Mr & Mrs H J Medland

St Anne's Residential Home

Inspection report

Whitstone
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Ratings

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

Overall summary

This was an unannounced inspection on 17 March 2015 and 19 March 2015. St Anne's Residential Home provides accommodation for up to 36 older people who require support in their later life or are living with dementia. There were 26 people living at the home at the time of our inspection. The home is on two floors, with access to the upper floors via a passenger lift, chair lifts, or wheel chair lift. All bedrooms have en-suite facilities which have a toilet and wash basin. There are shared bathrooms, shower facilities and toilets. Communal areas include four sitting areas, a conservatory and a dining room. The home is in a rural location, with country views and outside courtyard space.

At our last inspection in July 2014 we told the provider to take action to make improvements to how they respected and involved people, how the quality of the service was monitored and how records relating to people's care were documented. The provider sent us an action plan on 25 August 2014 confirming how improvements were going to

Summary of findings

be made, and advising us that these improvements would be completed by October 2014. During this inspection we looked to see if these improvements had been made. We found they had not all been completed.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People told us there were not always sufficient numbers of staff to meet their needs. We found staff did not always have time to speak with people, which meant people were not always treated with consideration, respect and dignity. We heard call bells ringing for 15 minutes and over before staff went to assist people. People's comments about the staff were variable; some people told us staff were kind and caring, whilst others felt differently.

Staff received training and supervision to carry out their role, and staff told us they felt supported by the registered manager. Staff were able to explain what action they would take if they suspected abuse was taking place. People were protected by safe recruitment procedures as all employees were subject to necessary checks which determined they were suitable to work with vulnerable people. People told us, if they had any concerns or complaints, they would speak with the registered manager, staff or their relatives. There was a complaints policy which outlined the procedure which was to be followed. However, the registered manager told us that complaints and concerns were not always written down, but dealt with at the time. This meant we were unable to review how many complaints the provider had received and how they had responded to complaints.

The registered manager and staff did not fully understand how the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) protected people to ensure their freedom to make decisions and choices was supported and respected. This meant decisions were being made for people without proper consultation. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. 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. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

People's end of life wishes were not documented and communicated. People's care planning documentation was not reflective of their wishes. Consideration had not been given to train staff in end of life care. This meant people were not well supported at the end of their life and did not always receive consistent and compassionate care because staff did not have the necessary knowledge or skills.

People told us they did not always get their medicine when they should. Ordering and administering of people's medicines were not managed effectively. Documentation relating to medicines was inaccurate.

People's individual nutritional needs were not always known and taken into consideration. People were not always supported to eat and drink. People had access to health care services however services were not always contacted in a timely manner.

Care plans and risk assessments were not always in place, reviewed and updated. They did not give clear direction to staff about how to meet a person's needs. This meant the care being provided was inconsistent between staff. People's care plans were not reflective of their choices because they were not involved in creating and reviewing their own care plan. People did not have personal evacuation plans in place which meant in an emergency, peoples individual care needs, were not shared with.

People's independence and social life were not always promoted. Although there were activities planned and the registered manager was making improvements, people told us there were not enough activities and there were no opportunities to go out.

The quality monitoring systems in place did not help to identify concerns and ensure continuous improvement. Falls and accidents were monitored; however the system in place was not used effectively to identify required changes. The Commission was notified appropriately, for example in the event of a person dying or experiencing injury.

Summary of findings

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff to meet people's needs.

People were not protected from risks associated with their care and documentation relating to this did not reflect people's individual needs.

Ordering and administering of people's medicines were not managed effectively to ensure they received them at the prescribed time. Documentation relating to medicines was inaccurate.

People told us they felt safe. Staff knew what action they would take if they suspected abuse was taking place. Safe recruitment practices were in place.

Is the service effective?

Inadequate

The service was not effective.

People's changing care needs were not always referred to relevant health services in a timely manner.

People were not supported to eat and drink enough and maintain a balanced diet.

People's consent and mental capacity was not always fully assessed and documented. This meant decisions were made for people without proper consultation.

People received support from staff who had the necessary knowledge, skills and training to meet their needs. However, consideration had not been given to train staff in end of life care.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

People's comments about staff attitude and approach varied. Staff did not always speak with and treat people in a respectful manner.

