St Martin's Residential Homes Ltd

St Martins

Inspection report

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Tel: 02476621298

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 May 2016. The inspection was unannounced.

St Martins provides accommodation with personal care for up to 16 people. The home is located in Coventry in the West Midlands. There were 14 people who lived at the home at the time of our visit. Eleven people who lived at the home were living with dementia.

A requirement of the provider's registration is that they have a registered manager. 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. There was a registered manager in post. We refer to the registered manager as the manager in the body of this report.

The service was last inspected on 30 November 2015 when we found the provider was not meeting the required standards. We identified one breach in the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The provider sent us an action plan telling us the improvements they were going to make. The provider told us these improvements would be completed by 19 February 2016.

At this inspection we looked to see if improvements had been made. Improvements had been made in how people's capacity was determined. Mental capacity assessments had been completed and the local authority had approved DoLS applications for nine people who lived at the home. The provider had taken sufficient action in response to the breach of regulations.

However, further improvements were still required. Some mental capacity assessments were not decision specific. Records of best interest meetings, and to show family members had the legal authority to make decisions on behalf of people who lacked capacity to make decision for themselves, were not always completed. The provider recognised further improvements were still required and was taking steps to address these.

There were not enough staff on duty to respond to people's needs and to keep people safe and protected from risk. Staffing levels also impacted on the availability of staff to provide the support people needed to take part in interests and hobbies that met their individual needs and wishes.
Most care records we reviewed were up to date and described people's routines and how they preferred their care and support to be provided. Staff had a good knowledge of the people they were caring for.

People were not always supported to develop the service they received by providing feedback about how the home was run. The manager did not gather feedback from people or their relatives through meetings or quality assurance questionnaires. However, quality questionnaires had been developed for future use. The deputy manager and provider spoke to people, staff and visitors to gain their views about the service provided during their visits to the home.

The provider had procedures to check the quality of care people received, and to identify where areas needed to be improved. However, these systems were not always effective. This was because audits were not always detailed and some areas requiring improvement had not been identified.

People who lived at the home were encouraged to maintain links with friends and family who could visit the home at any time.

People and their relatives told us staff were caring and kind. People were treated as individuals whose preferences and choices were respected. Staff treated people with dignity, and supported people to maintain their privacy and independence.

Staff knew how to safeguard people from abuse, and were clear about their responsibilities to report incidents to the manager. The provider had effective recruitment procedures that helped protect people, because staff were recruited that were of good character to work with people in the home. Staff had received the training they needed to support them to meet the needs of people they cared for.

Assessments had been carried out to determine risks to people's health and safety. Action was taken to reduce any identified risks. People accessed health care services when needed, and received healthcare that supported them to maintain their wellbeing. We saw there was a good choice of food, including snacks and drinks available. There were processes which ensured people received their prescribed medicines.

People and relatives spoke positively about the deputy manager who was approachable. They were able to talk with the deputy manager if they had any concerns and felt their concerns would be dealt with. The manager ensured staff had regular meetings in which their performance and development was discussed.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People told us they felt safe, but there were not enough staff on duty in the afternoons to respond to people's needs and to keep people protected from risk. Staff understood their responsibility to report any observed or suspected abuse and medicines were administered, recorded and stored safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Where people could not make decisions for themselves, people's rights were protected. However, important decisions made in peoples 'best interests' and who had the authority to make these decisions were not always recorded. Staff completed induction and training so they had the skills they needed to effectively meet the needs of people at the home. People were supported to maintain good health and a nutritious diet which met their preferences. People accessed healthcare services to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring and kind. Care and support was provided by staff who had a good knowledge of people's needs and how people wanted their care and support to be provided. People's privacy and dignity was respected and promoted. People were encouraged to maintain their independence and make everyday choices which were respected by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported to take part in interests and hobbies that met their individual needs and wishes. Care records were not always up to date. People and their relatives knew how

to make complaints if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance systems were not always effective in identifying areas for improvement. People and relatives felt able to speak to managers at the home when they needed to. Staff were supported to carry out their roles by the management team.

