The Sisters Hospitallers Of The Sacred Heart Of Jesus

St Augustine's Care Home

Inspection report

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Date of inspection visit:
28 June 2016

Date of publication:
12 August 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

St Augustine's Care Home provides residential care for up to 52 elderly people, some of whom were living with dementia. The home is divided into four units. Units A, B, C and D. The service places a strong emphasis on the teachings of the Catholic church with support also being provided by the religious Sisters who live in the adjoining convent.

The inspection took place on 28 June 2016 and was unannounced. There were 52 people living at the service at the time of our inspection. Due to new concerns raised during the feedback calls made after our visit, we sought additional information from the provider which has also been included in making our judgements within this report.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered 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. The registered manager had been in post since November 2015.

We previously carried out an unannounced comprehensive inspection of this service on 18 June 2015. At that inspection a number of breaches of legal requirements were found. As result the service was rated Requires Improvement in all domains and five requirement actions for the service to improve were set. Following that inspection, the provider sent us an action plan which identified the steps they intended to take to make the required improvements. Despite telling us that the requirement actions would be addressed, we found two continued breaches of regulations at this inspection.

Since the last inspection we have received a number of concerns from visiting professionals, relatives and staff about the services provided at the service. Some of these concerns are continuing to be investigated through a safeguarding investigation with our partner agencies. As this investigation has not yet concluded, we are unable to include specific details within this report.

Information gathered both through the on-going investigation into St Augustine's Care Home and this inspection, has highlighted some serious concerns with both the staffing and management of this service.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have taken enforcement action and issued Warning Notices in relation to staffing and quality monitoring. You can see what action we told the provider to take at the back of the full version of the report.

Our last inspection highlighted that staffing levels were not sufficient to meet people's needs. The provider told us that they had reviewed the number of staff required and increased staffing levels accordingly. During our visit to the service on 28 June 2016, there were more staff on duty. Some staff told us that the number of staff on duty that day were not typical of the usual staffing levels in the service The management team

assured us that they had recently increased staffing levels and that the number of staff on duty that day were representative of how the service was now being staffed.

Following our visit, we received new information that the staffing levels we observed had not been maintained. We therefore contacted the provider and requested that they submit their rotas to us. From this information, we saw that staffing levels had not been maintained to the minimum level determined by the registered manager as being safe on any day since our visit. On three separate occasions the service was staffed with less than half the number of care staff required.

Our last inspection identified that risks to people were not always adequately assessed and managed. Whilst the areas that were previously of concern had been addressed, people were still not properly protected by the risks relating to their care. In particular, the management team had failed to take appropriate action when people's needs had increased beyond the skills and expertise of staff and this had placed people at the risk of harm.

Whilst staff spoken with during our inspection highlighted that they understood their roles and responsibilities in relation to safeguarding, they had not always acted appropriately. The safeguarding investigation regarding the service also highlighted significant shortfalls in the way the service safeguards people. The management team delayed the on-going safeguarding investigations as they did not always provide sufficient and accurate information both to ourselves and our partner agencies.

Our last inspection also raised concerns about staff not having a good understanding of the Mental capacity Act and Deprivation of Liberty Safeguards and consequently people were not previously receiving care in the least restrictive way. At this inspection we found that staff had a better understanding of these areas and greater steps had been taken to ensure that people were not restricted without proper assessment and consent. Concerns were however raised through the on-going safeguarding investigations about the management team's understanding of the formal processes in this area which were directly relevant to their role. Delays in assessing and recording people's decisions about their end of life care did not adequately ensure that people's wishes were respected.

Our last inspection found that people living with dementia did not always have choice and control over their daily routines. We also noticed last year that people living with dementia were not always treated in a way that fully protected their privacy and dignity. At this inspection we saw that the provider had provided additional training to staff to improve their understanding about how to effectively support people living with dementia. We observed at this inspection that people were supported in a more respectful way and offered better opportunities to lead more meaningful and fulfilling lives.

In addition to looking at the concerns raised at our previous inspection, this visit also identified some new areas of concern. For example, the provider had told us that they had improved care records; however we found that care plans were still in the early stages of being updated. Whilst the care plans that had recently been updated had been completed to a good standard, it is of concern that this work was still outstanding a year after the shortfalls were identified. Care staff were providing care to some people without appropriate guidelines and risk assessments being in place and this placed people at the risk of receiving inappropriate and unsafe care.