People's confidentiality, privacy and dignity were not always respected by staff.

People's choices and wishes for the end of their life had not been considered or communicated to staff. This meant staff did not know how to meet people's individual needs.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People were not involved in the design and implementation of their own care

Summary of findings

plans which meant care planning documentation was not reflective of their wishes.

People's care plans were not individualised and did not provide guidance and direction to staff about how to meet people's care needs.

People told us there were not enough social activities and there were no opportunities to go out.

People told us if they had a complaint they would speak with the registered manager, member of staff or their relative. The provider had a complaints procedure in place. Complaints were not always recorded but dealt with at the time.

Is the service well-led?

Inadequate

The service was not well led.

People did not receive a high standard of quality care because the provider's systems and processes for quality monitoring were ineffective in ensuring people's needs were met.

The registered manager monitored incidents and risks; however these were not used to help ensure care provided was safe, effective and responsive.

There was a management structure in place and staff told us they felt supported by the registered manager.

The registered manager worked with external professionals to help ensure people's health care needs were met.

St Anne's Residential 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.

We visited the home unannounced on 17 March 2015 and 19 March 2015. The inspection team consisted of two inspectors and an expert by experience – this is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection, we spoke with eight people living at the home, two relatives, the deputy manager, five members of care staff, two care supervisors, the chef, and the receptionist.

We observed care and support in communal areas, spoke with people in private and looked at 10 care plans and associated care documentation. We also looked at records that related to medicines as well as documentation relating to the management of the service. We looked at policies and procedures, staffing rotas, the accident book, five staff recruitment and training files and quality assurance and monitoring paperwork.

Before our inspection we reviewed the information we held about the home and spoke with the local authority. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return the PIR and we took this into account when we made the judgements in this report. We reviewed notifications of incidents that the provider had sent us since the last inspection. A notification is information about important events, which the service is required to send us by law. After the inspection we contacted local commissioners of the service who funded people who lived at St Anne's to obtain their views. We also made contact with two district nurses and four GPs.

Inadequate

Is the service safe?

Our findings

At our last inspection in July 2014 we found the system in place to assess and manage risks to people's health, safety and welfare was not always effective. The provider sent us an action plan detailing how they would make improvements. At this inspection we found that improvements had not been made.

People's risk assessments, that give guidance to staff about how to minimise associated risks related to people's individual care needs, were not always in place. They had not been updated and reviewed effectively. For one person who was displaying behaviour which was unpredictable and challenged staff, there were no risk assessments in place that gave staff clear instructions about how to manage the risks. For example, staff had documented in care records the behaviour which had been exhibited but, in response to this, it was not clear how the person had been consistently supported. The person's care plan had been updated in March 2015, however had not identified risk assessments were required to be in place.

When a risk had been identified, the provider had not always taken action to minimise the risk. For example, for one person it had been identified in 2014 the person was at risk of not eating enough. We found the risk assessment had not been followed, for example the person had not been weighed since January 2015 and prior to this date the person had last been weighed in July 2014. When we spoke with this person, they told us they were concerned they had lost weight and records showed they had. The registered manager confirmed there had been a medical reason for this. However, the person's risk assessment and care plan had not been updated to reflect the action following GP intervention. This meant it was not clear to staff what care they needed to provide to meet the person's ongoing needs.

People's falls had been recorded and an accident book was used. Information was not being used to identify themes and necessary action which may be required. The falls audit did not detail the time people were falling. In February 2015 there had been 25 falls whereas previous months and previous years' falls had not been this high. The registered manager told us this had been because people had been unwell. However, no analysis had been undertaken to establish when these falls had occurred and whether action was required, for example an increase in staffing during this time, or referrals to external professionals, such as falls professionals. The care plan and risk assessment for one person had not been updated following a fall. This demonstrated that the falls audit did not prompt the review of people's risk assessments so staff did not know what preventive measures to take, to reduce the likelihood of a person falling.

We found risk assessments were not always in place as necessary, updated, and reviewed. Risk assessments were not always reflective of people's individual needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not have personal evacuation plans (PEPS) in place which meant, in an evacuation, emergency services would not know what level of care and support people may need.

