

Oakfoil Limited

St Andrews House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We carried out an inspection of St Andrews House on 16 and 17 January 2018. The first day was unannounced.

St Andrew's House provides accommodation and both nursing and personal care for 24 people who have a physical disability. It is an extended, detached older property located in the town centre of Barnoldswick. Accommodation was provided on two floors with a passenger lift. There were 13 people accommodated in the home at the time of the inspection.

St Andrews House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service was managed by a registered manager who had been in post since September 2017 and registered with CQC in December 2017. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 1, 2 and 11 August 2017 we found seven breaches of regulation in respect of infection control, recruitment processes, maintaining the environment, medicines management, care planning and risk assessment and quality assurance systems. The overall rating for this service was 'Inadequate' and the service was placed in special measures. This meant the service was kept under review and an inspection would be undertaken within six months to ensure significant improvements have been made. At that time we asked the provider to complete an action plan to show what they would do to improve the service and by when.

Following the last inspection regular meetings had been held with the registered persons, CQC, the local authority safeguarding team and the commissioners of services. Admissions to the home were suspended until commissioners and CQC were satisfied that significant improvements had been made. The medicines management team, infection control team and local commissioners worked with the provider, registered manager and staff to support them with improvements. Recent feedback from other agencies was positive regarding the improvements made and an action plan was available to support further improvements. The local authority suspension on admissions was lifted.

During this inspection we found new quality assurance and auditing processes had been introduced to help the provider and the registered manager to effectively identify and respond to matters needing attention. However some of these improvements had been introduced over a short period of time and were in their infancy; further work was needed to embed these processes into the day to day practice at the home. Therefore our findings demonstrated there was a continued breach of the regulations in respect of effective

quality assurance systems. You can see what action we told the provider to take at the back of the full version of the report. We will check this during our next planned comprehensive inspection.

Since the concerns raised at the last inspection the registered manager, directors and staff had worked hard as a team to introduce much needed changes and improvements. People and staff were happy with the improvements that had been made and considered the service was managed well. Communication had improved and people felt they had been involved in decisions and consulted about any changes.

People were happy with the personal care and support they received and made positive comments about the staff and about their willingness to help them. They also made positive comments about the registered manager and the directors. The registered manager, directors and staff were observed to have positive relationships with people living in the home and people were relaxed in their company.

Improvements had been made to ensure the home was a clean, safe, bright and comfortable place for people to live in. Appropriate aids and adaptations had been provided to help maintain people's safety, independence and comfort. People told us they were happy with the improvements to the home and described how they had been involved in decisions about the changes.

The recruitment of new staff had improved. A safe and robust recruitment procedure was followed to ensure new staff were suitable to care for vulnerable people. Arrangements were in place to make sure staff were trained and competent. People considered there were enough suitably skilled staff to support them when they needed any help. Staffing levels were monitored to ensure sufficient staff were available.

The way people's medicines were managed had improved. People had their medicines when they needed them. Staff administering medicines had received training and supervision to do this safely. Additional training had been arranged for staff.

The systems to obtain the views of people, their visitors and staff had been improved. People felt their views and choices were listened to and they were kept up to date with the recent changes. They were encouraged to be involved in the decisions about the day to day running of the home and were kept up to date with any changes. People told us that communication between management, staff and people in the home had improved.

Records relating to people's care and support had improved. The information in people's care plans was sufficiently detailed to ensure they were at the centre of their care. People's care and support was kept under review and they were involved in decisions about their care; arrangements were in place to improve their involvement in the review of their care. Risks to people's health and safety had been identified, assessed and managed safely. Relevant health and social care professionals provided advice and support when people's needs changed.

People told us they felt safe in the home and staff were caring; they said they were very happy with the service they received. People appeared comfortable in the company of staff and it was clear they had developed positive trusting relationships with them. Safeguarding adults' procedures were in place and staff understood how to protect people from abuse. There were no restrictions placed on visiting times for friends and relatives.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

From our discussions and observations it was clear staff acknowledged people's diversity, treating people equally and ensuring that they promoted people's right to be free from discrimination.

We found people had access to a wide range of appropriate and meaningful activities both inside the house and in the local community. People told us they enjoyed the meals and their dietary needs and preferences were met. People were offered a choice of meal; food and drinks were offered throughout the day. We observed meal times were a relaxed and enjoyable social experience.

People told us they were happy and did not have any complaints. They knew how to raise their concerns and compliments and were confident they would be listened to. Appropriate and prompt action had been taken to respond to people's concerns and suggestions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

People felt safe in the home and were protected against the risk of abuse.

Improvements had been made. The home was safe, well maintained and tidy.