St Martins

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 23 May 2016 and was unannounced.

The inspection was carried out by two inspectors.

We reviewed information we held about the service. This included information of concern received about the care provided to one person who lived at the home; as well as information from previous inspection reports and notifications the provider sent to inform us of events which affected the service. This is information the provider is required by law to tell us about.

We looked at information received from local authority commissioners of the service. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. They had no further information to tell us that we were not already aware of.

During our inspection we spoke with three people who lived at the home, two relatives of people, and two community nurses. We also spoke with three care staff, the cook, the manager, the deputy manager and the provider.

Eleven of the people who lived at the home were not able to tell us, in detail, about how they were cared for and supported. This was because they lived with dementia. However, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We looked at a range of records about people's care including three care files, daily care records, food and fluid charts, and medication administration records (MAR) for seven people. We looked at other records which related to people's care and how the service operated, including the service's quality assurance

checks.

Requires Improvement

Is the service safe?

Our findings

We were concerned there were not enough staff on duty at all times of the day to meet the needs of people who lived at the home. Staff did not always have the time to support people in a way they needed to help keep them safe and protected from risks.

People, relatives and staff, told us there were not enough staff to meet people's needs in an afternoon. One person told us, "There's not as many staff about now so you have to wait." A relative said, "Staffing levels could improve. We come every day and see the staff struggling to meet people's needs. There used to be three staff but now there is only two, so we [Family] come in at meal times to make sure [Person] has help with eating." Staff told us they were concerned about people's safety because some people needed support from two staff members. One staff member said this meant staff were not always available to support people in other areas of the home. They told us, "If we are both [Staff] in a bedroom then no one's [Staff] is in the lounge and people who re high risk of falls try to get up."

The rota for the last month confirmed staffing levels had been reduced from three staff in the afternoon to two. We discussed our concerns with the manager and the provider who assured us they would review staffing levels as a priority.

The manager told us the decision to reduce staff was based on cost and a reduction in the number of people who lived at the home, as opposed to an assessment of the dependency needs of people. The manager told us, "Now our numbers have gone up we will be looking at it again. I will be doing that today." The provider told us, "We are increasing staffing levels. We need to employ someone…, but until then we will ask staff to cover."

We found this was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The manager told us staffing levels had been increased on the day of our visit to enable staff to be available to talk to us. There was five care workers, a domestic assistant and cook on duty. We saw call bells were answered promptly and staff were available to respond to people's needs when needed.

People told us they felt safe living at St Martins because they trusted the staff and there was always a member of staff or other people in the home. One person said, "I do feel safe because they [Staff] are here." Relatives told us they were confident their family members were safe. Comments made included, "Absolutely, yes. [Person] is safe here.", And "Definitely, no concerns at all." We saw a staff member approach a person who was showing signs of anxiety, the staff member sat by the person and touched their arm, they said, "Don't worry, we are here to help you. You're safe with us." The person smiled and said "Thank you."

The provider protected people against the risk of abuse and safeguarded people from harm. People were supported by staff who understood their needs and how to keep people safe. Staff had undertaken training about how to safeguard people, and were knowledgeable in recognising abuse and who to report concerns

to. One staff member told us, "We learn in training about all the different types of abuse, like physical and financial. If we see anything or think something is not right then it's up to us to tell [Deputy]." Another staff member said, "As well as knowing the different types of abuse and what to do, it's important to make people feel safe."

Staff told us, they were confident the manager would take action if they reported any safeguarding concerns and stated they would not hesitate escalating these if they needed to. One staff member told us, "I know [Deputy] would talk to [Manager] if we report any concerns, but if nothing was done, I would go to CQC or the local authority."

The provider notified us when they made referrals to the local authority safeguarding team where an investigation was required. The manager followed the local authority procedures to ensure people were safe whilst safeguarding concerns were investigated. They kept us informed with the outcome of the referral and actions they had taken.

Staff were recruited safely. Before staff started working at the home, the provider checked they were of suitable character to support people that lived at the home. They contacted previous employers to obtain references, and checks were made with the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. This was to minimise the risks of recruiting staff who were not of suitable character to support people who lived in the home. Staff confirmed they were not able to start working at St Martins until the checks had been received.

