Franciscan Missionary Sisters

St Annes Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Anne's Residential Home is a residential care home providing personal care to up to 19 people. The service provides support to older people. At the time of our inspection there were 19 people using the service.

People's experience of the service and what we found:

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There was a lack of documentation in some areas of care, this meant people might receive inappropriate, ineffective, or unsafe care and the registered manager would not be aware of this. For example there was no plan to ensure people's oral hygiene was managed. The registered manager had not always told CQC of incidents that were legally notifiable.

People were not always included in writing their care plans and staff struggled to use the care planning system, telling us they felt they needed more training. Staff were not able to access risk assessments for people for guidance.

The registered manager did not have oversight of the service as they had failed to carry out any audits, checks or reviews for 8 months. Staff said they needed more support in the form of supervisions and they wanted to see the registered manager more active in the home. Staff said they didn't feel the registered manager acted on their complaints or concerns.

While the registered manager said she was always happy to talk to people, relatives, or staff, there had been no recent surveys or questionnaires sent out to prompt responses, meaning it was unclear what the majority of people and families felt about care at the home.

The provider's staff training matrix showed staff training had not been kept up to date, and the registered manager acknowledged training was an issue. The registered manager said she checked staff competency by watching them provide care, but this was not recorded and staff said they were not aware of this.

The quality of the food provided by the service was inconsistent. Kitchen staff were unclear if anyone had allergies or special diets due to food intolerance, and relied on care staff to select the correct food for people. A person told us they bought in their own food as they didn't feel the service was able to manage the diet they needed effectively.

People were mostly content at the home, although feedback from people varied. A person told us, "On the

whole they [staff] are very nice." Another person told us, "I don't normally see [manager]. [Manager] is not about much." They also told us, "The staff never normally check in with me. They don't just come by and see if I'm ok."

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

Rating at last inspection
The last rating for this service was Good 17 October 2019

Why we inspected
The inspection was prompted in part due to concerns received about neglect by staff, a lack of staff training and issues with oral hygiene and nutrition and hydration. CQC had received anonymous complaints about care at the home. A decision was made for us to inspect and examine those risks.

We undertook a focused inspection to review the key questions of effective and well-led only. For those key question not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for St Anne's Residential Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, notifications of incidents, good governance, and requirement to display rating.

Please see the action we have told the provider to take at the end of this report.

Follow Up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and effective care. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well-led findings below.

St Annes Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 2 inspectors.

Service and service type
St Anne's Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. St Anne's Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced

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

During the inspection
We reviewed a range of records. This included 5 people's care records. We looked at records in relation to staff training and supervision. We looked at various other documentation in relation to the management of the service. We spoke to 6 people and 8 members of staff and the registered manager.

Following our visit to the service we looked at additional documents the registered manager sent us including risk assessments. We also spoke with the nominated individual to seek assurances regarding the lack of management oversight of the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

● The registered manager was unaware that restrictions should only be referred to the DoLS team if people lacked capacity to consent to the restrictions and they were not the least restrictive option.
● The registered manager's lack of understanding of the Mental Capacity Act meant DoLS had been applied for on behalf of people who had capacity.
● Some people who had mental capacity had agreed to restrictions, for example not smoking indoors, for their own safety. A person told us, "I ask for a cigarette, and they will find me one." The registered manager told us as this was a restriction she had applied for a DoLS which was unnecessary.
● Some people had restrictions in place or would be prevented from leaving if they asked, and did not have either a mental capacity assessment in place or a DoLS applied for.
● Staff, including senior staff and the registered manager had not had training in mental capacity since 2019 or 2020 and the provider's training matrix showed this was overdue.
Awareness of mental capacity and when to apply for a DoLS was an area that required improvement.

Supporting people to live healthier lives, access healthcare services and support
● People were expected to arrange and manage their own dentist registration and appointments.
Assistance was not provided to people who were unable to manage their own dental healthcare and did not have relatives to assist them. Details of people's dental healthcare were not recorded on their care plans, and it was not recorded if people had accessed dental services.
● There were no plans or checks in place to ensure people's oral health was managed. Relatives told us staff did not ensure people cleaned their teeth and the registered manager said there had been no audits or checks to ensure good oral hygiene for people.
● The registered manager told us there were no plans for care if a person required urgent dental treatment,

she said the family would be contacted. People were at risk of pain and poor oral health as no consideration was given to this issue by the provider or the registered manager.