Three people told us, and relatives and staff also agreed, that there were not always enough staff. Comments included "I feel they are short staffed as sometimes I wait 30 minutes or more when I ring my call bell. Staff do not have time to talk to me", "there are not enough staff at times" and "sometimes I think, please come when I ring my bell". For others, they did not have any concerns regarding staffing.

During our inspection we observed staff were rushed, and call bells were ringing for 15 minutes and over. We observed staff were mainly focused on tasks such as serving breakfast, lunch, and undertaking laundry. People who wanted to get up at a certain time and have their breakfast were not able to. For one person, whose care plan stated they liked to get up at 7am and have their breakfast, were observed receiving their breakfast at 9.45am. We asked this person about this and they told us, "I have it when they bring it to me".

One person regularly required support and reassurance; the person's care plan stated that time should be spent engaging with the person to reduce their anxiety. However we observed staff did not always have time to do this. One member of staff told us that if they were to spend time speaking with the person every time the person called for help, they would not have time to care for other people. They went on to say, if this was the care which was

expected, then the person should receive one to one support. We were concerned to hear this because, from our observation and response from the member of staff, it was clear the person's individual care needs were not being met. We spoke with the registered manager, deputy manager and registered provider about this. We were told that staff had adequate time to speak with this person, and that it would be addressed with the staff team. We were concerned about how this person's needs were being met, so we referred our concerns to the local authority.

The registered manager explained she did not use a staffing dependency tool to calculate the required staffing, but did take into consideration people's care needs. However, during our inspection one person required end of life care and another person required intense support, and the staffing levels had not been reviewed. The registered provider and the registered manager explained the care staff numbers had not been reduced since a reduction in occupancy and both felt staffing levels were sufficient.

We found people's individual needs were not always being met because there were not sufficient numbers of staff. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not effectively managed to ensure they received them safely. For example, one person had to have their medicine at 7am, as it needed to be taken half an hour before they ate. However, on two occasions that week, because night staff were not all trained, the person had to have their medicine after they had eaten, because they had to wait until a member of staff trained to administer medicines came on duty at 8am. On the day of our inspection, two people had required their medicine at 7am; however, only one person had received their medicine at 7am and the other person had received their medicine at 8am. This had been because of a breakdown in communication between staff. The registered manager told us she would speak with the staff to find out why this had happened.

When there was a time change to when medicines were being administered, the recording of when the medicine had been administered was not accurately reflected on the medicine administration records (MARS). This could lead to medicines not being administered in line with prescribing requirements. Medicines should be administered in line with these requirements to ensure people obtained the maximum benefit from their medicine.

Medicine administration records (MARS) showed three people had not had their medicine delivered for March 2015. People's medicine was ordered on a monthly cycle and had started on the Monday of the week of our inspection. It was Thursday when we inspected the medicines, which meant people had been without their prescribed medicine for four days. One person had not received their medicine for one month. We were told this was because the person's medicine had been changed. However the staff member responsible for administering medicines was unaware of this and there was no documentation in place regarding the change. The care supervisor told us they had contacted the pharmacy a couple of days ago to ask where it was. The registered manager had not recognised that it was unacceptable for this person to not have their medicine for this amount of time and the risks this could pose to their ongoing health.

Medicine reviews are important to help people be involved in their health care and give people an opportunity to ask questions of health concerns related to their medicine. One person told us they had been taking paracetamol for five years. Care records showed this person had not received a medicine review.

People were not always given pain relief quickly or when requested. For example, at approximately 9.45am one person was heard to ask for pain medicine. However, this was not provided until the end of the medicine round at approximately 10.30am.

The room which was used to store medicine was found to be unlocked; there was medicine on display on top of cabinets and in the unlocked fridge. Oxygen was stored in this room but signage was not in place to warn people of the potential fire hazard, nor was it in place on the bedroom door of the person who used it. Policies and procedures were dated 2011 and had not been checked to ensure the most up to date guidance about medicines was included within the policy.

People who chose to self-administer their own medicines had a risk assessment in place. However the risk

Inadequate

Is the service safe?

assessment was not always reflective of the practice being carried out. For example, it stated one person's medicine was locked away in their room. However we found this was not accurate because there was no lock available.