The manager had identified potential risks related to each person who lived in the home, and care plans had been written detailing the actions needed to manage or reduce identified risks. Staff understood the risks associated with people's individual care needs. For example, staff knew how to support people who were at risk of falling and people who required assistance with moving. Risk assessments were up to date, and had been reviewed to ensure staff continued to meet people's needs as their health conditions changed. For example, we saw a risk assessment for a person who required assistance with moving. The risk assessment included the number of care staff and the equipment required to help move this person safely and to minimise potential harm to the person and to staff. Staff told us, and we saw they supported this person in line with their risk assessments.

The provider had plans to ensure people were kept safe in the event of an emergency or an unforeseen situation. Emergency equipment was checked regularly. Weekly fire tests had been completed and staff knew what action to take in an emergency. We saw each person had a personal emergency evacuation plan which staff could quickly refer to in the event of an emergency. These plans gave staff and the emergency services information about the level of support and equipment a person may need to evacuate the building safely.

People told us they received their medicines and staff always gave them at the prescribed times. One person said, "No problem with my tablets. They are there on the dot." We looked at four medicine administration records (MAR) and found medicines had been administered and signed for at the correct time. Medicines were stored securely and disposed of safely when they were no longer required.

People received their medicines from staff who had completed medicines training. Staff told us, and records confirmed staff's competencies were assessed by a member of the management team to ensure they had the skills they needed to administer medicines to people safely. One staff member said, "The deputy watches me do medication every six months to make sure I am doing everything right." We saw MARs were checked regularly to make sure people continued to receive their medicines as prescribed.

Some people were prescribed 'as required' medicine. These are medicines that are prescribed to treat short term or intermittent medical conditions or symptoms, and are not taken regularly. There was a procedure for each person to inform staff when and why the medicine was needed, and staff knew when the medicine should be given. We observed staff discreetly asking people if they needed "as required" medicine. This ensured people did not receive too much, or too little medicine when it was prescribed in this way.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 30 November 2015 we found the provider did not follow the requirements of the Mental Capacity Act 2005 (MCA). This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Consent.

Following our inspection in November 2015 the provider sent us an action plan outlining the actions they would take to ensure people who lived at the home were supported effectively in line with the requirements of MCA. The provider told us these actions would be completed by 14 February 2016.

At this inspection we checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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.

We saw improvements had been made. People who had capacity to make their own decisions told us they were no longer restricted from leaving the home to pursue activities of interest. Mental capacity assessments had been completed with the involvement of people, their families and healthcare professionals when people could not make decisions for themselves.

However, we found where people lacked capacity; information was not always decision specific which meant staff were not consistently given instructions on which decisions people could make for themselves, and which decisions needed to be made in their 'best interests'. Where families had signed 'consent' for care and support to be delivered in a specific way there was no record of lasting power of attorney (LPA), or a 'best interest' meeting. LPA is a legal document showing the name of person/s appointed to make decisions on behalf of a person who does not have capacity to make decision for themselves. Only people named on a lasting power of attorney (LPA), have legal authority to give consent on behalf of a person who lacks capacity to do so. We discussed this with the manager who told us; whilst improvements had been made since our last visit they recognised the need to do more to ensure they supported people effectively in line with the MCA. The manager said they had arranged further in-depth training for themselves and had been developing their knowledge by accessing resources on the internet, for example, Mental Capacity Act 2005 Code of Practice.

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 are called the Deprivation of Liberty Safeguards (DoLS). At the time of this inspection, nine applications had been approved by the local authority to make sure people's freedom were not unnecessarily restricted.

Staff had completed MCA training and were able to demonstrate they understood the principles of the MCA

and DoLS. Staff gave examples of how they obtained, and how they made sure people had consented before any care was provided. One staff member described how they supported a person who regularly refused assistance with personal care. The staff member said, "I know if [Person] says 'no' to go away and try again later."

