Anson Care Services Limited

# St Mary's Haven

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service:
St Mary's haven provides accommodation with personal care for up 46 people. There were 38 predominantly older people using the service at the time of our inspection. Since the last inspection the service had extended the premises to accommodate people living with dementia. The recent temporary closure of another home in the Anson Care Group had led to 10 people and the staff moving to St Mary's Haven whilst extensive building work took place. This led to two registered managers working together at St Mary's Haven.

People's experience of using this service and what we found:
Risks relating to people's care needs were not always well managed. Where risks had been identified risk assessments were not always carried out to guide and direct staff on how to reduce them. People's money, held by the service, had not been audited since July 2019.

Staff were not always trained to support people with specific health conditions. Some people living at the service had long term conditions such as epilepsy and diabetes, which required specific care and support. Guidance and direction were not always provided in care plans for staff on how to meet their needs.

Some people required specific monitoring. For example, food and drink intake, blood sugar monitoring or skin condition checks. Paper records used by staff, despite an electronic system being in place, contained many gaps.which meant we could not be certain they received the care needed to meet their needs safely.

Staff were not always being provided with supervision in line with the policy held by the service.

Staff received training. However, some mandatory training was not up to date. The registered manager confirmed, "No I don't think any staff have had epilepsy training." We were not provided with evidence that showed this training was scheduled in the near future.

The handover sheet used by staff to communicate information about people at shift changes was not up to date on the day of inspection. This placed people at risk of inappropriate care as staff did not have accurate up to date information.

The white board, used to record important information about people's care needs in the manager's office did not contain accurate up to date information.

The registered manager was not clear on elements of the Mental Capacity Act 2005. Information held on the white board regarding the Lasting Powers of Attorney held by people living at the service was not accurate.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; however, the policies and systems in the service did not

support this practice.

There was not an effective process in place to monitor people's Deprivation of Liberty status (DoLS) and when reviews were due. The registered manager did not have accurate information on which people had an authorisation in place.

Care plan reviews had taken place repeatedly in the past without key information and risk assessments being checked as present, accurate or updated as needed.There was no consistent system or process in place for staff to record information relating to people's care. Staff were recording information in different places, such as on the computer system, on paper charts and in one case, a separate book. All the monitoring records we reviewed contained gaps. No management oversight of these records was taking place.

Concerns identified, and recommendations made at the previous inspection continued to be a concern at this inspection.

Guidance provided for staff in some sections of the care plans was inaccurate and conflicting.

Oversight and governance arrangement of the service provided was not effective. Two registered managers and a head of care worked in the service yet had failed to identify the concerns found at this inspection.

Audits were not robust. New processes put in place by the new registered manager were not being effectively implemented.

Infection control measures were in place to prevent cross infection. However, the registered manager did not carry out any recorded audits on infection control to check if any improvements were required. The service appeared clean.

One staff meeting had been held for each staff team since the new registered manager took up their post in June 2019. The meetings were used to remind staff of best practice. Some issues raised at these meetings had not been effectively actioned.

The premises had been recently extended and refurbished. There were slopes in corridors which did not have any warning signs alerting people to this change in floor level. There were no hand rails to support people using the corridors where slopes were present. Toilets and bathrooms had only standard signage. No pictorial signage was in place in the dementia unit to help support people who needed orientation to their surroundings.

People received their medicines as prescribed. Medicine audits were not effective, as concerns identified were not addressed. Records were poorly completed by staff when they applied prescribed creams.

People and their relatives said they felt their loved ones were safe with the staff supporting them.

Staff were recruited safely in sufficient numbers to ensure people's needs were met.

People told us, "I am happy here, staff are good" and "I am alright here"
Relatives told us, "I am happy that [Person's name] is happy" and "I think it is a good place."

People were able to make choices about their life and how their care and support were provided. People's

preferences were reflected in people's care plans. Staff understood the importance of respecting people's wishes and choices.

People and relatives agreed the staff were kind and caring. Staff respected people's diverse characteristics and were clear that each person's individual needs were their priority. People told us they felt listened to and their privacy and dignity were respected.

There were activities provided for people seven days a week. A shared minibus enabled people to access the local community.

