

# The Southend On Sea Darby & Joan Organisation Limited

# St Martins Residential Home

## Inspection report

59 Imperial Avenue,  
Westcliff on Sea,  
Essex  
SS0 8NQ  
Tel: 01702 475891  
Website: [www.stmartinscare.org](http://www.stmartinscare.org)

Date of inspection visit: 25 November 2014  
Date of publication: 16/04/2015

## Ratings

### Overall rating for this service

Requires Improvement



Is the service safe?

Requires Improvement



Is the service effective?

Good



Is the service caring?

Requires Improvement



Is the service responsive?

Requires Improvement



Is the service well-led?

Requires Improvement



## Overall summary

St Martin's Residential Home provides accommodation and personal care for up to 26 people. Some people have dementia or dementia related needs.

The unannounced inspection was completed on 25 November 2014 and there were 24 people living in the service when we inspected.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

providers, they are 'registered person's'. Registered person's have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection on 22 July 2014 found that the provider was compliant with all areas viewed.

# Summary of findings

People and their relatives told us the service was a safe place to live. Staff were able to demonstrate a good understanding and knowledge of people's specific support needs, so as to ensure their and other's safety.

Staff understood the different types of abuse and knew how and who to report any concerns to.

We found that the deployment of staff was not always appropriate to meet people's needs.

We found that risks to people's health and wellbeing were assessed but had not always been reviewed and updated to reflect the most up-to-date information.

We found that the management of medicines did not ensure people's safety and wellbeing.

Staff told us that they felt supported and valued. They said that they received regular training opportunities. We found that staff received a robust induction, supervision and appraisal.

Comments about the quality of the meals provided were positive and people were supported to have adequate nutrition and hydration.

People told us that their healthcare needs were well managed and we found that the service engaged proactively with health and social care professionals.

Where people lacked capacity to make day-to-day decisions about their care and support, we saw that

decisions had been made in their best interests. The registered manager was up-to-date with recent changes to the law regarding the Deprivation of Liberty Safeguards (DoLS) and at the time of the inspection they were working with the local authority to make sure people's legal rights were being protected.

Not all people had been involved in the development of their care plan. We found that people's care plans were not fully reflective of their care needs as some of the information was not up-to-date.

People and their relatives told us that if they had any concerns they would discuss these with staff on duty. People told us that they were confident that their complaints or concerns were listened to, taken seriously and acted upon.

We found that an effective system was in place to regularly assess and monitor the quality of the service provided. The registered manager was able to demonstrate how they measured and analysed the care provided to people who used the service and how this ensured that the service was operating safely. However, the provider's quality assurance system had not picked up any of the concerns or areas for improvement that we found.

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

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not consistently safe. We found that the deployment of staff to meet people's needs was not always appropriate to support people living at the service.

We found that suitable arrangements were not always in place to ensure that the management of medicines were safe.

People and their relatives told us the service was a safe place to live.

Safeguarding concerns had been used as an opportunity for learning and improvement. People could be assured that robust procedures for responding to abuse were in place.

**Requires Improvement**



### Is the service effective?

The service was effective. The dining experience for people was positive and people were supported and encouraged to eat and drink enough.

Staff received appropriate opportunities for training, induction, supervision and appraisal.

People's healthcare needs were met and people were supported to have access to a variety of healthcare professionals and services.

Where a person lacked capacity, Mental Capacity Act (MCA) 2005 best interest decisions, had been made. The Deprivation of Liberty Safeguards (DoLS) were understood by the senior management team and appropriately implemented.

**Good**



### Is the service caring?

The service was not consistently caring. People and their relatives were positive about the care and support provided at the service by staff. Our observations demonstrated that staff were friendly, kind and caring towards the people they supported.

Staff demonstrated a good understanding and awareness of how to treat people with respect and dignity.

**Requires Improvement**



### Is the service responsive?

The service was not consistently responsive. There were gaps in people's care plan documentation and we found that the information did not always include the care and support to be planned and delivered to meet people's needs.

People told us that they were happy with the activities provided.

The service had appropriate arrangements in place to deal with comments and complaints. People told us that their concerns and complaints were listened to and acted on.

**Requires Improvement**



# Summary of findings

## Is the service well-led?

The service was not consistently well-led. A registered manager was in post. The management team of the service were clear about their roles, responsibility and accountability and we found that staff were supported by the registered manager and senior management team.

Staff told us that they felt valued and supported.

The quality assurance system was not effective because it had not identified areas of concern that we found. Systems did not ensure quality was consistent across the service.

## Requires Improvement



# St Martins 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.

This inspection took place on 25 November 2014 and was unannounced.

The inspection team consisted of one inspector, a specialist professional advisor, whose specialism was in dementia care and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service.