Following concerns highlighted through the safeguarding investigation, the provider had taken steps to improve the management of medicines. Whilst we found at this inspection that people had recently received the right medicines at the right times, the systems in place to manager and monitor were not wholly safe. For example, important information about people's allergies to certain medicines was not readily available.

Records relating to the auditing, storage and safety of medicines were incomplete and staff were not able to demonstrate that these areas were managed safely.

Staff had not always received the training and support to deliver their roles appropriately. Where staff had completed on-line training, this had not been followed up with competency checks to ensure this learning was effective and embedded. The provider had a policy for new staff to receive a two-week induction in which they shadowed other staff, but for the newest member of staff this had not happened. Over the last 12 months the needs of people living at the service had increased and new people with more complex medical needs had been admitted to the service. The provider had failed to ensure that staff had the necessary skills and experience to support these people appropriately.

The management of the service presented as chaotic with key information either not being available or in place but incomplete. The management team were not proactive in their leadership and had failed to competently deliver the service in a way that protected the well-being and safety of people. Internal monitoring and auditing had failed to properly identify and address the concerns repeatedly raised by professionals and where issues were addressed, this had not been done in a timely way. The provider submitted an urgent action plan in response to our verbal feedback on the day of our inspection which addressed some of the issues raised, but our subsequent engagement with them about staffing levels and risk management identified that this action plan could not be wholly relied upon.

There was a complex culture within the service and it was not always possible to evidence who was ultimately in charge. Care staff did not always feel their contribution was valued and the turnover of care staff within the last 12 months had been high. Some relatives said that whilst they knew how to complain, they did not always feel fully comfortable in doing so.

The service had systems in place to ensure people were suitably vetted at the point of recruitment. In addition to care staff, people were also supported by a team of religious sisters who provided assistance at mealtimes, offered activities and led prayer. Many people and their relatives told us that they received a great deal of emotional and spiritual comfort from the service.

Efforts had been made to improve the activities available to people, although activities were most meaningful for those people with higher levels of ability and cognition. The provider had taken steps to better engage with people living with dementia and help staff to understand the person behind the needs.

People enjoyed their meals and mealtimes were observed to be a social occasion where most people dined together.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is

still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient care staff employed to safely meet people's assessed needs.

Risks to people had not always been appropriately assessed and managed and potentially placed people at the risk of avoidable harm.

Systems to safeguard people from harm were not always followed.

The processes in place to manage the administration of medicines were not wholly safe.

Appropriate checks were undertaken when new staff were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

The service lacked appropriate systems to ensure staff were competent and supported in their roles.

The service did not always take appropriate steps to ensure people with complex health needs were cared for effectively.

Day to day care was provided in a less restrictive way and staff had taken some steps to ensure appropriate consent for people was sought.

Most people had choice and control over their meals and were effectively supported to maintain a healthy and balanced diet.

Is the service caring?

Good

The service was caring.

The atmosphere in the service was relaxed and friendly and people's emotional and spiritual needs were met.

People's privacy was protected and staff promoted their dignity.

Staff had a better understanding of the importance of involving people in their care and supported them to make decisions about their day.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People experienced a more personalised approach to care but systems did not ensure that staff had up to date information about their support needs.

There were good opportunities for people to participate in communal activities, but staffing levels meant that those who remained in their rooms received little meaningful engagement.

People and their relatives knew how to complain, but weren't wholly comfortable about doing so.

Is the service well-led?

Inadequate

The service was not well-led.

The leadership of the service was disorganised and it was not clear to people and relatives who was in charge of the service.

The management style was reactive and where improvements were identified, these had not been embedded or sustained.

Care staff felt their contribution was not always valued. There was a complex hierarchy within the service which made it difficult for care staff to challenge practices which they knew were wrong.

Internal monitoring systems had not addressed the concerns identified by other healthcare professionals.

St Augustine's Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This was a re-inspection of this service to check whether the provider was now 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 an updated rating for the service under the Care Act 2014.