Safe recruitment practices had been followed. There were sufficient staff available to meet people's needs at all times.

Accident and incident monitoring and the management of risks had improved to ensure people's safety.

People's medicines were managed safely and administered by trained and competent staff.

Is the service effective?

Good 

The service was effective.

Staff were provided with training and professional development which enabled them to meet people's needs; gaps in the provision of supervision were being addressed. People felt that staff were competent and could support them effectively.

Improvements to the environment had been made to provide safety and comfort for people. Further improvements were being made; a system of reporting required repairs and maintenance was in place.

People enjoyed their meals. Their dietary needs and preferences were met.

People were supported appropriately with their healthcare and were referred appropriately to community healthcare professionals.

Staff had received training to improve their understanding of the MCA 2005 legislation. People's capacity to make safe decisions

and to consent to care had been recorded.

Is the service caring?

Good ●

The service was caring.

Staff responded to people in a friendly, caring and considerate manner and we observed good relationships between people.

People were encouraged to maintain relationships with family and friends. There were no restrictions placed on visiting.

People's privacy, dignity and independence were respected.

People were able to make their own choices, where possible, and were involved in decisions about their day.

Is the service responsive?

Good ●

The service was responsive.

People were supported to take part in suitable activities inside and outside the home.

Each person had a care plan that was detailed and reflected the care they needed and wanted. Improvements had been made to ensure they were accurate and up to date.

People had been involved in discussions about their care but not in the formal review of their care plan; systems were being introduced that would improve this.

People told us they knew who to speak to if they had any concerns or complaints and were confident they would be listened to.

Is the service well-led?

Requires Improvement ●

The service demonstrated it was well led. However practices and improvements needed time to be embedded further to ensure they can be sustained.

The manager had been in post a short time and had introduced a number of recent improvements that needed to be embedded into practice over time. We were unable to determine their full effectiveness.

People made positive comments about the management and leadership arrangements at the service. They felt the service was

well managed and they were very happy with the recent changes and improvements made.

The systems to assess and monitor the quality of the service and to obtain people's views and opinions had improved and were being further developed. People told us they were happy and settled in their home.

Improvements had been made to the records to ensure they were accurate and stored securely.

St Andrews House

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 16 and 17 January 2018 and the first day was unannounced. The inspection was carried out by an adult social care inspector; a specialist advisor attended on the first day. The specialist advisor was a registered nurse who had personal experience of using or caring for someone who used this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed the information we held about the service such as notifications, complaints and safeguarding information. We obtained the views of the local authority safeguarding and contract monitoring team, the infection prevention and control lead, the medicines management team and local commissioning teams.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with both directors, the registered manager, two registered nurses and with three care staff. We also spoke with seven people living in the home.

We looked at a sample of records including five people's care plans and other associated documentation, three staff recruitment and induction records, staff rotas, training and supervision records, minutes from meetings, complaints and compliments records, medication records, maintenance certificates and development plans, policies and procedures and quality assurance audits.

Is the service safe?

Our findings

During the last inspection we found the provider had failed to ensure people were protected against the risks associated with poor infection control. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found unpleasant odours, dirty and damaged equipment and furniture, damaged flooring and pipework and a lack of clear cleaning schedules. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

The local authority infection prevention and control of infection lead nurse had visited the service and provided the management and staff with advice and support. An action plan had been developed to support them with needed improvements. They were satisfied with the action taken to address the issues.

During this inspection we found improvements had been made. We found all areas of the home were clean and fresh smelling. Improvements to the cleanliness of the sluices, bathroom and toilet areas had also been made. The basement and laundry areas were safe, tidy and clean although the plaster to the rear of the dryers remained in poor condition making it difficult to clean. The laundry was well organised with sufficient equipment to maintain people's clothes. Storage areas around the home were organised and any equipment in use was clean.

Domestic and laundry staff worked each day. An infection prevention and control lead had been appointed and was responsible for conducting checks on staff practice in this area and for keeping staff up to date. There were infection control policies and procedures for staff to refer to and staff had been trained in this area; further training sessions were planned. Revised cleaning schedules were in place. Staff were provided with protective wear such as disposable gloves and aprons and suitable hand washing facilities were available to help prevent the spread of infection. There were contractual arrangements for the safe disposal of waste.

All people spoken with told us the home was 'always clean' and 'very clean'; they told us the cleanliness in the home had greatly improved since the last inspection.

During the last inspection we found the provider had failed to follow safe and robust recruitment processes. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found the required employment checks had not always been obtained and confirmation that agency staff were experienced, qualified and fit to work in the home had not always been received. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we found improvements had been made. Recruitment and Selection policies and procedures were available. We looked at the recruitment records of four members of staff and found appropriate employment checks had been completed before they began working for the service. Checks included a full history of employment, suitable references and a Disclosure and Barring Service (DBS) check.