People spoke positively about the quality of food served and the range of choices available. One person told us, "Food is plentiful and it's good." Another person said, "I like bacon, egg, tomatoes and everything else that goes with it. I have it every day." The person told us, "If you don't like what's on offer you just ask for something else."

The cook told us they knew people's dietary needs and made sure people's food was prepared in a way that did not put them at risk. We saw information about people's dietary needs was available in the kitchen, including recommendations made by health care professionals. The cook told us they prepared a minimum of two meal choices at each mealtime. They said, "Some days I can do five or six different meals it just depends what they [People] fancy. I cook whatever they [People] want. I don't think people should eat what they don't want." The cook told us they cooked all meals from scratch using fresh ingredients. We observed the cook asking each person what they would like to eat for lunch. People made their selection from the two choices offered.

We saw breakfast and lunch being served. Food looked appetising. Staff were available to provide support where needed, and staff knew which people needed to be encouraged or assisted to eat and drink. For example, a staff member observed one person was not eating their lunch. The staff member knelt by the person and asked if they would like some assistance. The person said they would. The staff member seated themselves at the side of the person and assisted the person to eat their meal. The staff member told us, "Sometimes [Person] manages on their own but sometimes they need help. It depends how they [Person] is feeling. I just watch from a distance and help if I'm needed." Throughout the meal times we observe people and staff chatting and laughing together which provided social stimulation whilst people ate their meal. One person said, "I love the chatter. It makes me feel happy."

Throughout our visit people were offered drinks and snacks. Jugs of juice and bowls of fresh fruit were available in the lounge area. However they were placed in the middle of the lounge on a low table and this meant people with restricted mobility could not get to their drinks independently. Staff regularly encouraged and assisted people to have the drink of their choice from the selection of drinks on offer. One person told us, "I love a nice hot cup of tea. I drink it all the time." We heard another person say, "I would like a milky coffee please." The staff member responded, "Coming right up. Is there anything else I can get for you whilst I'm in the kitchen?"

At the time of our last inspection we identified shortfalls in relation to the completion and auditing of fluid and food charts. These charts were for people who needed to receive a specific amount of food or fluid each day to maintain their health. The provider told us at our last visit they had identified this issue and a new system for the daily recording and monitoring of fluids had been agreed for use. At this inspection we saw records had been completed on a daily basis. However, some records had not been added up at the end of each 24 hr period or had been incorrectly totalled. For example, one recently completed chart showed a total intake of 580mls. The actual recorded fluid intake was 870ml. This meant the monitoring of people's fluid intakes was not effective. The manager told us they would be introducing daily auditing of the forms with immediate effect.

People told us staff were knowledgeable and knew how to provide the care and support they needed. One person told us, "Staff know what I do myself, and when I need help." Another person explained how staff

supported them to move around the home because they were unable to walk. They said, "The girls know exactly what they're doing. I'm never worried." A relative told us, "Staff know what [Person] needs. All our family feel [Person's] needs are met." Their relative described how the person's well-being had improved because staff worked with a community physiotherapist to support their family member following their discharge from hospital.

Staff received an induction when they started to work at the home. Staff said their induction included working alongside an experienced member of staff, and completing training courses tailored to meet the needs of people who lived at the home. The manager told us the induction was linked to the Care Certificate which assesses staff against a specific set of standards. As a result of this, staff had to demonstrate they had the skills, knowledge, values and behaviours expected from staff within a care environment to ensure they provided high quality care and support.

Staff told us the deputy manager encouraged them to keep their training, and skills and knowledge up to date, and maintained a record of staff training. One staff member told us, "[Deputy] makes sure our training is up to date [Deputy] tells us when refresher training is due." Another staff member said, "Training is really good because things change and doing training keeps me up to date." The staff member gave an example of how they learnt about the different ways of using a hoist sling. We observed the staff member put their training into practice whilst working with a colleague to assist a person to transfer using a hoist.

People accessed health care services such as their GP or their chiropodist, when needed. During our visit we spoke with two visiting community nurses. They were complimentary about the staff team and the support people received. One nurse said, "I don't visit this home regularly but when I do I have no problems. Staff answer the door quickly and are polite. The care is good. We always go to see patients with a member of staff." The second nurse told us, "Staff know what's going on with patients which is really good and helpful."