This inspection took place on 28 June 2016 and was unannounced. The inspection team consisted of three inspectors, one of whom was a Pharmacist inspector and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because this was a follow-up inspection in which we were monitoring the service against the actions the provider told us they had taken to improve.

As part of our inspection we spoke with 19 people who lived at the service, seven relatives, six staff, and the area manager. We also engaged with a large number of other health and social care professionals involved with the service through our involvement in the on-going safeguarding meeting. We reviewed a variety of documents which included the care plans for six people, six staff files, medicines records and other documentation relevant to the management of the service.

We last inspected the service on 18 June 2016 where the service was rated as Requires Improvement overall and five breaches of regulations were found.

Inadequate

Is the service safe?

Our findings

Our last inspection identified that there were not enough staff in Unit B, the higher dependency unit of the service where people who lived with dementia or had high level needs lived. We set a requirement action for the provider to review staffing levels. Following that inspection, the provider wrote to us to tell us that additional staff would be recruited to increase staffing levels.

At this inspection we found that staffing levels were not consistently sufficient to meet people's needs across the service. People told us that they sometimes had to wait for support. For example, one person told us, "I take lots of pills and there are occasions when staff are late with them." When asked if people could get up and go to bed when they wanted to, one person told us "No, I have to accept some adjustments (to when I go to bed). It depends on when they can take me."

Some relatives also raised concerns about staffing levels in the service. For example, one relative told us "Sometimes there seems to be minimal staff around between about 7pm and 8pm when they are changing over shifts. They have to have a meeting then, but it can cause problems if [my relative] wants to go to the loo… Sometimes you don't see any staff [in the main sitting room during this time], as the ones not in the meeting are helping other people to go to bed." Another relative described staffing levels across the service as "Ridiculous" and went on to say that they felt the low number of staff had negatively impacted on the care their family member had received.

The person in charge of the service in the absence of the registered manager told us that staffing levels had been increased and that there should be 12 care staff on duty with each unit having a minimum of three care staff. There was also a fourth member of staff providing one to one support to one person in unit B. They also said that the Catholic Sisters were in addition to the minimum number of care staff. The sisters provided assistance at mealtimes, offered activities and led prayer. The number of staff on duty at the time of our visit reflected this. One staff member told us that the number of staff on duty on the inspection day was not reflective of the usual staffing levels in the service. When we raised this with the person in charge, they told us that was because the new staffing levels had only recently been introduced. Other staff we spoke with confirmed this and told us that staffing levels were better than at our previous inspection.

Whilst people received appropriate support on the day of our visit, we received feedback and a number of incident and accident reports after the inspection date that caused us to question whether the service continued to be adequately staffed. We contacted the registered manager and asked them to confirm their minimum staffing levels and send us the rotas for the hours worked in June and July 2016. Following a review of the rotas it was clear that the number of staff on duty during our visit was not typical of other days. For the period from the inspection of 28 June 2016 to 10 July 2016, the level of staff working in the service was below the safe minimum stated by the registered manager on every day. On three separate occasions, the service had been delivered with less than half of the number of care staff required to do so safely.

At the safeguarding meeting the registered manager was unable to demonstrate how staffing levels had been calculated or provide assurance to us that the minimum numbers stated were sufficient to meet

people's safe needs. The management team were unable to provide an explanation as to why additional staff had not been brought in to support the service when they were so short staffed.

The failure to deploy sufficient, suitably qualified staff was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection identified that risks to people were not always appropriately managed. A requirement action was set in respect of this lack of safe treatment. The provider wrote to us after the inspection and told us that the necessary care plans would be reviewed and updated within one month of the inspection date.

Prior to this inspection we received concerns in relation to the way staff were managing the risks associated with people's moving and handling and eating and drinking. Through this process, it was identified that the risk assessments in place were still not adequate to keep people safe. Following the safeguarding meeting, the person overseeing the running of the service contacted us on 19 May 2016 and informed us that all risk assessments would be reviewed and updated by 05 June 2016.

During our inspection on 28 June 2016, we saw that the management team were still in the process of reviewing and updating the risks assessments in place for all people. They told us that they had started reviewing people with the highest needs and that all risk assessments would soon be completed. They also told us that referrals had been made to the occupational therapist to support them in assessing people's mobility needs.