The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Regular checks on the registration status and fitness to practice of all nursing staff had been completed and confirmation was received that agency staff were fit and safe to work in the home.

During the last inspection we found the provider had failed to protect people against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found checks on staff practice had not been completed, policies and procedures were not reflective of the system in use, medicine records were incomplete and directions for administration were unclear. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

Following the last inspection the medicines management team had visited the service and provided advice and support to management and staff regarding the improvements needed. A recent report from the medicines management team indicated there had been improvements made and no major concerns were identified.

During this inspection we found improvements had been made. We found a monitored dosage system (MDS) of medicines was being used. This was a storage device designed to simplify the administration of medicines by placing the medicines in separate pods according to the time of day. Nursing staff who were responsible for the safe management of people's medicines had received training and checks on their practice had been completed.

There were safe processes in place for the receipt, ordering and disposal of medicines. We looked at four people's Medication Administration Records (MARs). We found the directions for the application of external medicines were not clear on two people's MARs and there were limited records to support whether external medicines such as creams and ointments were being applied. This had been recognised as part of a recent audit. Discussions with community pharmacists and GPs were taking place and records providing clear directions for staff were put in place during our inspection. In addition we were told the community pharmacist would provide care staff with training in the management and application of external medicines; the training was booked for the week of the inspection.

People were identified by a photograph on the MAR which reduced the risk of error, particularly as agency nursing staff were being used. Any allergies people had were recorded which meant staff and health care professionals were aware of any potential hazards of administering certain medicines. The appropriate codes and reasons for non-administration had been used. Records were in place to support the application of patch medicines and medicines given by injection. People had consented to either their medication being managed by the service or whether they were able, or wished to, self-medicate. There was a system to ensure people's medicines were reviewed by a GP which would help ensure people were receiving the appropriate medicines.

Medicines that were prescribed 'as needed' were supported by clear guidelines and any handwritten entries were witnessed to ensure accuracy. Bottled and boxed medicines were dated when opened and the application of patch medicines (to be applied to the skin each day) were recorded appropriately. There were records to support 'carried forward' amounts from the previous month which helped to monitor whether medicines were being given properly. We observed people's medicines were given at the correct time and in the correct manner in line with the information in their care plan; we also observed that staff provided careful, patient and considerate administration.

Appropriate arrangements were in place for the management of controlled medicines which were medicines which may be at risk of misuse. We checked one person's controlled medicines and found they corresponded accurately with the register. Medicines that needed to be crushed prior to administration were crushed with the recommended appliance. Systems to monitor whether people's medicines were being managed were in place; shortfalls had been identified and appropriate and prompt action had been taken.

During the last inspection we found the provider had failed to ensure people were protected against the risks to their health, safety and well-being. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found individual assessments of risk had not been regularly updated and the severity of the risk had not been considered when determining the review. Financial risk assessments were not in place. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we found improvements had been made. Potential risks to people's safety and wellbeing had been assessed and recorded in their care plans. The assessment information was based on good practice guidance in areas such as falls, skin integrity, nutrition, dependency and moving and handling which ensured the best outcomes of care, treatment and support were achieved for people. Management strategies had been drawn up to provide staff with guidance on how to manage risks in a consistent manner without restricting people's freedom, choice and independence. Records showed that the assessments were regularly reviewed and updated in line with changing needs. However, the severity of the risk had not always been considered when determining the review frequency was not always considered. We discussed this with the registered manager who assured us this would be addressed.

Appropriate risk assessments and consent documents were in place for people whose personal allowances were managed by the home. We checked two people's personal monies and found the balance was correct. We discussed further improvements to the safety of the systems in use, with the registered manager.

Environmental risk assessments had been undertaken in areas such as fire safety, the use of equipment and the management of hazardous substances; additional environmental assessments and procedures were being developed. We found records were maintained of accidents and incidents; the records were analysed in order to identify any patterns or trends and to determine whether there was any action that could be taken to prevent further occurrences.

Information from accidents and incidents, action plan audits, complaints and safeguarding alerts were analysed to help identify any patterns or areas requiring improvement and shared with the staff team at monthly meetings to look at lessons and learned. This meant steps could be taken to reduce the risk of foreseeable harm occurring to people.

At our last inspection people were unhappy with the high reliance on agency nursing and care staff and the numbers of staff were not provided consistently. During this inspection we looked at staffing levels at the home. People told us they did not have any concerns about the staffing levels or the availability of staff and they were happy with the staff team; people considered they received appropriate care and support. They told us new staff had been recruited and they were happy with them. They said, "There is always someone around. I get prompt attention", "We don't use as many agency staff now; we have new staff" and "There are enough staff when I need help I get it." Staff confirmed there were sufficient staff.