We had not asked the provider to complete a Provider Information Return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and the

improvements they plan to make. We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people who used the service, six relatives, nine members of staff, the registered manager, operations manager and registered provider. We spoke with one healthcare professional to obtain their views about the quality of the service provided.

We reviewed six people's care plans and care records. We looked at the service's staff support records. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

# Is the service safe?

## Our findings

People told us that they received their medication as they should. We found that suitable arrangements were in place to ensure that medicines were stored safely.

We found that the arrangements for the administration of covert medication for one person was in accordance with the Mental Capacity Act (MCA) 2005. 'Covert' refers to where medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in drink.

The medication administration records (MAR) for seven out of 25 people who used the service were looked at. We found a number of discrepancies with the records. For example, for two people the records showed that one of their prescribed medications had not been given in line with the prescriber's instructions. This had resulted in one person being given an extra dose of medication and one person not receiving their full dose of medication. In addition, the records suggested that another person had not received two of their 'topical cream' medications in line with the prescriber's instructions and instead of these being administered twice daily, these had only been applied once daily over a three and four day period respectively. We also saw that one person did not receive pain relief medication in a timely manner as the service had run out of stock. Two first aid kits were incomplete and some of the equipment was past its use by date.

We found that the registered person had not protected people against the risk of poor medicines management. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that staffing levels were generally appropriate for the numbers and needs of the people currently being supported. Staff told us that if there was a 'wish list' they would request an additional member of staff to be on duty throughout the day as this would enable them to have more time to sit and talk with people living at the service. One member of staff told us, "We could always do with an extra pair of hands." Another member of staff told us, "The staffing levels are alright. There are times when we are a little short."

Our observations showed that the deployment of staff was not always suitable to meet people's needs and communal lounge areas were left for long periods without staff support. For example, our observations showed that there were eight people in the small lounge, one of whom was a relative of a person who lived at the service. Between 11.45am and 12.30pm we observed that the small lounge was left without staff support for a total of 45 minutes and when staff appeared they did not verbally engage with any of the people there. Staff were seen to look in and then to walk away. The relative was observed to provide assistance for one person with their cup and saucer as they were at risk of spilling their drink into their lap. We also observed one person on several occasions attempt to get up from their chair. The person's mobility was seen to be very unsteady and their legs and arms were seen to shake with the effort of the task. The person eventually gave up trying to get up from their chair after a while. We discussed this with a member of staff and they confirmed that the person's mobility was poor, they were at risk of falls and required staff support to help them mobilise.

This was not an isolated case. We found that the conservatory was intermittently left without staff support during the morning. Five people were seated in the conservatory for approximately 15 minutes. One person was observed repeatedly to try and stand but found this difficult to achieve. No staff were present in the conservatory during this time. The person's care plan recorded that they were no longer able to walk, was at risk of falls and required staff to assist them with their mobility and manual handling needs. This showed that the arrangements for the deployment of staff within the service was not always suitable to meet people's individual needs or ensure their safety.

We found that the registered person had not protected people against the risk of insufficient numbers of appropriate staff. This was in 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 told us that they felt safe and secure. One person told us, "Oh yes I feel safe." One relative told us, "I feel [relative] is safe here and well looked after. The carers are all very nice and look after my [relative] very well."

## Is the service safe?

The majority of staff had received safeguarding training. Staff we spoke with were able to demonstrate a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. Staff told us that if they had any concerns they would report these to the management team and where appropriate to external agencies such as the Local Authority and the Care Quality Commission. The registered manager was able to demonstrate that, where safeguarding concerns had been raised, they had responded appropriately by following local safeguarding procedures.

Risks to people's health and wellbeing had been appropriately assessed and recorded. However, we found that some risks identified had not been reviewed to reflect the most up-to-date information. For example, one person's manual handling assessment had not been updated to show that they were no longer able to walk,

stand or get in and out of bed as a result of a significant change to their mobility needs. In addition, a formal pressure ulcer risk assessment tool for this person was last completed in September 2014. This had not been reviewed and updated to evidence the changes in the person's circumstances and to show that they now spent the majority of their time in bed. However staff we spoke with were aware of the person's individual risks and risks to others. For example, staff were able to tell us who was at risk of falls or poor nutrition and the arrangements in place to help them to manage this safely.

Staff told us that the recruitment process had been thorough. We looked at the staff recruitment records for two members of staff appointed since July 2014 and this showed that staff employed had had the appropriate checks to ensure that they were suitable to work with vulnerable people.

# Is the service effective?

## Our findings

Relatives told us that their member of family received effective care and support. One relative told us, "It's all good here-very nice." Another relative told us, "I come every day, there are no problems. It's all good."