We found that whilst risk assessments were in process of being updated, they still did not adequately show how identified risks to people's safety were being managed. For example, the risk assessment for one person recorded that they used a standing hoist which was no longer the case. The associated guidelines referred to the person using a hoist, but did not state which sling should be used and how many staff were needed to support them safely. For another person with a catheter in situ, there was no risk assessment or guidelines in place for how this was being managed safely.

Concerns in relation to the moving and handling support for this person had been raised previously in May 2016. Following the inspection, the provider informed us that a person had a fall in the service. There was no mobility and falls risk assessment for this person prior to this fall. The registered manager stated that the person had not been at previous risk of falls however this was not the case as they had been admitted due to numerous falls at home. The risk assessment as a result of this latest fall did not address the new risk highlighted with their mobility.

Other concerns regarding the management of risks to people are still being investigated and as such are not included within this report. We will review what action we will take on conclusion of these investigations.

The failure to provide care and treatment in a safe way for service users was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The processes in place to manage the administration of medicines were not wholly safe. The safeguarding meeting in May 2016 had identified that people's records did not contain accurate and accessible information about people's allergies to medicines. This had placed people at risk of receiving medicines for which they were allergic to. Whilst the management team had liaised with the doctors surgery to get a complete list of people's medicine allergies, these were not fully documented on the Medication Administration Records (MAR charts) on the day of the inspection and therefore not immediately available

to staff.

Records for administration of medicines that had been prescribed for people on a "when required" basis did not always give details of the quantity of medicines given. Additionally, some medicines that had not been prescribed for regular use had been amended by hand to "when required" with no explanation. There were also several MAR charts that had been handwritten and not signed, dated and countersigned to reduce risk of transcription errors.

There were no systems in place to receive and act upon medicines safety alerts. This meant that it was not possible to guarantee that all medicines held at the service were safe for use. Apart from one recent medicines error, there were no historical records of errors or near misses to view, or any analysis and learning as a result of these. The last medicines audit was completed in 2015. Information received following the inspection, identified that previous errors in medicines had not been appropriately reported and dealt with.

Records showed staff had received training on medicines. However, there were no records to demonstrate that checks had been undertaken to ensure they were competent to administer medicines safely.

Medicines were stored securely, but appropriate steps had not been taken to ensure medicines were kept at a safe temperature. There were two medicines fridges at St Augustine's. Records to demonstrate the fridge temperature was suitable for medicines requiring refrigeration were not available at all for one fridge and had not been recorded since March 2016 for the other.

These failures to ensure the proper and safe management of medicines were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed three people being administered their medicines. This was done in a caring and respectful way and the nurse stayed with people to ensure they had swallowed the medicines and drinks safely. On the day of the inspection no people were being given their medicines covertly (without their knowledge, mixed with food and/or drink). However, there was a policy in place to support this practice if required in the future. A range of GPs ensured appropriate monitoring of people's medicines was undertaken.

Arrangements for ordering and receiving people's medicines from both the GP and pharmacy were suitable. There were also arrangements to obtain medicines that might be needed urgently in addition to people's usual requirements (such as antibiotics). Processes were in place for ensuring waste medicines were disposed of correctly.

We checked a sample of medicines which had been supplied in blister packs against the MARs. The amounts remaining in the blisters matched what was recorded as having been administered. Medicines administration records (MARs) in use at the time of the inspection found were accurately signed by staff who administered medicines.

Systems to safeguard people from harm were affected by the lack of leadership in the service. People told us that staff looked after them well and no one raised any concerns about how they were treated. The majority of relatives said that they had no concerns about the way their family member was looked after and described staff as "Kind" and said that they did not worry about the safety of their relative at St Augustine's. One relative however expressed some worry that some staff might be "Abrupt or lack patience" with people and went on to say that they thought this was because the low staffing levels placed them under pressure.

During the safeguarding meetings the management team failed to provide accurate and timely information so as to enable the safeguarding concerns to be investigated. These delays meant that people were not always properly protected from harm. For example, significant delays were caused in the investigation into one person's care due to the lack of correct information being available from the management team about where the person had died and which doctor had certified the death. Similarly, multiple actions from the safeguarding meeting had not been completed within the timescales set which further prevented these concerns from being resolved appropriately.