We looked at the staff rotas and found there was a new staff structure in place. There was a minimum of one registered nurse on duty at all times with four care staff during the day, three care staff in the evening and

two care staff at night. Appropriate numbers of ancillary staff were available at all times including domestic, kitchen and maintenance staff. We noted any shortfalls due to leave or sickness were usually covered by existing staff or by regular agency staff which ensured people were cared for by staff who knew them. There were systems in place to monitor and respond to staff sickness and absence.

The management team told us they monitored staffing levels to ensure sufficient staff were available to provide the support people needed. Dependency risk assessment tools were used to determine people's needs and the numbers of staff required; this was reviewed monthly or as required. During our inspection we observed there was a good skill mix of staff and staff were attentive to people's needs in a timely way.

During the inspection we observed people were comfortable in the company of staff. We observed staff interaction with people was kind, friendly and patient. People living in the home told us they did not have any concerns about the way they were cared for and said they had confidence in the staff who supported them. They told us they felt safe. They said, "It's a good place, best I've ever been in. Everyone is treated well" and "I didn't feel safe before but I feel safe and happy now and I know I can speak to the staff if something was bothering me."

Staff had safeguarding vulnerable adult's procedures and whistle blowing (reporting poor practice) procedures to refer to. Safeguarding procedures are designed to provide staff with guidance to help them protect people from abuse and the risk of abuse. Staff had received safeguarding training. Additional training was being provided and a designated safeguarding champion had been appointed to provide advice and guidance to other staff in this area.

Staff we spoke with understood how to protect people from abuse and were clear about the action to take if they witnessed or suspected abusive practice. They told us they would have no hesitation in reporting any concerns either to the management team or to other agencies. Information about recognising and reporting abuse was displayed in the entrance for people and their visitors to read. Records showed the management team was clear about their responsibilities for reporting incidents and safeguarding concerns and they worked in cooperation with other agencies. Action to be taken and lessons learned from incidents had been discussed with staff. Arrangements were in place to respond to external safety alerts to ensure people's safety.

Equipment was stored safely and was serviced at regular intervals. People had access to a range of appropriate equipment to safely meet their needs and to promote their independence and comfort. The service employed a maintenance team who were responsible for day to day maintenance. Records showed any requests for maintenance or repair were responded to promptly.

Training had been provided to support staff with the safe movement of people. We observed staff using safe practices when supporting people to move around the home. Staff were trained to deal with healthcare emergencies.

Regular fire alarm checks, fire safety training and regular fire drills had been recorded and staff knew what action to take in the event of a fire. Staff had received training in fire safety. Each person had a personal evacuation plan in place in the event of a fire which assisted staff to plan the actions to be taken in an emergency. We noted recommendations made following a visit from the fire and safety officer in 2017 had been fully addressed. The fire safety officer visited the service during this inspection and made recommendations; no major concerns were raised.

The registered manager told us the business continuity plan, to respond to any adverse events such as loss

of power or severe weather, was being developed. The environmental health officer had awarded the service a five star rating for food safety and hygiene in March 2017.

Visitors were asked to sign in and out which would help keep people secure and safe. There was open entry to the home during daytime/evening hours and people would use the doorbell at other times. Following concerns being raised about people's safety and security a decision had been taken to install CCTV to external areas; this meant safety would be maintained without placing limitations on people's freedom and independence. This had been discussed with people and their relatives. The provider also told us additional security measures were being considered such as push pad door entry for wheelchair users.

All staff were bound by contractual arrangements to respect people's confidentiality. People's records were kept safe and secure.

Is the service effective?

Our findings

During the last inspection we found the provider had failed to ensure the home was properly maintained. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found areas of the home were untidy and in need of redecoration and repair and little progress had been made with this since our previous inspection. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we found improvements had been made and the home was comfortable, well lit, warm and well maintained. Aids and adaptations had been provided to help maintain people's safety, independence and comfort. Consideration had been given to ensuring the environment, furnishings and décor was suitable and safe for the people living there. We noted appropriate signage was in place throughout the home. The corridors had been re-decorated and modernised and new lighting provided in a number of areas. Sluice areas, the kitchen, toilet and bathroom areas had been refurbished.

Further improvements were planned and included installation of CCTV and redecoration of the dining room. Action was being taken in response to the fire safety officer's advice and redecoration of bedrooms was underway. We were told the hydro pool was not in use and would be removed; the room had been cleared and would be used for storage. The conservatory was being used as an additional TV room and a meeting room; the blinds had been replaced and the roof had received attention. However, we noted the roof continued to leak in one place and the room remained cluttered. The director advised that the old table and chairs would be removed to ensure adequate wheelchair access.