Records were stored appropriately and accessible. However, information was not always held in a consistent manner making it difficult to find specific information when needed.

Visiting healthcare professionals told us, "It is often difficult to obtain entry to the service." The provider had implemented a measure whereby all visitors must ring the bell to be allowed in to the service. The provider was aware there had been a fault with the outer door which had led to people having to wait and was rectifying this. Comments also included, "We find documentation is a problem sometimes, it is not always easy to establish if something has taken place. When something happens with a person there is often no sign of it in their care plan" and "I don't think that the home is really working as well as it could just at the moment. We don't have any concerns about people's care."

Systems were in place to deal with concerns and complaints.

Two staff teams had recently merged during the temporary closure of one home in the Anson care group. Staff told us they enjoyed working at the service and that the teams worked well together.

Rating at last inspection and update:
The last rating for this service was requires improvement (report published 28 January 2019) and there were two breaches of regulation. The service has been rated requires improvement for the last two inspections. One of these inspections was under the previous legal entity, although still under the same provider. At this inspection we found insufficient improvements had been made and the provider continued to be in breach of the regulations.

Why we inspected:
This was a scheduled inspection to review the action taken by the provider following our previous inspection.

You can see what action we have asked the provider to take at the end of this full report.

We found no evidence during this inspection that people remained at risk of harm from this concern. Please see the safe, effective, responsive and well-led sections of this full report.

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

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Follow up:
We will meet with the provider following this report being published to discuss how they will make changes

to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

We always ask the following five questions of services.

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|---|---|
| **Is the service safe?**<br><br>The service was not entirely safe<br>Details are in our safe findings below. | **Requires Improvement** |
| **Is the service effective?**<br><br>The service was not entirely effective<br>Details are in our effective findings below | **Requires Improvement** |
| **Is the service caring?**<br><br>The service was caring<br>Details are in our caring findings below. | **Good** |
| **Is the service responsive?**<br><br>The service was not entirely responsive.<br>Details are in our responsive findings below | **Requires Improvement** |
| **Is the service well-led?**<br><br>The service was not well-led<br>details are in the well led findings below | **Inadequate** |

# St Mary's Haven

**Detailed findings**

## Background to this inspection

The 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection was carried out by two inspectors and a member of the medicines team.

Service and service type:
St Mary's Haven is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. People and staff from a sister home in the Anson Care Group had moved in to St Mary's Haven temporarily while refurbishment was carried out.

The service had a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager from the sister home was also managing the service at the time of this inspection.

Notice of inspection: This inspection was unannounced.

What we did before the inspection:
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We reviewed the last inspection report, information we had received from other agencies and feedback we had received from other interested parties. We used all of this information to plan our inspection.

During the inspection:
We spoke with five people who used the service, one relative, six staff members, two registered managers, the head of care and the operations manager. We reviewed the care records of five people and medication records for 14 people who used the service. We reviewed records of accidents, incidents, compliments and complaints, staff recruitment, training and support as well as audits. Some people were not able to tell us verbally about their experience of living at St Mary's Haven. Therefore, we observed the interactions between people and the staff supporting them. 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.

After the inspection:
We looked at staff training data and staff supervision records. We continued to seek clarification from the provider to validate evidence found. We contacted the local authority for further information. We spoke with three healthcare professionals.

Requires Improvement

# Is the service safe?

## Our findings

Safe –this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection, the provider had failed to ensure that care plans, for people with specific long-term conditions, contained sufficient guidance and direction for staff on how to support the person.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not taken the necessary action and the regulation continued to be breached.

● As at our previous inspection, some people who were living with long term specific conditions, had care plans which did not hold accurate necessary guidance and direction for staff, to help ensure people were supported appropriately. For example, people with epilepsy and diabetes. We found their care plans did not have any information around their conditions that would help staff understand and be able to react to their needs safely.
● Risks relating to people's care needs were not always well managed. Where risks had been identified, risk assessments were not always carried out to provide guidance and direction for staff on how to reduce known risks. For example, people who had been identified as requiring moving and handling support from staff.

The failure of the provider to ensure that risk was robustly managed is a repeated breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Fire doors and systems were regularly checked to ensure they were in good working order. Regular fire drills took place.
● Utilities and equipment were regularly checked and serviced to make sure they were safe to use.