Staff spoken with during our visit demonstrated a good understanding about their safeguarding responsibilities. They were confident about their role in keeping people safe and demonstrated that they knew what to do if they thought someone as risk of abuse. Policies and procedures were in place for staff to follow if they suspected harm and all staff were clear about how to correctly report abuse to the outside agencies if necessary. Following the inspection however, we received new information that safeguarding procedures had not always been followed.

The failure to protect people from abuse and proper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Appropriate checks were undertaken before staff began work. We saw criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history, written references and identification documents in staff files to show that staff were suitable to work in the service.

Requires Improvement

Is the service effective?

Our findings

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 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).

At our last inspection we found that the service was not working within the principles of the MCA and people were not receiving their care in the least restrictive way. A requirement action was set for the service to improve. Following the inspection, the provider wrote to us to tell us what action they would take which included assurance that all staff had been trained and competency checked in relation to DoLS.

At this inspection, staff demonstrated a better understanding of the MCA and were able to demonstrate the things they had done to ensure people were less restricted. For example, staff no longer prevented people living on unit B from having access to their rooms. Previous concerns about people being left in recliner chairs that they could not get up from had also been addressed. We observed that people were better involved in decisions about their care. We read in care records that people's consent had been considered in relation to a range of topics. For example, the care plan for one person highlighted that the person had greater capacity to make decisions in the morning than they did in the afternoon.

The provider had a policy that new staff would complete an induction which included starting the Care Certificate and a two-week period where they 'shadowed' more experienced members of staff. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. One new member of staff had started two weeks prior to our inspection visit and there was no evidence of an induction programme for them. The management team also confirmed that due to staffing levels, this person had been unable to work in a supernumerary capacity either.

The service lacked appropriate systems to ensure staff were competent and supported in their roles. Whilst the management team had a programme of training, staff had not received all the training identified as necessary to carry out their roles effectively. The management team highlighted that staff training had been difficult to complete due to the turnover of staff in the last year and the difficulty in maintaining staffing levels. The service was now providing care to more people with higher medical needs and complex needs associated with advanced dementia. Whilst some staff were seen to support people with a lot of kindness and thought, as a team they lacked the knowledge, skills and experience to support people with such complex needs safely and effectively. For example, staff didn't have the experience in the management of pressure care, catheter care and dysphagia.

Where staff had attended training courses, there had previously been no competency checks to ensure that

their learning was embedded in practice. For example, staff had previously completed training in moving and handling and yet other health and social care professionals had recently observed staff lifting people under the arms. These concerns were raised with the management team at the safeguarding meeting in May 2016 and as a result staff had been retrained in moving and handling and reminded in staff meetings about best practice. We observed staff following best practice during our inspection visit and one relative told us "I can say that have seen staff using the hoist a lot more now, rather than lifting people."

People's healthcare needs were not always fully met. The service was not registered for nursing care and yet it was providing support to some people with complex medical needs, including end of life care. The management team had not appropriately considered the skills of staff when undertaking either the pre-admission or re-assessment of a person's needs. The management team had failed to recognise when the service was not able to safely and effectively support a person and as such placed people at risk of harm by continuing to care for them.

The service had a heavy reliance on community healthcare services and there was no contingency in place for if these referrals were not responded to quickly. Due to the recent concerns the management team had made multiple referrals to the local Occupational Therapy (OT) and Speech and Language Team (SaLT). There had been no prioritising of these cases in order to ensure the most at risk were seen first. For one person in receipt of end of life care, there was no urgent follow-up advice for advice when the SALT had not responded to their referral.

Most people had choice and control over their meals and were effectively supported to maintain a healthy and balanced diet. We received mixed feedback about the quality of meals and choice of meals provided. Some people described the food as "Very good" or "Excellent", whilst another person said "The food could do with improving" and similarly "The food is ok. I'm used to institutional food." People with specialist diets, such as being vegetarian told us that their dietary preferences were always respected.

Whilst the serving of lunch was a structured event, we also observed that for most people this was a social occasion which brought people together. Lunch in the dining room started with one of the Catholic Sisters offering prayer. Tables were arranged in small groups and where people required support, this was done in a sensitive and dignified way.