Good

Is the service caring?

Our findings

People told us staff were kind and they found staff friendly and approachable. One person told us, "I was welcomed with open arms. They [Staff] have done everything to make things easier for me." Another person told us, "The staff are lovely. They [Staff] are pleasant and cheerful." A relative told us, "The staff are very friendly and caring." Another relative said, "The staff are very caring…they [Staff] think about the small things and often these are the important things. Nothing is too much trouble."

Staff told us the service provided to people at St Martins was caring. One staff member told us, "If you don't care you're in the wrong job. It's like having an extended family. We all care about each other." Another staff member said, "All the staff here are caring. We are here to do everything they [People] need us to do, and more."

We spent time in the communal areas of the home and saw the interaction between people and the staff who provided care and support. Staff were caring and kind towards people, engaged them in conversations and addressed people by their preferred names. Staff were friendly and respectful and people appeared relaxed with staff. People had a good rapport with staff, and spoke to them with confidence.

Staff responded to people's needs and staff regularly checked people's wellbeing throughout the day. For example, one staff member saw a person rubbing their legs. The staff member asked, "Are you cold [Person]?" The person said they were, so the staff member fetched a blanket which they tucked around the person legs. The person responded, "Oh that's better thank you." This demonstrated people were supported by staff with kindness.

Staff took time to listen to people and supported them to express themselves. For example, staff crouched down to be at eye level when talking to people who were sitting down.

People told us they looked forward to visits from their friends and relatives, and this was an important part of their lives. One person said, "I look forward to seeing my daughters. One of them visits most days." Another person told us, "My family can come and see me whenever they want it's my home." During our visit we saw visitors offered drinks and were made to feel welcome by staff. One relative told us, "It's a pleasure to come and visit. The staff make you welcome. I think they know how important my visits are for [Person]." This helped people maintain relationships with people who were important to them.

People's dignity and privacy was respected by staff. One person told us, "Staff cover me up when I'm in the bathroom." Staff told us they understood the importance of treating people with dignity and respect. One staff member said, "I treat them [people] how I would like to be treated myself." We saw staff knocked on people's bedroom doors and announced themselves before entering their room. We heard staff speak discretely and quietly to people regarding personal care routines, to respect people's privacy. People who wore skirts had their legs covered with blankets when staff assisted them to move using specialist hoist equipment. This ensured their dignity was maintained.

People told us staff treated them with respect and supported them to maintain their independence where possible. One person described how they were able to make regular visits to the local bingo hall with support from staff. The person said, "I just need help to get there and back. Once I'm there I'm fine on my own." A relative told us, "Staff are very caring, they have gone beyond to help [Person] to mobilise, and as a result of their [Staff] support, her mobility and independence has improved."

We saw one person had difficulty putting food on to their fork at breakfast. With the consent of the person, a staff member put food on the person's fork, which enabled the person to continue eating their meal independently. This showed staff recognised it was important to promote independence so people continued to do as much for themselves as possible.

People were supported to make everyday choices which were respected by staff. One person told us, "I tell the staff what time I want to go to bed. Sometimes I go early. Sometimes I'm later." We heard one staff member who was assisting a person to get ready for the day say, "Let's look together what clothes we've got in the wardrobe. Shall we put something cooler on today as it's warmer outside?" We heard the staff member describing different items of clothing until the person said, "I'd like to wear that." Staff gave people choices about how and where they spent their time. For example, we saw some people were up when we arrived, and other people were still in bed. During our visit some people chose to spend time in their bedrooms; other people chose to sit in the lounge.

Requires Improvement

Is the service responsive?

Our findings

People told us the care and support they received was centred around their needs. They felt involved in making decisions about their care. One person said, "I take it day by day. I never know how I'm going to feel or what help I need. So they [Staff] check with me in the morning. Then they help me if I need them."