Learning lessons when things go wrong
● Learning from accidents and incidents to reduce them being repeated was not happening. Staff knew how to report accidents or incidents. Records showed accidents and incidents had been recorded. However, such events were not audited by the registered manager, or the provider to help ensure any themes or trends were identified and action was taken to reduce the risk of any such events reoccuring.
● Areas of concern found at the last inspection had been not effectively addressed and new processes implemented had not been effective. For example, ineffective audit processes, long term conditions not having specific care plan guidance for staff, conflicting information in different parts of care plans and inaccurate DoLS information recorded by the registered manager.

The failure of the provider to ensure effective quality assurance systems and processes were in place to constantly improve the service where necessary is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Issues raised by people or their families had been listened to and addressed. A recent concern from a neighbour had been addressed.

Preventing and controlling infection
● People could be at risk from ineffective infection control measures. Whilst the service appeared clean and was free from malodours, infection control audits were not in place. The registered manager carried out informal checks by walking around the home, but there was no systematic approach by the registered manager or provider. This could mean infection control processes were not being fully and routinely checked to ensure the measures to prevent and control infections were effective.
● Cleaning schedules were not in place. Minutes of the staff meeting held in October 2019 stated that staff had requested cleaning schedules be provided to them. The minutes stated the registered manager would implement this. This had not taken place. The registered manager told us, "No we don't have any cleaning schedules."

We recommend the service take advice and guidance from a reputable source to ensure robust infection control management processes are in place.

● Staff had access to aprons and gloves to use when supporting people with personal care. Staff were seen wearing person protective equipment (PPE) appropriately throughout this inspection. This helped prevent the spread of infections.

Using medicines safely
At our last inspection the provider had failed to ensure medicines was managed in a safe way. Some people had not always received their medicines as prescribed due to a lack of stock. Handwritten entries on the medicine records had not been signed by two staff according to the medicines policy. Medicine audits were not effective. Identified errors requiring action were not addressed in a timely manner. Care plans did not always include protocols detailing the circumstances in which 'when required' medicines should be used.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had taken some action and improvements were noted. However, further action is required.

● There were protocols in place for medicines prescribed to be taken 'when required', to guide staff as to when it would be appropriate to give a dose. However, some people did not have these in place for all their 'when required' medicines.
● Medicine audits were not always effective. Robust actions were not being completed to address issues identified, to help improve medicines management. Daily audit checks were not always being carried out, as directed, on the records completed by staff when they applied prescribed creams. The audit was not effective as the records contained many gaps. This had been identified but no action had been taken to address this concern.
● There were suitable arrangements for storing and disposal of medicines, including those needing cold storage and extra security. The temperatures recorded in one treatment room were sometimes higher than recommended. Staff were aware of this and informed us that a ventilation system was to be fitted. This had

not been addressed in a timely manner and did not ensure the safe storage of medicines.

The failure of the provider to ensure effective audit processes were in place for medicines management is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All handwritten entries were signed by two staff according to the medicine policy.
● People had received their medicines as prescribed. Stock levels were being monitored to ensure they did not run out of medicines.
● If people were given their medicines covertly (without their knowledge or consent) then mental capacity assessments were made and 'best interest' decisions recorded. The pharmacy checked that medicines were safe to be given in this way.

Systems and processes to safeguard people from the risk of abuse.
● The service held some people's money in safe keeping so that they could access this for small purchases. We checked all the money held and it tallied with the records held. However, these records had not been audited or overseen formally since July 2019.
● Information about how to report safeguarding concerns externally was displayed in the service.
● People were protected from potential abuse and avoidable harm by staff who had safeguarding training and knew about the different types of abuse. However, nine staff including the registered manager and head of care had no safeguarding training recorded. The provider advised us after the draft report had been received that the registered manager and head of care had in fact received this training but it was not recorded on the matrix.
●The provider had effective safeguarding systems in place and staff had a good understanding of what to do to help ensure people were protected from the risk of harm or abuse.