Most people ate in the dining room or for those living in Unit B, in the communal area. People did say that if they requested to eat in their room or one of the lounges then this too would be accommodated. We saw that people were offered a choice of meals and the food served. Meals, including those that were pureed were nicely presented.

Portion sizes varied which indicated that people's appetites were known and staff made appropriate enquiries where people did not eat their meal. Where there were concerns about the food or fluid intake for a person, we saw that this was being recorded and monitored alongside the person's weight.

Good

Is the service caring?

Our findings

Our previous inspection found that people who lived in Unit B were not always treated with the same courtesy and respect as other people who lived in the service. For example, some staff were curt with how they spoke with people and were critical of behaviour that they considered to be disruptive. In the same area of the service, staff automatically locked people's bedroom doors during the day, rather than appropriately supporting the people who went into the rooms of others. As a result, we set a requirement action. The provider wrote to us following the inspection outlining the steps they had taken to address our concerns.

At this inspection, we found that people across the service were treated with a greater level of dignity and respect. Staff had made attempts to get to know the person and not just treat the illness. For example, around the service, including Unit B, the provider had displayed photos and information about people's lives before they came into care. This not only helped staff appreciate people better as individuals, but also stimulated conversations with people about their histories and families.

The feedback we received from people and relatives was complimentary about the way staff treated people and the relationships they had. For example, one person told us, "They all do their best. The Sisters are very kind and generally it is a happy home." Similarly, another person spoke of care staff saying "They're lovely girls. They never stop" and "The staff are kind; exceptionally so. They go out of their way to try and comfort people." Most of the comments from relatives also echoed the "Kind" and "Caring nature" of staff. The only complaint one relative made was that staff could sometimes be "Abrupt", but clarified that this was due to them being busy rather than unpleasant.

The atmosphere in the service was relaxed and friendly and people's emotional and spiritual needs were met. Both people and their relatives placed a lot of emphasis on the comfort people received at the service. We too observed that if a person was upset, staff spent time talking and comforting them. For example, when a person became tearful, a staff member noticed immediately and made them a cup of tea, They then went and sat with them and reassured them, speaking gently and kindly. On another occasion, a person was feeling anxious and we observed one of the Sisters taking them for a walk whilst chatting with them and very soon the person presented as relaxed and calm again.

Staff at this inspection were more interested in finding ways to connect with people. For example, one staff member had brought in a pram from home and placed it in the corner of the room. We heard her say to a person whilst pointing at the pram "I am not sure what I should do with it. Can you tell me?" The staff member then moved away and after a few moments, the person walked over to the pram and started rocking it. It was obvious that this created a sense of belonging for the person.

People's individual preferences were known and respected. A relative highlighted that staff always took the time to dress their family as they liked to, including matching accessories which they knew was so important to them. During our visit we also noticed how a staff member had spent a lot of time supporting people in the morning and making sure they had everything they liked to have with them for the day.

People's privacy was respected. People told us that staff respected their privacy. We observed that staff respected people's private space and as such they routinely knocked on people's bedroom doors and sought permission before entering. People had the option of locking their bedroom doors when they were out if they wished to.

Staff had a better understanding of the importance of involving people in their care and supported them to make decisions about their day. We observed that people were better consulted about where they wished to spend their time and as such their choices were better respected. Visitors told us that they were made to welcome and could pop in at any time.

People had some involvement in the running of the service. Whilst formal opportunities to involve people were not always followed, there were lots of informal ways in which people could have influence over the things that mattered to them on a daily basis. For example, there was a suggestions box where people could post their comments about the service and they were regularly consulted with about activities, meals and suggestions for prayer.

Requires Improvement

Is the service responsive?

Our findings

Our last inspection identified that people did not always receive person centred care and that care plans were often too generic to provide proper guidance to staff. We made a requirement action in respect of this. Following the inspection, the provider wrote to us to tell us that they had updated care plans and would continue to review them.

The safeguarding meeting identified that care plans were still not sufficiently detailed and as such staff did not have access to the right information to support people effectively. For example, where people had complex needs with regards to mobility, behaviour eating and drinking care records failed to provide sufficient information for staff to provide appropriate care. As a result, it was an agreed action from the meeting in May 2016, that the provider would take steps to improve all care plans, starting with the people who were highlighted to be most at risk.