People told us they were happy with the improvements and described how they had been involved in decisions about the re-decoration. They said, "It looks miles better than before." People told us they were happy with their bedrooms and they could have keys to their bedrooms. Bedrooms were decorated to the person's tastes and a homely environment had been created with personal items such as furniture, photographs, posters and ornaments. This promoted a sense of comfort and familiarity. Bedrooms in use were single occupancy with en-suite facilities. Outside areas included seating and a covered smoking area.

People were happy with the service they received. They told us, "It's not home but it's as good as" and "It's a good place. I don't regret moving here at all."

We looked at how the service trained and supported their staff. From our discussions with staff and from looking at records, we found they received a wide range of appropriate training to give them the necessary skills and knowledge to help them look after people properly. The registered manager was aware of some gaps on the training matrix and a programme of training, supervision and observation had been planned.

Additional training and support had been provided to nursing staff to assist with meeting people's specialised care needs and with maintaining their professional registration with the Nursing and Midwifery Council (NMC). The Care Certificate had not yet been introduced. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. However, all staff had

completed a nationally recognised qualification in care or were currently working towards one.

All staff spoken with confirmed their training was useful and beneficial to their role and was delivered either face to face in a classroom environment or as e-learning. They told us the training was useful and kept them safe and up to date and they were supported in their work. They said new staff received an induction when they started working in the home. They said, "There is a lot of training but it has to be done", "The support has improved", "New staff work with experienced staff and get to know the residents" and "The training is good, really helpful."

Records showed new staff received an induction into the routines and practices of the home. This included a period of time working with more experienced staff until they were confident they had the confidence and skills to work independently.

From looking at records and from our discussions we found staff were provided with support and formal supervision sessions had been planned; this would help identify any shortfalls in their practice and any additional training needs. Staff told us they felt supported by each other and by the management team. Regular staff meetings allowed staff to express their views and opinions and to be supported and kept up to date.

Regular handover meetings, handover records and communication diaries kept staff up to date about people's changing needs and the support they needed. Staff spoken with had a good understanding of people's needs.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There were policies and procedures to support staff with the MCA and DoLS. Records showed staff had received recent training in this subject and staff expressed an understanding of the processes relating to MCA and DoLS.

At the time of the inspection two DoLS applications had been authorised by the appropriate agency; the reasons for the authorisation were clearly documented in the care plan. This meant people's best interests or choices would be considered as staff were aware of who was subject to any restrictions. We observed staff asking people for their consent when providing care and treatment, for example when administering medicines, providing care and treatment or supporting people with meals. People's consent, in areas such as taking photographs and medicine management were recorded in the care plans. One person had not consented to photographs being taken and this was respected by staff. The registered manager told us people's consent to share their information with others was being developed.

The service had a policy in place with regards to resuscitation (DNACPR - do not attempt cardiopulmonary resuscitation). People's decisions were recorded in their care files and determined whether the decisions were indefinite or whether they needed to be reviewed. This helped staff to recognise people's needs quickly and ensure that appropriate action was taken, for example in the case of a medical emergency.

We looked at how people were protected from poor nutrition and supported with eating and drinking. People told us they enjoyed the meals. They told us, "It's okay", "I can have what I want. I ask them and they make it for me", "I only eat salads and that doesn't cause anyone any problems" and "I get a choice."

During our visit we observed lunch being served. Most people sat in the main dining room although they could dine in other areas if they preferred. People were offered a choice of meal and drinks were offered during the meal. The meals looked appetising and the portions varied in amount for each person. The dining tables were set and condiments and drinks were available. Adapted cutlery and crockery and protective clothing was provided to maintain people's dignity and independence. Food and drinks were available throughout the day. Catering staff were aware of people's dietary risks, needs and preferences; this information was maintained on people's care plans and in the kitchen.

Staff were attentive to people's needs. We saw people being supported and encouraged to eat their meals and they were given the time they needed. We overheard friendly conversations between staff and people using the service during the lunchtime period. People told us they ate supper with staff which gave them chance to 'catch up' on the day's event. We noted specialist dietary advice was followed in line with people's care plans and records were made of people's dietary and fluid intake where needed. People's weight was checked at regular intervals and appropriate professional advice and support had been sought when needed.

We looked at how people were supported with their healthcare needs. People's care records included information about their medical history and any needs or risks related to their health. We found evidence that appropriate referrals were made to a variety of healthcare agencies including GPs, dieticians, speech and language therapists, tissue viability nurses, occupational therapists, dentists and opticians.