Staffing and recruitment
● People were supported by suitable staff. All pre-employment checks had been carried out before staff started work, such as criminal record checks and references.
● Staff told us they had enough time to support each person.
● There were night staff vacancies at the time of this inspection. Existing staff were covering these vacant posts.
● People had access to call bells to summon assistance when needed. People told us staff responded quickly to them when they called.
● One person told us, "I think there are enough staff. I never have to wait long if I call them"

Requires Improvement

# Is the service effective?

## Our findings

Effective –this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At the last inspection this key question was rated as good. At this inspection this key question has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● People received care from staff who were not always up to date with training. The Provider Information Return (PIR) stated "With the staff having been trained and educated to the needs of the clientele." However, staff had not always received necessary required training. Some mandatory training was not up to date. The training matrix stated moving and handling training should be provided annually. Many staff were overdue this training, despite the head of care being a moving and handling trainer. Some people living at the service had specific conditions such as epilepsy and diabetes. Guidance on specific conditions was held in a file in the office but not linked to people's individual needs around the conditions. However, most staff were not provided with training on these specific conditions. This meant they were not able to effectively understand and support some people's needs. Staff confirmed they would not know what to do in the event of a person having a seizure.

● Documents provided to the inspector at inspection were inaccurate. The handover sheet used a shift change was not correct. The records for both supervision and training were reviewed by the registered manager following the inspection and re-sent to the inspector. Both reviewed records were held in a different format. Some staff did not appear on both records. The names of both the registered manager and the head of care were on both records but showed no training or supervision completed by them. This meant the registered manager did not have a robust process in place to monitor all staff requirements.

● Supervision was not provided in accordance with the policy held, which stated staff should receive this support every three months. The head of care could not recall their last supervision when asked.

The failure to ensure staff received necessary training and support to meet the needs of people living at the service is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014

● The registered manager had held meetings with each staff team. There were other opportunities for staff to meet with the registered manager on a regular basis. However, these were not always documented.

● Staff induction procedures were in place. New staff spent time working with experienced staff until they felt confident to work alone.

● Staff told us, "I love this job I never wake up and don't want to come to work," "I've been here for a while now. We work well as a team. It's a really good atmosphere" and "I am very proud of what we do. It's important to use the home is clean and fresh. I have the training and things I need to do that."

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
At our last inspection records held relating to DoLS authorisations were not entirely accurate. This was addressed following the inspection. This contributed to the breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014 at the last inspection. At this inspection we found inaccurate information continued to be held and the system used to manage this legislation continued to be ineffective.

● The Provider Information Return (PIR) received by CQC on the 10 January 2020 stated the service had six people who were subject to a DoLS authorisation. At this inspection the white board in the manager's office stated seven people had an authorisation in place. Following the inspection, we contacted the local authority DoLS team who confirmed only three authorisations were in place. Three people were restricted to leave the service unsupervised. Three were inaccurately recorded as having an authorisation in place, but had an application in process and one person had not been applied for. This was confirmed as a recording error by the operations manager. The registered manager did not hold an accurate overview of this information. This meant that some people may have been unlawfully restricted. This concern was addressed following the inspection by the local authority providing the correct information to the service.
● The white board in the manager's office recorded which people, living at the service, had appointed Lasting Powers of Attorney (LPA's). This information was not accurate. The registered manager had accepted a general power of attorney document which is not valid under the Mental Capacity Act 2005 when a person no longer has capacity. This meant management and staff may have requested family members to make decisions they did not have the legal power to do.

We found no evidence that people had been harmed however some people were at risk of being unlawfully restricted. This is a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (regulated Activities) 2014.

● Capacity assessments were completed to assess if people were able to make specific decisions independently.
● Most staff had received specific training which had led to staff having an understanding of the requirements of the Mental Capacity Act 2005.
● People told us, and we observed, staff always asked for their consent before commencing any care tasks.

Adapting service, design, decoration to meet people's needs
● People with dementia were at risk of being disoriented and unsafe around parts of the home. The premises had been recently refurbished and extended, offering a variety of communal areas. There were slopes in some corridors which did not have any warning signs alerting people to this change in floor level. There were no hand rails to support people using the corridors where slopes were present. Toilets and bathrooms had only standard signage. No pictorial signage was in place in the dementia unit to help support people who needed orientation to their surroundings. We spoke to the dementia liaison nurse

about the service, who carried out a visit to the service and provided us with verbal feedback which they had shared with the operations manager. A further meeting was agreed to provide support to the service. The lack of pictorial signage had been raised with the provider in the last report. We were assured this would be addressed with the building work which was planned to enhance the environment for people with dementia. These assurances had not been actioned. The dementia liaison nurse has advised the service to provide clear pictorial signage and provide hand rails to support people's needs.