This was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care documentation had recently been moved to an electronic system. The records were not always current and care plans lacked detailed information on how people needed to be supported. The records lacked assessment and mitigation of risk, and some care plans lacked any personal history of the person.
● Staff were unable to locate risk assessments when asked by the inspector. A staff member told us some staff "Do not use the care app. They did not know how, and they had not been taught."
The lack of recording and staff knowledge of the care plan system placed people at risk of inconsistent and uncoordinated care.
● People's care plans lacked goals and some care was task driven. For example, people had allocated bath or shower days twice a week. People at the home accepted the care and facilities offered, for example during a conversation about which programmes a person liked to watch on television, a person told us "I don't think the television [in my room] works, but that's OK I read my book."
● People were not routinely included in the planning of their care. The registered manager said some people were "lazy and neglected themselves"; there were no plans to explain how staff might motivate or include people in their care. A staff member told us, "Staff don't go the extra mile. There is little social interaction between people. They don't have coffee together. Some people would like a newspaper, staff don't ask people." A person told us they did not know what a care plan was.
Staff confidence in using the electronic care planning system and involving people was an area that required improvement.

Staff support: induction, training, skills and experience
● The registered manager did not ensure staff had the skills, knowledge and experience to deliver effective care and support.
● Staff training was not up to date according to the provider's staff training matrix and the registered manager told us she was aware staff training 'was not looking great'. Some staff said they would prefer further training on the care plan system to be able to use it fully.
● The registered manager told us they had not carried out supervisions or 1:1s to ensure staff competency and had no evidence of adhoc observations of staff caring for people. There was no current documentation to show staff were competent. There was no evidence that people had come to harm, but this was an area that required improvement.

Supporting people to eat and drink enough to maintain a balanced diet
● Some people were not supported to maintain a balanced diet. A person at the home said they relied on family to bring in food as they had a food intolerance. Staff and managers had not investigated or discussed with the person the reason for this. We discussed this with the registered manager who described a person as "fussy." The manager said they would speak to the person after the inspection to discuss a suitable diet.
● Kitchen staff told us they prepared food, but care staff were responsible for ensuring it was appropriate for people. When kitchen staff were asked if anyone had an allergy or any special requirements, they said "Not that I'm aware of." They were unaware of the person with a food intolerance.
● People and staff told us the quality of the food was inconsistent. A staff member said, "Today it's good. It depends which staff are here." A person said, "I get heartburn from the food, but that is just because it's not what I am used to."

● People were offered drinks and we saw people had access to water in their rooms. The registered manager told us how people were offered ice lollies in the summer to help them remain well hydrated.

Staff working with other agencies to provide consistent, effective, timely care

● There was a lack of documentation by staff at the home about community nurses visits and nursing care provided, in people's care plans. While visiting health care professionals kept their own records, they were reliant on the staff to document the details of their visit in people's care plans. Some staff did not understand how to use the care recording app which meant visits could not be recorded appropriately.

Adapting service, design, decoration to meet people's needs

● People could access all parts of the home via a lift if needed. There was also outside space which the registered manager told us people used in the summer. People could choose to eat in the dining area or in their rooms.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;

- The provider had not followed their responsibilities under the legislation and had not ensured that all significant events were notified to the Care Quality Commission. A staff member told us, "[Name] has a fracture from a fall a couple of weeks ago." The registered manager confirmed this incident during the inspection. However, the registered manager did not send a formal notification to CQC until after the inspection. The notification did not include details of a risk assessment or any changes to the person's care as a result of the incident. After the inspection the registered manager reassessed care for the person. It was not known how the incident had been assessed or responded to at the time because of the registered manager's failure to notify. The registered manager had also not informed the local authority. The registered manager said the family were kept informed of the person's health as part of the duty of candour.

Failing to notify CQC of serious injuries is a breach of Regulation 18: Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009 (Part 4)

- The provider had failed to display a rating for the service on the website, which is a legal requirement.