Appropriate information was shared when people moved between services such as transfer to other services, admission to hospital or attendance at health appointments. People were accompanied by a summary of their essential details, information about their medicines and a member of staff or a family member. During the inspection visit one person had attended a specialist appointment with a member of staff; we observed how staff effectively communicated the outcome of the appointment and any changes to the person's care. In this way people's needs were known by staff and taken into account and care was provided consistently when moving between services.

We looked at how technology and equipment was used to enhance the delivery of effective care and support. We noted light sensors had been fitted in some areas to provide timely illumination. The service had internet access to enhance communication and provide access to relevant information. This enabled people to have on-line contact with families and friends. E-learning formed part of the staff training and development programme.

Is the service caring?

Our findings

People told us the staff treated them with kindness and were respectful of their dignity and choices. They described them as 'lovely', 'approachable', 'kind', 'caring' and 'friendly'. People's comments highlighted the caring approach taken by staff and included, "Thank you for your kind care and friendliness", "Superb residential and nursing support at St Andrews House" and "We look after each other. We are more of a family and care about each other."

People appeared comfortable in the company of staff and it was clear they had developed positive trusting relationships with them. We observed staff taking time to chat with and listen to people. There was a named nurse and key worker system in place which provided people with a familiar point of contact in the home to support good communication. People confirmed there were no restrictions placed on visiting.

People in the home and staff told us that communication was good. Staff were aware of people's specific communication needs and alternative methods were used as appropriate. These included talking equipment, electronic communication devices, pictures, simple language and the use of body language and touch.

Staff were considerate of people's feelings and welfare. We observed good relationships between staff and people living in the home and overheard banter, laughing and encouragement during our visit. We observed people were treated with dignity and respect at all times and without discrimination. There were policies and procedures for staff about caring for people in a dignified way which helped staff understand how they should respect people's privacy, diversity, dignity and confidentiality in a care setting. People were encouraged to maintain their independence. They said, "I go out when I want; I let the staff know and there is no problem" and "Staff let me do what I want and help me if I need it."

People's wishes and choices with regards to receiving personal care from female or male carers or from carers who were from similar cultural communities were considered when recruiting new staff. Consideration was also given to employing staff from varying ages and educational attainment to meet the needs of the ageing young disabled residents.

From our discussions it was clear staff understood the importance of acknowledging people's diversity, treating people equally and ensuring that they promoted people's right to be free from discrimination. However, we noted people's ethnicity and sexual orientation was not recorded in their care documentation; this meant people's needs may not be fully met. The registered manager told us this information would be considered as part of the pre-admission assessments and care planning.

Information about people's spiritual or religious needs had been recorded in their care plans. People were supported to follow their faith and take part in worship services according to their individual beliefs. This meant staff were aware of these needs and how to meet them.

People were dressed appropriately in suitable clothing of their choice. One person said, "I wear what I want."

Each person had a single room which was fitted with appropriate locks and people told us they could spend time alone if they wished. We observed staff knocking on doors and waiting to enter.

People told us they were able to make choices and confirmed there were no rigid routines imposed on them that they were expected to follow. People were encouraged to express their views by means of daily conversations, completing satisfaction surveys and at residents' meetings.

Useful information was displayed on the house notice boards and informed people about how to raise their concerns, any planned activities, events in the local community and any changes in the home. Information about advocacy services was displayed. The advocacy service could be used when people wanted support and advice from someone other than staff, friends or family members.

The registered manager told us the information guide about the standards of service people should expect was being updated and would be shared with people; we were shown a draft copy of the document. The web site was also being reviewed to ensure it was up to date and reflective of the service and facilities provided. We were told the information would be available in other formats to ensure it was accessible to everyone.

Is the service responsive?

Our findings

During the last inspection we found the provider had failed to have suitable arrangements in place for planning people's care and support, in a way that met their individual needs and preferences. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found people's care records were not always reflective of the care being given and had not been kept up to date or reviewed in line with changing needs. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

During this inspection we looked at five care plans and associated records and found improvements had been made. The registered manager told us further improvements were being made to the care plan system and the PIR indicated staff were receiving training in the new paperwork. We found each person had an individual care plan which was underpinned by a series of risk assessments. The care plans were organised and included valuable information about people's likes, dislikes, preferences and routines; this helped ensure they received personalised care and support in a way they both wanted and needed. Information about people's changing health needs and specialised care needs were recorded clearly; the advice given by health care professionals was clearly documented and followed. The care plans provided staff with clear guidance and direction on how best to support people and to be mindful of what was important in their lives when providing their support.