Staff told us they had received regular training opportunities and this provided them with the skills and knowledge to undertake their role and responsibilities and to meet people's needs. We spoke with one newly employed member of staff and they confirmed that they had received an induction which included the principles of the Skills for Care Common Induction Standards. These are the standards people working in adult social care need to meet before they can safely work unsupervised and are designed to enable staff to demonstrate their understanding of how to provide high quality care and support. They told us that their induction had been completed over several days and included several shifts whereby they shadowed a more experienced member of staff.

Staff told us they received regular supervision and an annual appraisal of their performance and development needs. They told us that supervision was used to help support them to improve their practice. Records confirmed what staff had told us.

Not all staff confirmed they had received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training since our last inspection. A few staff did not have a full understanding of MCA and DoLS but confirmed that they discuss any issues with senior staff if they had any concerns.

The registered manager told us that no applications to deprive a person of their liberty had been made to the

supervisory body (Local Authority) for their consideration and recommendation. However, the care record for one person showed that they had attempted to leave the service on several occasions and were subject to continuous supervision which prevented them from leaving the service. We discussed this with the registered manager and were given an assurance that a DoLS application would be completed as a priority. Appropriate assessments had been carried out to assess people's capacity.

Our observations of the lunchtime meal showed that the dining experience for people within the service was positive and flexible to meet people's individual nutritional needs. We saw that people were provided with enough to eat and drink throughout the day. People told us that they enjoyed the meals provided even though they found the vegetables to be hard on occasions. One person told us, "I enjoyed the gammon but the carrots and vegetables are very hard." Another person told us, "The food is alright here but I can't eat too much of this." They told us that the vegetables were hard and they hurt their mouth. We brought this to the attention of staff and another meal choice was offered which the person happily received.

The nutritional needs of people were identified and where people who used the service were considered to be at nutritional risk, we found that an appropriate referral to a healthcare professional such as GP, Speech and Language Therapist and/or dietician had been made.

People told us that their healthcare needs were well managed. They said that they were supported to attend hospital appointments and were able to see the District Nurse or GP. Relatives' told us that they were kept informed of the outcome of healthcare appointments. One relative told us that they were regularly contacted and updated about the health and wellbeing of their member of family.



# Is the service caring?

## Our findings

People and their relatives told us that they were happy with the care and support provided. One relative told us, “It doesn’t matter when you come in here, it’s always friendly and nice.” Another relative told us, “The staff are all very compassionate, and I’m very happy with how [relative] is being looked after.” People also told us that the staff were kind and caring. Comments included, “The staff are really good,” “The staff are all very compassionate and I’m very happy with how my relative is being looked after.”

People confirmed that they were not routinely involved in making decisions about their care. One person when asked if they were involved in decisions about their care or if they had had sight of their care plan, told us, “I have no idea what is in my plan.” Other comments included, “I think the care plan was discussed with me when I moved here but I have not seen it.” Not all relatives spoken with could remember if they had been involved in the planning of their relative's care other than at the initial pre-assessment stage. Following the inspection the provider confirmed that relatives were invited to attend a meeting with the manager to discuss their member of family's care. In addition, the provider told us that the manager had an 'open door' policy which meant that people's relatives were able to discuss the care and support provided at any time.

We observed that staff interactions with people were variable throughout the day. Some staff were observed to demonstrate affection, warmth and compassion for the people they supported. However, we found that there was

an over reliance on routine and tasks. For example, there was an over reliance on the use of television in communal areas and we saw that people were not interested in the television programs being shown. In addition, we observed long periods of inactivity where people were either sleeping or disengaged for long periods of time. Although staff were seen to respond quickly to people’s requests for assistance, we saw that the care and support provided was focussed on getting a specific task completed, and did not always promote people’s wellbeing. For example, staff were observed going from room to room, attending to people’s personal care needs, without spending time to sit and talk with them for any meaningful period of time.

People told us that staff respected their privacy and dignity. One person told us, “I have a choice of when I get up and when I go to bed at night. I can also choose if I want to join in activities or not.” Another person told us, “I don’t like to be rushed with my personal care [washing]. I like to wash myself but am happy to be assisted by staff if I need help. Staff are able to recognise this.” We saw that staff knocked and waited before entering people’s bedrooms and that care and support was offered discreetly. Staff were observed to address people respectfully by using the term of address favoured by them. We also saw that staff ensured that people were appropriately dressed and that their clothing was arranged properly so as to preserve their modesty and to promote their dignity.

We saw that people who used the service were supported to maintain relationships with others. People’s relatives and those acting on their behalf were able to visit the service when they wished.

