regarding the activities provision, all except one told us they enjoyed the activities provided by the service. However, three of these people felt there

were not enough and one person told us they were not specific to their likes and interests. One person told us, "We don't get any visits out which is a shame as a change of scenery would do us good. I join in the activities but they're nothing special." Another person said, "I don't get out and we are doing painting this morning but there are no real activities on Saturdays or Sundays." A third person explained, "I would like a little more to do during the day."

We saw that the service employed a staff member whose role it was to arrange and deliver activities and that these were provided five days a week. Activities took place during our inspection and we saw that the responsible staff member encouraged and supported people to engage in these. However, with the exception of this staff member, we saw that other staff did not have time to spend with people as they were seen as being consistently busy throughout our inspection.

Most of the people we spoke with told us they had no reason to complain. One person said, "I can't think of a reason to complain; everything is fine for me." Another person said, "I have nothing to complain about. I am happy with what I get." The one person we spoke with who had had reason to complain since our last inspection, told us the registered manager, at the time, had listened and responded appropriately. We saw that the service had processes in place to manage any concerns or complaints people may have. A copy of the complaints policy was on display within the foyer of the home.

Inadequate

Is the service well-led?

Our findings

This service has been consistently non-compliant with the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 since September 2014. This inspection found the service in breach of Regulation 17 for the fifth consecutive inspection and Regulation 12 for the fourth consecutive comprehensive inspection. The service has also had other breaches of the regulations, at every comprehensive inspection, since September 2014. The service's compliance history shows that, following inspections, whilst improvements had been made in some areas, it had often been at the detriment of others. The provider has consistently failed to demonstrate sustained improvement, in all areas of the service, since September 2014.

In addition, the service has had an unstable management team and has seen a number of registered managers, interim managers and deputy managers since September 2014. At the time of this inspection, although a registered manager had registered with the Care Quality Commission to manage the service, they were no longer working at the home. The deputy manager had left their post the week before this inspection. On the first day of our inspection visit, there was neither a manager nor a deputy manager in situ and the home was being run by a senior care assistant whilst simultaneously trying to undertake their senior role. Senior managers arrived later in the day. This had put both the service, and its staff, under considerable strain. On our second inspection visit, an interim manager was in situ.

The instability of the management team had contributed to the poor performance of the service. This, together with the service's three year history of non-compliance, demonstrated that the system the provider had in place to assess, monitor and improve services had failed to be effective. The provider's governance of St Mary's Care Home had failed to ensure that a good quality, effective and safe service had been consistently delivered despite management team changes.

The concerns found at this inspection had not been identified by the provider and actions had not been taken to rectify them. Whilst an electronic system had been in place to record and analyse incidents and accidents, those referred to in this report had not been inputted onto the system. This meant that no manager above that of senior care assistants were aware of them and therefore they had not been appropriately analysed and assessed. Consideration had not been made to the fact there was no longer any manager within the service and that incidents ran the risk of not being properly reported and responded to. We saw from the paper copies of the incident forms that staff at the home had attempted to report them to the on call manager at the time but that they had received no response. This was brought to the attention of the management team at the time of this inspection who informed us issues with the on call rota had been rectified.

The provider's monitoring system instructed that at least one care plan audit be carried out each week for the purpose of quality assurance. We asked for copies of those completed leading up to our inspection which were provided. We saw that the number of care plan audits had not been completed as specified by the provider's quality monitoring system. We also noted that an audit had been completed on a care plan we viewed on inspection and that the omissions we had found had not been identified by the audit. We

found that the system the provider had in place to audit care plans had not been effective at ensuring their accuracy and completion.

A senior manager attended the location once a month to carry out an audit of the home and the service it delivered. Following our inspection visits, we were provided with those that had been completed in July and August 2017. The one for September 2017 had been carried out between our two inspection visits carried out on 27 September 2017 and 2 October 2017. We saw from those carried out in July and August that they too had failed to identify and rectify the issues found at this inspection. For example, the senior manager's audit requests that they check whether two care plans have been reviewed correctly. For the July 2017 report, we saw that the senior manager had checked the care plan that both the home had audited in August 2017 and that we had viewed on inspection. The senior manager's audit had also failed to identify that the care plan did not contain adequate information in order for the person to have their needs met in relation to a specific healthcare need.

However, a number of issues had been identified during the senior manager's audit carried out between our two inspection visits. Whilst the audits for July and August had recorded a compliance rate of 90% for the service, the audit carried out in September during our inspection had identified this as being only 55%. Issues identified included care plans not completed in line with the provider's policy, a lack of understanding around meeting nutritional needs and managing associated risks and gaps in documentation. We were not provided with any information or action plan on how the service intended to address these issues.

The provider had also failed to have an effective system in place to ensure appropriate recruitment processes had been followed. They had failed to identify that, for two recently employed staff members, not all checks and information had been gathered in order for them to be able to fully assess the suitability of the staff member. This had put those that used the service at risk of receiving care and support from staff not suitable to work in the service.

These concerns constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we became aware of a number of significant events that had taken place that had affected people's safety and that had not been reported to us by the provider. This is required by law.

This constituted a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

The people we spoke with who used the service told us it caused them concern that the registered manager had left. They told us this was because the registered manager had made improvements in the home and had time for them. One person said the registered manager, "Got things done." Staff also raised concerns about the instability of the management team within the home and the lack of support and reassurance received over its imminent future. One staff member told us that the provider made them feel responsible for the failures within the home and that they had lost all faith in the them. They said, "I don't know who to believe anymore."

Whilst staff described a staff team that was strong, motivated and supportive of each other, they felt disillusioned by the management of the home and senior management team. One staff member told us they had not felt supported for a long time. They told us they felt, "Let down, upset, angry, deflated." Another staff member described it as a, "Kick in the teeth" when they were not consulted about changes made by an

often changing management team.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of reportable incidents which occurred whilst a service provided a regulated activity. Regulation 18 (1)

The enforcement action we took:

An NoP was issued to impose positive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risk to service users and do all that is reasonably practicable to mitigate such risks. Regulation 12 (1) and (2)(a)(b)

The enforcement action we took:

An NoP was issued to prevent further admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's systems and processes to protect people from abuse and improper treatment had failed. Regulation 13 (1) (2) and (3)

The enforcement action we took:

An NoP was issued to impose positive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to implement effective systems to assess, monitor and improve the quality of the service.

	Regulation 17 (1) and (2)(a)(b)(c)(d)(f)

The enforcement action we took:

An NoP was issued to impose positive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to implement robust recruitment procedures and undertake relevant checks. Regulation 19 (1)(a)(b) and (2)

The enforcement action we took:

An NoP was issued to impose positive conditions.