People's care and support had been kept under review and records updated on a regular basis or in line with any changes. People spoken with said they were kept up to date and involved in decisions about care and support. People said they were aware of the new care plans; we noted they had been involved in providing useful information about their preferences, interests and routines for a 'This is Me' record. However, formal evidence of their involvements in reviews had not yet been documented for everyone. The registered manager told us this work was being progressed. Daily records were maintained of how each person had spent their day and these were written in a respectful way by care and nursing staff.

There were systems in place to ensure staff could respond quickly to people's changing needs. This included a handover meeting at the start and end of each shift and the use of communication diaries and handover sheets. Staff considered communication had improved since our last inspection visit.

There had been no new admissions to the home since our last inspection visit. We discussed the assessment process with the registered manager. Before a person moved into the home assessments of their physical, mental health and social needs would be undertaken by an experienced member of staff. People would be invited to visit the home and meet with staff and other people who used the service before making any decision to move in. This allowed them to experience the service and make a choice about whether they wished to live in the home and staff were able to determine whether the home was able to meet their needs.

People were happy with the personal care and support they received and made positive comments about the staff and about their willingness to help them. People told us they knew who to speak to if they had any

concerns or complaints and could raise any concerns with the staff or with the registered manager. People said, "The staff are brilliant and it is a first class place", "I have no complaints at all now; the place has improved and everything is back to how it should be", "The staff are great. I'd just tell them if I had any complaints", "It feels like my home again. I was worried and unhappy when you came last time but I am happy now" and "We have our own staff and they know us and we know them. The staff are fantastic and they know how to support me in the right way. I have no worries now at all."

We looked at how the service managed complaints. The service had a new policy and procedure for dealing with any complaints or concerns, which included the relevant time scales and the contact details for Care Quality Commission (CQC) and external organisations. We noted there was a complaints procedure displayed in the entrance of the home. There had been one complaint made about this service since the last inspection visit. Records showed appropriate and timely action had been taken to respond to the complaints. The information had used to help improve the service and to prevent any re occurrence.

We also saw complimentary comments had been received about the service. Comments included, "Thank you for all the love and kindness you showed to [my family member]", "[Family member's] true family was everyone there at St Andrews House" and "Thanks to each and every one of you for the wonderful work you do. St Andrews House is a special place that will stay in my heart for ever."

At the time of our inspection the service had a part time activities person. We found people were able to engage in meaningful and enjoyable activities both inside and outside the home. On the day of our visit we observed people participating in a game of giant skittles; we overheard much laughter and banter. Another person was baking a cake with the kitchen staff; we were told they regularly baked the teatime desserts. Adapted baking equipment was provided to allow them to do this safely; we observed staff offering encouragement and support when needed. We observed other people moving freely in and out of the house, going to local shops and other people sitting around the kitchen table relaxing and chatting to staff, visitors or each other.

We were told social evenings were held where everyone enjoyed a take away and drinks of their choice and about a party held outside the home for people and their relatives. People told us about the holidays they had enjoyed or had planned for this year. Two people regularly attended local football matches with staff and others were due to attend a pantomime. People were able to go out shopping with staff, to the local leisure centre or to local cafes and bars. A huge projector screen with surround sound had recently been purchased; people told us they enjoyed weekly movie nights in the lounge. One person said, "It's good, just like going to the cinema without the hassle. We have snacks and drinks. It's great."

Some people were independent of staff and would go shopping, meet friends and family, go out for meals and drinks and attend appointments whilst other people relied on staff to accompany them. The service had developed and maintained good links with the local community. We were told the local town provided good access for wheelchair users.

Where possible, people's choices and wishes for end of life care were being recorded, kept under review and communicated to staff. Where people's advanced care preferences were known, they were shared with GP and ambulance services. The service had developed good links with specialist professionals and staff were supported to develop their knowledge, skills and confidence to deliver end of life care. A member of staff was the designated end of life champion; they had received additional training and provided staff with guidance and support in this area. There were systems in place to ensure staff had access to appropriate end of life equipment, training and advice.

We checked if the provider was following the Accessible Information Standard. The standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We noted information was displayed on notice boards that were at wheelchair height; some of the information was in large print and easy for people to read. The fire safety notice was displayed around the home and in people's bedrooms, was in pictures and words. We were shown a copy of the guide to the service which was being developed; we were assured that the guide and people's care plans would be made available in various formats. This would ensure people using the service could understand. We noted alternative communication devices were in use to ensure clear understanding of people's needs.

Is the service well-led?