We recommend the provider take advice and guidance from a reputable source regarding best practice in dementia environments.

● The first floor sluice was not secure. A chair was placed against this door to prevent people accessing the sluice. Someone could move the chair if they wanted to which could have placed them at risk of harm.
● People in the dementia unit had different coloured doors to help them identify their own rooms.
● People had access to call bells to summon support when needed. Pressure alarm mats were used to ensure staff were aware when a person was moving around their room. The maintenance person checked these and many other aspects of the premises and equipment regularly.
● Secure outside space was available to people. People were encouraged to spend time outside.
● Small kitchenette areas enabled people to make drinks and snacks when required.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and preferences were assessed prior to a person moving in to the service. This helped ensure the service could meet their needs and that they would suit living with the people already at the service.
● People, or if appropriate their representative, were asked about any support they required related to protected characteristics under the Equality Act 2010. For example, if they had a preferred gender for their carer.
● Everyone at the service had a care plan. Most needs were clearly identified although some risk assessments and specific conditions were not well recorded.
● Health and social care professionals were regularly consulted to help ensure people's care and support reflected best practice.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff recorded some people's food and drink intake, where concerns had been identified. However, there were many gaps in these records. We checked people's weight and found there was no loss of weight for these people. However, the risk of dehydration had not been addressed. Vegetarian meals were available. People told us they enjoyed the food provided. People told us, "I like the food here, we get plenty of it" and "I have no problem with it."
● Staff were aware of people's dietary needs and preferences. Care plans contained details of any support that people required at meal times, as well as any risks associated with eating and drinking.
● A visual meal choice was available for people who needed support with making decisions about food.
● Staff supported people to eat and drink. Staff were heard saying, "[Person's name] would you like to come for lunch. Here I'll help you up," "Just follow me, I'm going slowly so you can keep up" and "How are you feeling [Person's name]. How about a little lunch."?

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were encouraged and supported to attend regular health appointments. A hygienist had visited the service to support staff with people's oral health needs.

● Staff liaised with a range of organisations on behalf of people, depending on their individual support needs. Health and social care professionals visited people regularly.

Good

# Is the service caring?

## Our findings

Caring –this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People felt cared for. Comments included, "I am happy here, staff are good" and "I am alright here"
- There was a relaxed atmosphere in the service and staff provided friendly and compassionate support. People had built caring and trusting relationships with staff. We observed people were confident requesting help from staff who responded promptly to their needs.
- Staff understood the importance of treating people equally and fairly.
- Relatives told us "I am happy that [Person's name] is happy," "I have every faith in the managers and staff. They are very good at keeping me informed about any changes" and "[Person's name] always looks happy and well cared for. That gives me piece of mind."
- Staff had been provided with training to help ensure people's rights were protected at the service. Staff told us, " [Person's name} Loves having this choice in a morning. I think she would have this for most meals, but we do encourage a balanced diet for everyone. Yes, we do respect choice as you can see. Resident shave whatever they want even a cooked breakfast if they want one."

Supporting people to express their views and be involved in making decisions about their care.

- People told us they felt able to speak with staff about anything they wished to discuss. Relatives felt able to raise any issues with the registered manager or staff.
- Care plans did not indicate that people had been involved in their own care plan reviews. The registered manager provided care and support to people at the service regularly and spoke with people to discuss any changes they wished to make to their care and support.
- Staff gave us examples of how they used different forms of communication to help people understand information and make decisions.

Respecting and promoting people's privacy, dignity and independence

- Care staff were person-centred in their interactions with people. They knew people well and held many relevant and meaningful conversations with people throughout the inspection visit. Confidential information was kept securely.
- People were supported to maintain and develop relationships with those close to them. Relatives were regularly updated about people's wellbeing and progress.
- People were encouraged to do as much for themselves as possible. People's care plans showed what aspects of care they could manage independently and when staff needed to support them. Staff promoted

people to be as independent as possible by encouraging and praising them.