At the inspection, we found that the management team had been undertaking these care plan reviews. For those people whose records that had been updated, care plans now contained a much better level of information. These included a summary sheet which provided a good overview of how to support the person effectively. Life histories had been completed for these people and the information used to complete plans of care that were more personalised to people's individual needs.

People told us that they were generally happy with the care they received. Feedback from relatives indicated that the quality of care varied according to how independent the person was. For example, one relative told us that their family member had previously received good care, but that this had "Dipped" when their needs increased. The concerns raised by other visiting professionals through the safeguarding meetings echoed this feedback.

For those people whose care had not been recently reviewed, the records remained of varied quality depending on who had completed the initial assessment and care plan. For one person, a detailed pre-admission assessment had been completed, but this had not yet been transferred into a plan of care. For example, the initial assessment identified that the person had been discharged from hospital with a catheter, but there was no corresponding care plan bout how staff were expected to manage this. On speaking with staff it was clear that they were aware how to support this person and they showed us how they were monitoring the person's fluid intake and output. This highlighted that the issue was more one of recording than practice.

Whilst it was evident that steps were being made to improve the quality of care planning, the failure to have a robust system which ensured care and treatment was appropriate to meet people's needs and preferences was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection highlighted a lack of opportunity of people living in Unit B to access meaningful activities. As such we set a requirement action in this area. Following the inspection, the provider wrote to us

and told us that they had taken steps to improve. At this inspection we found that there was a greater level of engagement with people across all areas of the service.

The provider had now employed two activity co-ordinators to work across the service which had resulted in a hub of activities both in the main lounge and he communal area of unit B. People told us they were able to spend time doing things they enjoyed. For example, one person said "We have days out from time to time, but most important for me is the chapel. I can go to Mass every morning and I wouldn't be able to do that if I wasn't here." A visitor also told us "The activities have improved. There is more to do than there to be. They try all sorts of things, even if it's difficult to maintain people's interests."

There was lots of meaningful engagement with people throughout the inspection visit. For example, we watched people enjoy a group game of bingo in the main dining room during the morning. We noticed that staff moved around people checking their playing cards with them. When someone won, staff were seen to cheer and clap and there was an atmosphere of fun and inclusion. At the same time in Unit B, we saw a group ball game take place in which staff were encouraging people to play and interact with each other whilst doing so. Later we observed more individual activities with one person being supported by a staff member with finger painting.

There was however, less interaction with those people who were either unwell or spent time in their room. Staffing levels did not afford staff the time to spend with these people and as such unless they had external visitors, they unless for most of the day. One relative commented that there was very little engagement for their family member now that they were not able to participate in the main activities. Feedback from surveys sent residents, relatives and staff in April 2016 highlighted that nearly two thirds of respondents wished for more activities in the service.

People and their relatives knew how to complain, but weren't wholly comfortable about doing so. The culture across the service was one where people were encouraged to express gratitude and thanks and as such people were hesitant to say anything negative. Whilst people said they wouldn't complain, jocular comments included "It reminds me of boarding school" and "We don't argue with the Sisters do we?" Comments from relatives indicated that whilst they knew how to complain, they may not always feel comfortable doing so, especially to the local management team. One relative said that even though they raised concerns, they still felt they needed to monitor the care their family member received.

Complaints were not used to demonstrate how the service learned from complaints. Whilst the service had a complaints policy and procedure in place, only written complaints had been recorded and this was not reflective of the complaints received by the management team. From our discussions with relatives and information shared, one complaint recorded for 2016 was not the reflective of the number of concerns actually raised in the service. The management team's approach was individual and reactive in relation to how complaints were managed and did not look at the wider issues or themes.

Inadequate

Is the service well-led?

Our findings

Our last inspection highlighted that the registered manager had not always effectively monitored the quality of service. Since that inspection, a new registered manager had joined the service in November 2015. At this inspection and through our engagement with the management team through the safeguarding process, we have found the leadership of the service to be disorganised.