We found the management of medicines was unsafe and ineffective. People were not always receiving their medicine when it was prescribed. Documentation relating to medicine management was not being completed accurately. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 (2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at St Anne's Residential Home. Staff were able to tell us about what action they would take if they suspected abuse was taking place. Staff told us they would have no hesitation in reporting it to the registered manager or registered provider. Staff confirmed they had access to the relevant policy which helped ensure they followed the correct procedures.

People were protected by safe recruitment procedures. The provider followed their policy which ensured all employees and volunteers were subject to necessary checks to determine they were suitable to work with vulnerable people.

There was a system in place to ensure equipment was serviced in line with manufacturing guidelines so that it was safe for people to use. Documentation showed equipment was well maintained.

Inadequate

Is the service effective?

Our findings

At our last inspection in July 2014 we found that people were not protected from the risks of unsafe or inappropriate care because accurate and appropriate records were not maintained. The provider sent us an action plan detailing how they would make improvements. At this inspection we found that improvements had not been made.

People could choose if they wanted to eat their meal in the dining room or elsewhere. People required different levels of support at lunch time, but were not always given it. For example, for one person who was blind, their meal was placed in front of them without an explanation about what the meal was or where it was on the plate. The person had to ask another resident if there was water they could drink, as staff had not informed the person of this. The person's care plan gave details about how to meet this person's nutritional needs; however the staff had not followed the care plan.

People's nutritional risks were not always monitored. For example, we read in the daily records for one person they had been eating and drinking very little for over a week and this person, on the day of our inspection, had declined to eat their breakfast. This person also declined to eat their lunch and it was taken away; however staff did not offer the person another alternative. Staff had not recognised the importance of offering and trying to tempt the person with other alternatives.

Accurate information was not available to share with health professionals to enable any necessary action to be taken as food and fluid charts had not been put in place to monitor exactly how much the person was eating and drinking.

People's weight was not being monitored effectively. One person's care records and weight charts showed they had been weighed in July 2014 and January 2015, and had lost weight in that time. The person told us they thought they had lost more weight since January 2015, however had not been weighed to verify this. People who were vulnerable to weight loss, but could not stand on scales, had not been weighed since 2014. The registered manager said this was because they did not have the right equipment to weigh people who were unable to stand on scales. However, in the meantime, the provider had not considered other weighing alternatives such as the malnutrition universal screening tool (MUST). Therefore the registered manager and staff did not know whether people were losing weight and were at risk of malnutrition.

Documentation required to support people in relation to their nutrition and hydration was inaccurate leading to people's individual needs not being met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the meals, but did not have a choice. However, from looking at documentation we found there were choices for people to choose from and people's choices were accommodated. The chef confirmed people could also ask for something else if they did not want it. The chef was aware of people's nutritional needs and records were kept to document any changes.

People had recently been asked to complete a survey about the menu and had requested some changes to be made. As a result, action was being taken. One example of this was people had requested that they would like more to eat. We saw people were offered second portions at lunch time and the supper menu had been adapted to incorporate sandwiches and cakes. This demonstrated people's opinions were listened to.

The legislative framework of the Mental Capacity Act 2005 was not always being followed. People's consent was not always obtained in relation to the care and treatment provided to them. For example, the registered manager had recently changed GPs for some people, but there was no documentation in place to show this had been carried out in consultation with people. Two of these people had been identified as lacking capacity to consent. The registered manager told us that she had consulted with people's families; however, there was no documentation in place to show this. Under the Mental Capacity Act 2005 (MCA) adults are deemed to have capacity unless there is reason to think that they do not. If there is reason to question an adult's capacity there is a set procedure to be followed to establish if they are able to make their own decisions about important matters, such as who their GP should be, or not. This assessment must be properly carried out by a suitable professional and it must be

properly recorded. The registered manager had limited knowledge of the deprivation of liberty safeguards (DoLS), however, informed us that no one living in the home was being deprived of their liberty.

The registered manager told us she felt everyone who lived at the care home had capacity, apart from possibly two people; however, mental capacity assessments for these two people had not been carried out to determine this. So it was not clear how these two people were supported in making decisions if their mental capacity had not been assessed.