● People told us they felt respected. We observed care staff lowered their voice when speaking with people about any support they may need.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive –this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
At our last inspection the provider had failed to ensure that staff recorded the care and support provided in a timely manner. The information held on the front page of some care plans had not been updated when a review had taken place. This meant some information was out of date. Care plans did not always provide sufficient recorded guidance for staff on when to re-position people. We made a recommendation about this in the last report. At this inspection we found improvements had been made to staff recording daily notes when care was provided. However, information held in some areas of care plans remained out of date following reviews. Guidance was not always provided for staff when required.

- People's needs were at risk of not being met fully. New processes put in place by the registered manager to improve staff communication and handover between shifts were not effective. We saw details of people's changing needs having been recorded but this had not resulted in any care plan review or increased monitoring.
- Some people required regular re-positioning by care staff while being cared for in bed to reduce the risks of skin damage. This was recorded in care plans. Staff recorded some skin care monitoring on paper records and not on the electronic system. There were gaps in these records. This meant it was not possible to check if the re-positioning had always been provided as required which placed people at potential risk or pressure damage.
- One person was unable to walk and required staff to use a hoist for all transfers. This person had skin damage from a previous admission to hospital. There was no risk assessment in place to ensure staff were given guidance on how to reduce the risks. This person was found sitting on an inappropriate sling during the inspection. Whilst this was addressed immediately the lack of understanding placed this person at risk of further skin damage.
- Some people had been assessed as requiring pressure relieving mattresses. These were provided. However, mattresses were not always set correctly for the person using them. The registered manager told us a weekly audit was in place to check these. Staff were recording mattresses settings daily although there were gaps in these records. The checks and recordings had not ensured that mattresses were always set correctly. This meant people were at risk of potential skin damage.
- Sections of people's electronic care plans were reviewed regularly. They described people's individual needs, preferences and routines. However, the review process was not robust and did not ensure the whole care plan and all risk assessments were always checked, updated and reviewed to ensure accurate up to date information was provided for staff. No audits of care plans was in place.
- Some people were living with long term conditions such as epilepsy and diabetes. There was no specific care plan for these conditions, to provide specific guidance and direction for staff on how to meet these

people's needs or respond to any change. This was particularly important when staff had not received any training around these needs. One person had recently had a seizure, this was recorded, however, no risk assessment was present, and no care plan review took place and no increased monitoring was being carried out. We saw a statement in the senior's communication book asking staff to 'monitor' the person. However, no detail on what staff should look for was recorded and the monitoring was not being done.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to ensure people received safe and appropriate care. This placed people at risk of harm.

The failure of the provider to ensue people received safe care and treatment is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Throughout our inspection we observed people and staff communicated openly using a range of verbal and non-verbal communications which people fully understood and responded to positively. We saw this enabled people to be fully involved in communicating their needs and preferences at any time to any of the staff team.
● There was information in place to enable the provider to meet the requirements of the Accessible Information Standard (AIS). Each person had a communication care plan, recording any visual problems or hearing loss and instruction for staff about how to help people communicate effectively.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Activities were provided for people at the service seven days a week. A minibus provided opportunities for people to be taken out in to the local area. Smart speakers were used to support people with activities.
● Visitors were encouraged at any time. Comments included, "I come when I want, there is no problem. It is difficult to sometimes get the door answered though."
●St Marys Haven had a non-denominational chapel that was accessible to all. People were supported to attend their own church if they wished.
● One person told us, "I prefer to stay in my room and the staff are always popping in. I'm very settled"

Improving care quality in response to complaints or concerns
● The service held an appropriate complaints policy and procedure. This was accessible to people living at the service.
● We were told there were no formal complaints in process. A recent concern from a neighbour had been responded to.
● Many compliments had been received by the service.

End of life care and support
● The staff were supported by the community nursing team to provide good quality end of life care to people. Staff had been supported to participate in the implementation of an end of life care passport. This record helps share information across agencies.
● Care plans showed people had been asked for their views and wishes about how they wished to be cared for at the end of their lives.