During our visit we saw call bells were answered promptly and staff were available to support people when needed. However, people told us this was not always the case. One person told us, "I used to press my bell, and it's a good bell, and staff would come. Now they have more work to do so I have to wait." A relative told us, "They [Staff] are very rushed at the moment. There are times when we visit and there are no staff in here [Lounge] because they are helping out in a bedroom." This meant staff were not always available to support people when needed.

At our last inspection we received mixed responses from people about the activities provided by the home. Some people told us they would like more enjoyable and stimulating activities. We saw the information about available activities on display was not accurate. The provider told us this was an area which needed to be improved and they were planning to appoint an "activity coordinator" and to advertise daily activities and events on an "interactive display screen".

During this inspection people told us activities continued to be limited. One person told us, "There's not really anything to do. I watch the telly." Another person said, "I think they [Home] should have a leaflet saying what's happening so you know what you can do instead of just waiting to see if something happens." We did not see activities information on display in the home. A relative told us, "When [Person] first came here there were lots of things to do but not anymore. The staff can't do everything."

We saw with five staff on duty, because of our visit, staff had more time to provide activities which people enjoyed. For example, a staff member said, "Right then. We are going to do something. We are going to have a little game of play your cards…" The staff member explained to people sitting in the lounge how to play the game which they enjoyed. The staff member told us, "We can do it today because there are more staff on. Normally we don't have any time." Another staff member was observed sitting with a person playing a card game. The person told us they had enjoyed playing cards and would like to do it more often. Staff told us they found it difficult to find time to do activities with people.

The manager told us they recognised social activities was an area which still required improvement. The manager said, and records confirmed they were being supported by the local authority contract monitoring officer and an occupational therapist (OT) to develop a meaningful activities programme. We saw the occupational therapist had recently met with the manager and people who lived in the home and plans were now being developed to support the home to develop their activities programme.

People and their relatives were involved in planning their care and support needs. One person told us, they had recently moved into the home and staff had spent time with them asking about things they liked and what support they needed. A relative told us, "We are invited to meetings to discuss [Person's] care, but we

speak to staff on a daily basis so we are involved and informed about [Person]."

We reviewed the care records for three people. We found some care records were not up to date. For example, a medication care plan for one person had not been updated to reflect a change in their prescribed medicine which was recorded on the person's MAR record. Another person's care plan had not been updated to show they no longer needed to sit on a special cushion to protect their skin because the person could now move independently. We asked the deputy manager why these records had not been updated. They were unable to give an explanation, but told us they would update the care records straight away.

Some care records to show people had been supported with their personal care needs were incomplete. For example, one person's care plan stated they needed twice daily assistance with cleaning their teeth. The person's "teeth cleaning record" had only been completed on 2nd, 3rd, 14th, 16th, 17th and 23rd May 2016. We asked staff if this was because they had not assisted the person to clean their teeth or if they had not completed the record. One staff member said, "I'm not sure. We do our best. With less staff when were busy sometimes we miss things." We asked the manager how they could give assurances that the people had been supported to meet their personal care needs and why these records had not been completed. The manager told us with immediate effect they would be speaking with staff and introducing daily spot checks.

Other records detailed people's preferences and gave staff information about how people wanted their care and support to be provided. For example, we saw staff supported one person to walk to the local shop to buy a newspaper. This reflected the information recorded in their care plans about their daily interests. Staff told us they understood how important it was to read people's care plans so they knew what people's preferences were and to ensure they supported people in the way they preferred. However, staff told us they did not always have time to read care plan updates. Staff said this was because of the reduction in staffing levels.

Staff handover meetings took place before a new shift of staff started work. Staff leaving their shift provided staff starting their shift, with information about any changes to people since they were last on duty. For example, staff coming on duty were informed that a visit from the community nurse had been requested for one person. Staff told us handovers were important as it meant they had the information they needed to support people and respond to any changes in people's physical and emotional needs.

People and relatives told us they knew how to make a complaint and felt able to do so. One person said, "No complaints from me. I would soon say if I had." A relative told us, "If I had a complaint they would all hear about it. I would go to the office and talk to them [Management team]." Another relative said, "If I had any concerns at all I know who I would need to talk to, and I feel that they would listen."