People should be involved in their care and consent to decisions which are made. One person told us they would like to self-administer their medicines, but had not been allowed to. As they were not aware of the rationale for this, we looked at this person's care plan to establish the reasons why, and found it did not detail that they lacked capacity. It was unclear how this decision had been made in line with the Mental Capacity Act. The registered manager explained they had discussed the concerns with the person's family and a decision had been made but the consent of the person concerned had not been obtained.

People's treatment escalation plans (TEP) were contradictory to care plans. For one person, it stated on their TEP form that they lacked capacity; however their care plan stated they had capacity. There was no documentation within the person's care plan to indicate if the person agreed and consented with the recorded decision on the TEP form. This meant the decision regarding resuscitation may not be in line with the person's wishes. The registered manager told us a new TEP form would be requested.

We found the legislative framework of the Mental Capacity Act 2005 was not always being followed. People's consent was not always obtained in relation to the care and treatment provided to them. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to health care services to receive ongoing health care support; however referrals to relevant health services when people's needs changed did not always happen quickly. We read in the daily notes for one person that staff felt the person had looked unwell for nearly two weeks; however a GP had not been called during this time. This person's behaviour had also changed dramatically over the past two weeks; however no referral had been made to assess this person's needs or speak with a psychiatric nurse.

Another person told us they were concerned about their teeth. The GP had visited two days earlier and said the person needed to be seen by a dentist. The necessity for this person to see a dentist had not been identified by staff or management.

On the first day of our visit a third person told us they were experiencing pain in their stomach. We informed care staff about this; however, when we reviewed their daily notes on our return visit two days later this had not been documented, so it was unclear what had been done about this. This demonstrated that this person's care needs had not been recorded to enable treatment to be discussed with external health care professionals. GPs did, however, confirm they had no concerns with the communication at the care home and told us referrals were sought appropriately. A health care professional informed us they felt communication about people's care needs was variable. For example, on occasions, district nurses had been asked to visit a person, however, the person had already been seen by another health professional, and treatment had already commenced. We were also told that staff willingness to help and accompany nursing staff to meet with people was not consistent amongst the team.

Staff said they felt well supported by the registered manager and received relevant training to help ensure they had the knowledge to meet people's needs. Staff also received an induction when they first started working at the home, ongoing supervision in the form of one to one meetings with their line manager, and annual appraisals of their work. Staff told us they felt the supervision was a positive process. Supervision is a process by which a person reflects on their work performance and identifies training and development needs. The registered manager was aware of the Care Certificate which was being introduced in April 2015. This demonstrated the registered manager was aware of the change in legislation and the impact on staff training. Staff undertook training applicable to their role, for example medicine administration, safeguarding, first aid, Mental Capacity Act and fire safety.

Health care professionals felt staff competence varied amongst the team. Specialist training opportunities were

Inadequate

Is the service effective?

offered to the registered manager to meet people's individual care needs by visiting health care professionals. However, although some staff had attended training sessions, practice was not always put into place. We were told future training dates which had been arranged, had been cancelled by the registered manager.

The environment was suitable for people who had mobility difficulties, and for those who used equipment, such as wheel chairs and stand aids. Areas were spacious and people's bedrooms were of a good size. The home was clean and free from malodours.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in July 2014 we found that people's privacy, dignity and independence were not respected and people's views and experiences had not been taken into consideration in relation to their care. Did they send an action plan? At this inspection we found the provider had made some improvements, however further improvements were required.

Overall staff were kind and caring, but some staff showed more patience and compassion than others. One member of staff spoke inappropriately and in an unprofessional manner about one person in front of other people who lived in the home and their visitors. This did not show respect to the person, or to other people. We told the registered manager about this who expressed their disappointment and said that they would take action to address this.

One person was ignored at times by staff. On one occasion the person had been left in a wheel chair in the centre of the lounge (with their back to people) whilst others behind and in front of the person viewed and participated in a game of skittles. The person tried to get the attention of the activity staff by raising their arm, but was ignored. When we brought this to the attention of the activity staff, we were told the care staff had had to go and help someone else. The activity staff did not recognise that this person needed assistance and made no attempt to obtain assistance for the person.