Inadequate

# Is the service well-led?

## Our findings

Well-Led –this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection the provider had failed to ensure an effective system help monitor aspects of the service. Concerns found at that inspection had not been identified prior to our visit. We found out of date guidance appearing in some care plans, and a lack of guidance for staff on when to check people's skin for pressure damage.
Some records held were not always accurate and up to date. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the same concerns remained and the provider remained in breach of Regulation 17.

● The concerns identified at the last inspection had not been addressed. The governance arrangements had failed to be effective to ensure action had been taken, to address the breaches of the regulations and the recommendation in the last report. The monitoring arrangements in the service and by the provider had failed to identify areas for improvement which meant people were receiving care from a poorly managed service.
● Communication processes were not effective. The provider information return (PIR) stated "A confidential communication book has been introduced for senior carers to pass on relevant detail to each other…… This has ensured that any event or particular resident need will not be missed and can be acted on as necessary." This was not what we found. One person's needs had changed, although the change had been recorded, no action had been taken. There had been no review of their care plan and risk assessments were not present. There was no guidance for staff regarding how to monitor this person.
● Audits were not taking place of many aspects of the service such as infection control, monitoring records and care plans. Audits which were in place such as medicines administration and mattress settings were not effective This meant opportunities to identify failings and therefore improve the service had been missed.
● The registered manager was not well supported. They were new to the role since June 2019. The roles and responsibilities of the two registered managers and head of care were not clearly defined. All three had not identified the concerns found at this inspection.
● The provider had a defined organisational management structure. However, there had not been effective regular oversight and input from senior management of the new registered manager. Monitoring of the service provided at St Mary's Haven was not effective.
● Visiting healthcare professionals told us, "It is often difficult to obtain entry to the service. We have now been given codes to enable us to access all areas as we require. Staff are always available when we visit," The provider had implemented a measure whereby all visitors must ring the bell to be allowed in to the

service. The provider was aware there had been a fault with the outer door which had led to people having to wait and was rectifying this. Other comments included, "We find documentation is a problem sometimes, it is not always easy to establish if something has taken place. When something happens with a person there is often no sign of it in their care plan" and "It is a pity that this home is not really working as well as it could just at the moment."

The provider continued to fail to have effective oversight and governance arrangements that helped improve the quality of the service. This was a repeated breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●The registered manager and staff were clear about their aim of providing good care and this was reflected in the way staff spoke about how they supported people.

● Residents and family meetings had been held to share information with people and seek their views of the service provided.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager promoted the ethos of honesty and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

● The registered manager was aware of the need to report to CQC, any event which affected the running of the service, including any deaths as they are legally required to do.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager had held meetings with each staff team. There were other opportunities for staff to meet with the registered manager on a regular basis. However, these were not always documented. Staff said they felt well supported and that they could talk to management at any time, feeling confident any concerns would be acted on promptly.

● Residents meetings had been held to seek people's views.

● Relatives felt able to raise any issues with the registered managers or head of care at any time.

Continuous learning and improving care

● The Provider information return stated the service had introduced 'a senior management handover showing a 'week to view' handover to ensure continuity and to make sure that we are all aware of every resident's care and support needs and are able to act upon concerns raised in a timely manner.' This had not been effectively implemented as we identified changes in people's needs that had not been responded to effectively.

● Following the inspection, the registered manager reviewed the staff training and supervision record and a few days after the inspection visit sent us an updated version of this document. The two records still did not contain all the names of staff. This had not been identified prior to this inspection but was rectified following the inspection.

This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Working in partnership with others

● The community nurses visited people at the service regularly to support any nursing needs. One person told us, "I have the district nurse come in. They tell the staff if I need anything Like cream going on."

● The service communicated with commissioners and external healthcare teams appropriately about people's care.

● Care records held details of external healthcare professionals visiting people living at the service as needed. Regular meetings were planned with the community nursing teams to improve communication.

● The provider visited the service regularly. The provider was involved in a number of local and national initiatives such as the Care Association Alliance (CAA), Cornwall Partners in Care (CPIC) and Care England.

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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to take effective action following the recommendation in the last report and to ensure that robust systems and processes were in place to manage the Mental Capacity Act 2005 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider did not ensure that all staff received necessary training and support to meet the needs of people living at the service. |