Our findings

During the last inspection we found the provider had failed to operate effective quality assurance and auditing systems. This was a continued breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we found limited systems to obtain people's views about the running of the home and shortfalls identified at the last inspection and as part of the quality monitoring systems had not been addressed within agreed timescales. Following the inspection, the provider sent us an action plan which set out the action they intended to take to improve the service.

At the last inspection we found there had been a lack of consistent management and the management team at that time was ineffective; there was no registered manager in place. There had been a lack of effective communication between the manager and staff which had resulted in limited progress to address any shortfalls; this had also had a negative impact on people living in the home.

During this inspection we found a new manager had been recruited in September 2017 and registered with CQC in December 2017. We observed the registered manager was visible and active within the home interacting warmly and professionally with people, visitors to the home and with staff. The PIR indicated improvements planned for the next 12 months including monitoring and auditing risk assessment and person-centred care plans, listening and observing staff practices, developing staff and planning for future senior management roles. The office had been moved to the ground floor which meant the registered manager was easily available to people living in the home, visitors and members of staff. We noted the relationship between the management team and staff and people living in the home had vastly improved and the atmosphere in the home was relaxed.

The registered manager was described as 'approachable', 'very nice' and 'efficient at getting things done'. One person living in the home said, "I like [registered manager] she is daft and just what we need." A member of staff said, "[Registered manager] fits in so well." The directors were described as 'committed to the home', 'approachable' and 'nice people'.

Since the concerns raised at the last inspection the registered manager, directors and staff had worked exceptionally hard as a team to introduce much needed changes and improvements in areas such as people's care and support records, the cleanliness and maintenance of the home, recruitment processes, management of people's medicines and the quality assurance systems.

The registered manager had recently introduced checks and audits to monitor the quality of the service and the effectiveness of the new processes. We found that positive changes had been made to the systems and processes in the home in a short period of time and the breaches in regulation, noted at the last inspection, had been addressed. However it was clear that many of these improvements were in their infancy and further work was needed to ensure the processes were embedded into the day to day practice at the home.

The provider had failed to operate effective quality assurance and auditing systems. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was completing quarterly reports for the health commissioners which included an overview of falls, pressure sores, DoLS and infection rates in the home. She undertook a daily walk around the home to monitor standards and to discuss any concerns with staff and people living in the home and had carried out unannounced visits at weekends and stayed overnight to monitor quality provision at different times. One person said, "At first it was strange when [registered manager] slept over but we got used to it. It's good she checks what is going on."

At the last inspection we found people using the service were anxious and unhappy. During this inspection people made positive comments about the management team and staff and improvements to their home. They said, "I want it to be right, it's my home", "It's better than it was before", "It feels like a home and we all get on like friends" and "The home is managed well; staff are brilliant" and "I think staff are very good."

People told us they were encouraged to share their views and opinions about the service by talking with management and staff, attending meetings and reviews and by taking part in the annual customer satisfaction survey. Regular resident and relative meetings had been re-instated and people's feedback was very positive; they had been kept up to date and their opinions had been sought and acted on. The last customer satisfaction survey had been undertaken in April 2017; the registered manager assured us a survey would be repeated mid-year and the results would be shared with people. The views of visiting health and social care professionals had been obtained, shared with staff and used to improve the service.

People felt their views and choices were listened to and they were kept up to date with the recent changes. They told us, "They listen to us and we can say what we think", "They involve us in decisions", "We know what needs to be done and they have told us why. We help where we can" and "It's our home and we have a say."

At the last inspection we found the staff team was unhappy and unsettled. During this inspection we found staff were positive and happy with the changes and improvements made by the directors and registered manager. They said, "It's a hundred times better; not perfect yet but getting there", "We try new things but if they don't work we try something else; it is a work in progress", "Things have improved a 100%", "This place is loads better; everyone has worked so hard to make it better" and "[Registered manager] and [the directors] are a good team; just what this place needs."

Monthly staff meetings had commenced and records showed they had been kept up to date and were listened to. Staff were provided with job descriptions, contracts of employment and policies and procedures which would make sure they were aware of their role and responsibilities. Staff were aware of who to contact in the event of any emergency or concerns. If the manager was not present, there was always a senior member of staff on duty with designated responsibilities.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding and deprivation of liberty teams. Our records showed that the registered manager had appropriately submitted notifications to CQC and other agencies.

The provider had achieved the Investors In People award. This is an external accreditation scheme that focuses on the provider's commitment to good business and excellence in people management. The home had recently signed up to the Red Bag scheme and the Assess to Discharge scheme. This helped to improve the services for people living at St Andrews House.

We noted the service's CQC rating and a copy of the previous inspection report was on display in the home. This was to inform people of the outcome of the last inspection

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to operate effective quality assurance and auditing systems. Regulation 17 (2) (a) (b)