People's comments about staff varied. Some people told us, "the staff are very kind to me and they treat me with respect. The staff come to my room throughout the day so they know I'm alright. I could always press my call bell if I need anything.", "staff are lovely, they always speak to me with respect". One relative told us, "staff are caring and respectful, X always seems happy with the staff." One person told us "you get some staff who are sharp…I don't need to be spoken to like that" and another person told us staff had been unkind to her. We shared this with the registered manager who told us this would be addressed with the staff team.

A healthcare professional told us there was an inconsistency amongst staff, as some staff appeared to be caring whilst others were not.

People's end of life wishes were not care planned. During our inspection end of life care was being delivered and external health professionals were supporting this person, although the person did not have an end of life care plan in place. This meant the person was at risk of not having their choices and wishes for the end of their life met because it was no written information for staff to follow.

People's dignity and privacy were not always protected as there were no locks on bathroom or bedroom doors. There were signs on bedroom and bathroom doors which indicated when personal care was taking place; however, if a person forgot to use the sign their privacy could be compromised. One person told us they would like a lock, but instead had been placing a suitcase over their door at night for security.

People told us the laundry service was not effective and explained, "Sometimes they lose my clothes so I sometimes do my own washing" and "my clothes have gone missing". The registered manager confirmed there had been some problems recently and they were working to make improvements.

Whilst some people told us they had a choice about when they went to bed and got up in the morning, other comments included, "you can get up what time you want to, but they encourage us to go to bed early" and a relative told us "X has a limited choice of times to get up and go to bed". We asked the registered manager about this, who told us she had been speaking with staff to address this.

People were not always treated with respect and consideration, and their privacy was not always maintained. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records were not always kept secure. The office door which stored people's confidential personal information was left open, and unlocked which meant people's confidential files were accessible to people. We spoke with a member of staff who said that usually all documents were locked away; however, information was waiting to be archived.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in July 2014 we found people were not protected from the risks of unsafe or inappropriate care because accurate and appropriate records were not maintained. The provider sent us an action plan detailing how they would make improvements. At this inspection we found that improvements had not been made.

People had not been involved in planning their own care to ensure they received the care they needed, in the way they wanted it provided. People told us they were not aware of their care plan and documentation confirmed this. One person told us, "I don't think I have a care plan. Nobody has actually sat down and talked to me but I think they would if I asked" and "I do not have a care plan, no one has sat down with me to ask what care I needed." One relative told us, "we've not seen a care plan." What did the RM say about this please?

People's care plans did not always include a personal history so staff were aware of what a person achieved in life prior to getting older and moving into the home. A person's history helps to enable staff to have meaningful conversations with people and tailor social activities to people's past interests and memories.

People told us there were not enough social activities. Comments included, "I'm not taken out by staff, if it wasn't for my friends I wouldn't go out. Now and again we have entertainers visit but we do not have activities very often, I would like to have more activities" and "staff do not have time to talk to me, it would be good to go out occasionally, maybe to a tea shop or to a garden centre". Another person told us, they would like to get outside for a walk, they explained, "I haven't been out in weeks".

We saw activity and social entertainment was planned and the registered manager had been making improvements. The registered manager and provider explained trips out occurred mainly in summer months. We were told by some people that the planned activities did not always happen. During our inspection a member of care staff came to the lounge to do a jigsaw with one person. We were told by another person that it was unusual to see this.

People's care plans did not guide and direct staff to deliver consistent care to people. Care plans were reviewed, however changes to care plans were not always made. For example, for one person, their daily notes showed during the beginning of March, the person had been facing difficulties. The person's care plan had been reviewed on 9 March 2015; however no changes had been made to the relevant care plan sections. The person's daily records did not show if the staff were meeting this person's care needs in a consistent way. This same person had fallen in February 2015 however this had not been identified as part of the care plan review. Therefore staff were not provided with the most up to date information about how to meet this person's care needs and reduce the likelihood of the person falling again.

People's needs were not always re-assessed and reviewed to ensure they could be properly met by staff. For one person, who had shown an increased change in their behaviour, the registered manager had not reviewed the person's care plan, assessed whether the person's needs could be met or contacted relevant external professionals, such as the local authority.