This was a breach of Regulation 20A: Requirement as to display of performance assessments of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

- The registered manager had not completed checks on the quality performance at the home. Staff had not received supervisions to assess their competency at care tasks and their training was overdue. Staff told us they rarely saw the registered manager while at work, although the registered manager said she spoke to staff frequently. A staff member told us, "The management [deputy and manager] should be checking the home more… I never see the registered manager, [they] are always in the office."
- The registered manager told us she relied on looking at the home to check it was clean, and said she thought staff would tell her if other staff were not working appropriately. A staff member told us their last supervision was "about a year or more" ago. They said they, "did not talk things through with senior staff" and that staff meetings were not helpful.

Failing to assess, monitor and improve the quality of the service is a breach of Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Continuous learning and improving care

● Governance systems were not sufficiently robust to identify areas for improvement to enable actions to be taken. There had been no audits carried out for over 8 months and people were not asked about their care. The provider did not monitor the quality of care provided in order to drive improvements. The registered manager said audits were not reviewed by the provider, and the provider did not oversee performance at the home. This led to a risk of lack of change and improvement within the home.

● The provider had not ensured that effective systems and processes were in place to assess, monitor and improve the quality and safety of the service. In addition, systems were not in place to demonstrate the service operated effectively to ensure compliance with the regulations. The provider said they intended to carry out monthly visits to assess and monitor the quality of the service provision but these did not always take place, were not documented and had not identified the concerns we found during the inspection.

● There was no learning from incidents and accidents. When asked how a person's care changed after a fall, the registered manager said there was no change in care, there was no documentation to show any formal assessment to ensure the care provided was appropriate. A staff member told us the person's care had not changed after the falls. They were unable to find any guidance detailing actions for staff to take to reduce the person's risk of falls. Staff said, "[Name] has fallen a few times. [They] can't get in the toilet. [They] get quite confused and forget to ring the bell." There was no documentation to show a reassessment after a fall. There was no consideration for alternative means of staff being notified about the person's need for assistance.

Failing to assess, monitor and improve the quality of the service and mitigate risks is a breach of Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● People gave us mixed feedback about the running of the home, some seemed happy and said they had no complaints, others said staff could be brusque. A person told us, "On the whole they [staff] are very nice." Another person told us, "I don't normally see [manager]. [Manager] is not about much." They also told us, "The staff never normally check in with me. They don't just come by and see if I'm ok." We saw a member of cleaning staff interacting in friendly and positive ways with people, however the majority of staff went about care without speaking to people other than in relation to the task.

● People were able to talk to the registered manager at any time, however there was no documentation to show people took this opportunity to provide informal feedback. There was no system in place to prompt people to share their views, for example there were no surveys or questionnaires for people or their families. The lack of staff supervision and staff surveys meant staff did not have a mechanism to provide feedback about the quality of the service provided.

Failing to seek and act on people's and staff feedback is a breach of Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● Some staff expressed concerns regarding the culture. A member of staff told us working at the service was, "stressful". They said some staff, "don't listen to the seniors." They said they had, "Told the managers and they haven't done anything. You tell them and nothing changes."

● We saw the home was quiet. Staff did not actively engage with people outside of the tasks they carried out. People remained in their rooms all day on the day of the inspection. People said they did not usually see the manager.

● We discussed the issues of the staff team morale with registered manager who told us they had "an open-door policy" and "no one has raised anything with me." The registered manager told us they couldn't "make the staff like each other."
● Staff had complained directly to CQC before the inspection and we discussed with the registered manager why she felt staff did not raise their concerns directly with her. The registered manager said she did not always feed back to staff if they raised a concern. She also said a way for staff to raise issues anonymously might help in future.
This was an area that required improvement.

Working in partnership with others
● People were at risk of inconsistent and uncoordinated care. Care plans lacked information. For example, a care plan mentioned a person had a catheter, but the only information about the care was the person was "self-managing of toilet needs." There was no information about how other healthcare professionals might be involved in the person's care.
● The registered manager did not liaise with dentists about people's oral care.
● The registered manager told us the provider was supportive, and there was money when needed for essentials at the home.

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 The provider had failed to notify the Care Quality Commission of significant events. Regulation 18(1)(2)(a)(iii)(b)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the care and treatment of service users was shared with or transferred to appropriate persons to ensure the health safety and welfare of the service users. Regulation 12 (2)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to demonstrate the service was well managed. The provider failed to ensure the regulations were being met. The provider did not have effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17(1)(2)(a)(b)(c)(d)(ii)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display the CQC rating on their website for the service. Regulation 20A (2)(a)(b)(c)