Staff understood their responsibilities to support people to share concerns and make complaints. One staff member said, "If someone wasn't happy about something I would talk to them and sort it out." Another staff member told us they would inform the deputy manager if a person or a visitor shared concerns with them. The provider told us complaints were taken seriously. No written complaints had been received in the home in the last 12 months. However, a complaint had been made about the home which was investigated by the local authority. The manager told us they were waiting to formally hear the outcome of the complaint. The manager said, "Once we know the outcome we can look at any changes we need to make."

Requires Improvement

Is the service well-led?

Our findings

People told us they were satisfied with the running of the home. One person said, "[Deputy] is lovely. We get on. You can always talk to [Deputy]." A relative told us, "I don't have anything to compare it with but from what I can see the home is well run. I have no concerns." Another relative said, "We don't see the manager much but [Deputy] is always about and is very approachable."

There was a clear management structure within St Martins to support staff. The registered manager was part of a management team which included a deputy manager and senior care workers. We were told the 'day to day' running of the home was the responsibility of the deputy manager with the manager overseeing more office based functions. The deputy manager told us the provider was available if there were any concerns or issues they required support with. The manager was also a director so was not present at St Martins on a daily basis. The provider told us, for the past two months they had been actively seeking to recruit another registered manager. They said, "This will release [Director] so they will have time to focus on overseeing the operations of the service."

Staff felt supported by the deputy manager and each other. One staff member told us, "[Deputy] is very approachable. Nothing is too much trouble and you can talk about, or ask about anything." Another staff member said, "It's all about team work. We all pull together. [Deputy] works with us which really helps us work as a team." Staff told us the manager and deputy manager were available to support them outside "normal office" hours. One staff member said, "If we need something we just ring. We have all the phone numbers."

Staff told us individual and team meetings were held at more regular intervals than when we last visited. Staff said team meetings gave them the opportunity to be informed about any changes and to share their views and ideas. Two staff members, however, told us they felt the manager did not always respond to their concerns. One staff member said, "I don't feel [Manager] is listening to us. We said we were struggling with staffing but nothing happens." Staff told us they found individual meetings with the deputy manager useful. One staff member said, "It's good because we talk about training and how I'm doing my job."

At our last inspection we found people's views were not always sought about the quality of the service or how the home could improve. Formal systems such as 'resident and relative' meetings or quality feedback surveys were not in place. During this visit we were not able to establish improvements had been made. The provider told us, a quality questionnaire had been developed which would be issued to people and their relatives. The provider said, "We have got the questionnaire but have been slow in issuing it. This is something we will prioritise." A relative told us they had been asked to complete a questionnaire on the day of our visit. The deputy manager told us meetings had been held with people who lived at the home. However, minutes of meetings could not be found during our visit.

The provider completed a number of checks to assess the quality of service provided. This included weekly announced and unannounced visits to the home to speak with people, relatives and staff. One the day of our visit the provider was in the home to undertake a quality monitoring visit. The provider told us their visit

had identified the need for two bedrooms to be deep cleaned. They said, "These residents choose to rarely leave their rooms for us to deep clean. It makes it difficult." We heard the provider speaking with the manager and discussing how they could encourage people to agree to their rooms being deep cleaned. Further improvements had been made to the environment following their quality visits. These included redecoration and carpeting in one of the hallways.

The checks which assessed and monitored the quality of the service had been completed but were not always effective. Medicines audits were not sufficiently detailed to ensure all areas of medicines management and administration were reviewed. Monitoring had not identified inaccuracies and gaps in the completion of food and fluid charts. Care plan audits had not identified that some care records were out of date and did not reflect people's current needs. This meant staff did not have accurate information about people's needs and wishes.

The manager and provider recognised some of the required improvements identified at our last visit had not been made. The manager explained to us the reasons why the changes had not been made as quickly as expected. The provider told us they hoped the appointment of a new manager would assist in driving the improvements forward.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient number of suitably qualified, competent and skilled staff to meet people's care and welfare needs.