The service lacked the visibility of strong leadership and oversight on a day to day basis. The management team had failed to ensure the service delivered its statement of purpose by taking steps to effectively manage the needs of people who lived or were admitted to the service.

Despite a registered manager being in post, it has not been possible to identify who was in charge of running the service. When we asked different members of the management team for information, we were directed to one of the other managers, there was little ownership or accountability being taken. For example, when it was highlighted that a new member of staff had not been inducted in accordance with the provider's policy for the training of new staff, none of the management team accepted responsibility for this not having occurred.

The registered manager lacked a detailed understanding about the running of the service. Following our inspection visit we contacted the registered manager for details of staff that had worked in the service. The registered manager was unable to provide an accurate account of the number of staff required to safely support people or who had worked in the service and on what days. After multiple emails with the registered manager we had to obtain this information from the provider. Similarly, the registered manager did not have a good knowledge about the support needs for the people for whom she was responsible.

The management team delayed the ongoing safeguarding investigations as they did not provide clear and accurate information. Through the safeguarding process, the management team shared incorrect information about a person despite being asked on three occasions to clarify the facts. At the safeguarding meeting in July 2016, it was identified that actions set against the registered manager and area manager in both March and May 2016, had still not been met. This lack of co-operation and engagement with the safeguarding process people continued to at risk.

The running of the service was reactive to individual issues rather than adopting a proactive management of the service. For example, where concerns had been raised about people at risk of falling or choking, this learning had not been applied to minimise the risk to other people with the same issues. Similarly, on the inspection visit date it was discussed that staffing levels needed to be sustained at a safe level and yet each day afterwards, they were not maintained. Despite the submission of repeated action plans to address the staffing levels and other areas of concern dates and commitments continued not to be met.

Monitoring systems on behalf of the provider had failed to effectively audit and quality assures the service. Despite monthly reviews of the service by the area manager, the systems in place had failed to identify the multiple concerns identified in this report and as expressed by our partner agencies through the

safeguarding process. The management team had failed to effectively monitor the accidents and incidents in the service, which if they had would have identified that staffing levels were insufficient and that they continued to support people whose needs they could not meet.

The dynamics between care staff and religious Sisters was complex and some care staff felt their contribution was not valued. The culture amongst the staff team was not always positive and the turnover of care staff was high. Conversations with care staff identified a hierarchy between the Sisters and care staff in which some care staff told us they could not challenge if they felt something was wrong. Staff meeting minutes in April 2016 reflected that staff had raised concerns about staffing levels across the service, but action to remedy this in a timely way had not occurred.

The management team had failed to effectively to engage with people and their relatives regarding the ongoing concerns. Some relatives expressed that they did not feel they were kept up to date with what was going on within the service and on some occasions had been "Misled". Despite the ongoing concerns with the service and the action from the safeguarding meeting requiring the provider to inform people and their representatives about the safeguarding investigation, there had been no opportunity for this to be formally discussed. As such worried relatives had contacted us and the local authority regarding the service.

Poor record keeping across the service meant that it was difficult to track whether appropriate care and treatment was provided. For example, where the service had engaged with other health care professionals about people's care, this involvement was not properly recorded and as such the service was unable to evidence that appropriate advice was followed.

There was an electronic system in place for the recording of information with care plans being printed when updates were completed. Some staff had not received training on how to use the system and this had resulted in numerous recording gaps, especially in people's daily records. This not only meant that they could not input their information, but also they could not access the information other staff had entered. Staff told us that they relied on daily handovers to obtain the most up to date information, but with a high turnover of staff and regular use of agency staff, a more robust system was required until all staff were competent in using the system in place.

The failure to assess, monitor and improve the quality of the services provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we identified that one statutory notification had not been sent to us in respect of an incident which was reportable under the definition of the Health and Social Care Act. The management team were aware that this should have been reported, but were unable to explain why they had not done so.

The failure to notify the Commission of required events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents Required notifications had not always been submitted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Failure to provide care and treatment that was appropriate and met the needs and preferences of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to ensure that systems and processes operated effectively to prevent abuse of service users.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to assess, monitor and improve the quality of the services provided.

The enforcement action we took:

Issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's assessed needs.

The enforcement action we took:

Issued a Warning Notice