People who were vulnerable to pressure ulcers, or were receiving assistance from district nurses, did not have documentation in place to reflect the care being provided. For example, in one person's notes, it said the district nurse had visited in March 2015 and had re-dressed the person's wounds. We were informed by the registered manager that district nurses kept care plans for people regarding their skin integrity. However, there was no information in the person's care plan about this to enable staff to know what care was needed.

One person had bruises on their left arm however, when we looked in the person's care plan, there were no body maps in place or any other documented reasons, so it was unclear how the person obtained the bruises, and when. Body maps are a tool which staff may use to identify and monitor any concerns with a person's skin. Because of this unexplained bruising, we reported our concerns to the local authority.

The registered manager explained care plans were being reviewed and developed into a new format. We looked at care plans in the new and old formats; however neither format reflected the current care people were receiving. One example of this was, for one person, the care plan stated to prevent skin damage they should be sat on a specialist cushion at all times. However this person had not

Requires Improvement

Is the service responsive?

been provided with the specialist cushion to sit on. This demonstrated staff were not delivering care in line with the person's care plan and the person's needs were not being properly met.

Care plans did not reflect the care being delivered. The care being delivered by staff was not always consistent. There was not always an understanding from staff about the recognition of a person's changing health care needs and the necessary action which may be required. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (1)(a)(b)(c)(3)(a)(b)(c)(d)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us, if they had any concerns or complaints, they would speak with the registered manager, staff or their relatives. One person told us "I complained about one member of staff, she seems better lately." There was a complaints policy which outlined the procedure which was to be followed. However the registered manager told us that complaints and concerns were not always written down but dealt with at the time, however, would consider recording these in the future.

Inadequate

Is the service well-led?

Our findings

At our last inspection in July 2014 we found the quality monitoring system was not effective in identifying areas that required improvement. The provider sent us an action plan detailing how they would make improvements. At this inspection we found that improvements had not been made.

People did not receive a high standard of quality care because the provider's systems and processes were ineffective. The registered provider had an auditing system which they were using to identify improvements which were required. However, the provider's auditing system had failed to ensure effective care planning, documentation about people's care and treatment, risk assessments, the management of medicines and the attitude of some staff. It had also failed to ensure that consent to care was obtained in line with the legislative framework the Mental Capacity Act. The registered manager and registered provider both told us they thought all improvements had been made since the last inspection.

The systems in place to monitor the quality of service people received and to identify, assess and manage risks were not effective. This is a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management structure in place consisted of the registered manager, deputy manager and care supervisors. Staff knew what the management structure was. The registered manager told us she felt well supported by the registered provider. The registered provider carried out the registered manager's supervision. The registered manager was in the process of undertaking training in management and leadership. This demonstrated the registered manager recognised the importance of obtaining further qualifications to improve further skills and knowledge with regards to the day to day management of running the care home.

It was apparent from speaking with the registered manager that she cared, was passionate about people who lived at St Anne's, and took her responsibility as registered manager seriously. However some staff told us that, because the registered manager did not delegate certain tasks, communication was not always effective, for example leading to a delay in contacting GPs and medicine ordering.

Staff spoke highly about working at St Anne's and spoke positively about the registered manager. One member of staff told us, "X does a really good job it's a hard job. I take my hat off to her." Another member of staff said the registered manager was very supportive, allowing them considerable flexibility in their working hours. They said "she is very understanding."

The whistle blowing policy which was in place assured staff if they were to report concerns it would be "without fear of reprisals". Staff told us they would not hesitate to report to the registered manager or provider concerns about abusive practices.

The registered manager told us and documentation showed the staff team worked in partnership with agencies, such as the local authority, commissioning and health care professionals. External health professionals told us communication within the care home varied. Some professionals told us it was effective, whilst others told us it was not. One professional told us they felt the management of the care home had improved with the introduction of administration and senior care staff.

The registered manager had notified the Commission of significant events which had occurred in line with their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Dignity and Respect Regulation 17(1) (a) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always treated with respect and consideration, and their privacy was not always maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Staffing Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not deploy sufficient numbers of staff in order to meet people's needs.