# Is the service responsive?

## Our findings

We looked at people's care plans and found that these were not fully reflective of people's care needs. Where a person's needs had changed the care plan had not always been updated to reflect the new information. For example, the care plan for one person recorded that there had been a significant decline in their mobility needs in recent months. The person's mobility care plan had not been updated to reflect that the person could no longer mobilise and still referred to them being able to use a walking frame and to walk with staff assistance. We discussed this with staff and they confirmed that the latter information was inaccurate and no longer reflective of the person's needs.

Two people's care plans relating to eating and drinking recorded between May 2014 and October 2014 they had sustained a weight loss of approximately five kilo grams. Neither person's care plan contained sufficient information to guide staff on how best to support them or to show how this was being dealt with.

One person's care plan showed they had been diagnosed with diabetes and this was managed by the administration of insulin twice daily. The person's care plan did not contain sufficient information to guide staff on how to support this person to manage their diabetes. For example, there was no guidance for staff on the symptoms to look for if the person's blood sugars should become too low or too high. There were no instructions as to the frequency these checks should be made. Staff told us that they had received diabetes training however, we found that only one member of staff had received this training.

We found that the registered person had not protected people against the risk of people's care plans not being accurate and reflective of their care needs. This was in breach of regulation 9(1)(b)(i) and (ii) of the Health and social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that there were some people who could become anxious and distressed. The care plans considered people's reasons for becoming anxious and the steps staff should take to reassure them. Staff we spoke with had a good understanding and awareness of how to support people during these times.

People told us that they were able to participate in activities to meet their needs. One person told us, "They have activities here and I sometimes take part." Another person told us, "I enjoy most of the activities provided." We spoke with a member of staff designated to lead on activities and they told us of the activities provided to people at the service. We observed during the inspection that they provided both one-to-one and group activities to a small number of people. However, we observed that limited opportunities for activities were provided to people with dementia or people who had limited communication needs. The care plans relating to people's individual hobbies or interests did not evidence how these were to be enabled or supported. For example, the care plan for one person detailed that their interests included, gardening and sport. No information was recorded as to how this was to be facilitated.

There was an effective complaints procedure in place and the service listened to people's concerns and learnt from people's experiences. People and their relatives told us that if they had any concerns they would discuss these with the management team or staff on duty. One relative told us, "If I did see anything wrong I would say immediately to the manager." Staff told us that they were aware of the complaints procedure and knew how to respond to people's complaints. The complaint records showed that there had been no complaints since our last inspection in July 2014. A record of compliments had been maintained to capture the service's achievements. One compliment recorded, "I felt that I had to write to thank you all for the wonderful care and kindness [relative] received at St Martins."

# Is the service well-led?

## Our findings

The service had a registered manager in post. The registered manager was supported by senior members of staff. It was clear from our discussions with the registered manager and senior members of staff and from our observations that they were clear about their roles and responsibilities.

Staff told us that they felt valued and supported by the registered manager and senior management team. They told us that the registered manager was approachable and there was an 'open culture' at the service and their door was always open. Staff confirmed that they found the service to be a good place to work and that they enjoyed working there. They told us, "There is a lovely atmosphere here. I think the home is well run and I would recommend this home to others."

The registered manager told us that the organisation did not have a 'mission' statement. This relates to a written declaration of an organisation's core purpose and focus. Staff we spoke with were not aware of the service's aims and objectives.

At this inspection we found that although there were arrangements in place for assessing and monitoring the quality of service provision, these had not highlighted the areas of concern we had identified. The provider did not have an effective system in place to review staffing levels

and to ensure that the deployment of staff within the service was suitable to meet their needs. The impact of this on people was that the deployment of staff within the service was poor and did not meet people's needs.

The quality assurance system in place did not identify that there were gaps in people's care plan documentation and that the information did not always include the care and support to be planned and delivered to meet people's needs. In addition, the quality assurance system had not identified that there were gaps in the management of medicines or that the deployment of staff was not always appropriate.

The manager confirmed that the views of people who used the service, those acting on their behalf and staff had been sought in October 2014. The majority of comments received were noted to be positive and raised no key issues for further corrective action. For example, of the 11 responses received from relatives, all stated they were satisfied with the overall care provided within the service, felt staff were approachable and friendly, were kept informed of important matters and were happy with the care home environment. The provider recorded that the feedback responses were disappointing as out of 31 members of staff employed at the service, only 10 staff had replied. Overall, comments were generally positive but where issues had been highlighted for action, these referred specifically to better communication required between staff members. This was to be discussed at the next staff meeting.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>We found that the registered person had not protected people against the risk of people's care plans not being accurate and reflective of their care needs. This was in breach of regulation 9(1)(b)(i) and (ii) of the Health and social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>We found that the registered person had not protected people against the risk of poor medicines management. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>We found that the registered person had not protected people against the risk of insufficient numbers of appropriate staff. This was in 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.</p>

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.