# 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 |

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|---|---|
| Is the service safe? | Good |
| 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 30 November 2015. The inspection was unannounced.

St Martins is a care home providing personal care and accommodation for a maximum of 16 older people. The home is located in Coventry in the West Midlands. There were 14 people living at home at the time of our visit. Half the people 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. St Martins had a registered manager who was on leave at the time of our visit. However, we spoke with the 'floor manager' and one of the directors. As part of our inspection process we spoke with the registered manager on their return from leave to gain clarification about information we had gathered during our visit. We refer to the registered manager as the manager in the body of this report.

People were not always supported in line with the principles the Mental Capacity Act 2005 (MCA), People were able to make some everyday decisions themselves, which helped them to maintain their independence. However, not everyone at the home was able to make decisions about how they spent their time, and the activities they might enjoy.

People and their relatives felt the manager and floor manager were approachable. Staff said they were supported by the management team. We found the arrangements made by the provider for management cover for the home during the manager's absence were not fully effective.

People and their relatives told us they felt safe with staff, and staff treated them well. Staff knew how to safeguard people from abuse, and were clear about their responsibilities to report these 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.

There were enough staff at St Martin's to support people safely, though staffing levels did not always enable people to have the support they needed to take part in interests and hobbies that met their individual needs and wishes. People who lived at the home were encouraged to maintain links with friends and family who could visit the home at any time.

Risk to people's health and welfare were assessed and care plans gave staff instruction on how to reduce identified risks. However, risks to people's health and safety were not always minimised as staff did not consistently follow the advice of nutritional health professionals.

People were supported to attend health care appointments with health care professionals when they

needed to, and received healthcare that supported them to maintain their wellbeing. There were processes in place to ensure people received their prescribed medicines in a safe manner.

Overall, care records were up to date and described people's routines and how they preferred their care and support to be provided by staff. Staff had a good knowledge of the people they were caring for. People and their relatives thought staff were caring and responsive to people's needs.

Staff had received the training they needed to support them to meet the needs of people they cared for. Staff reassured and encouraged people in a way that respected their dignity and promoted their independence. People were given privacy when they needed it.

People and a relative told us they knew how to make a complaint if they needed to. 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, the floor manager worked alongside people at the home, and gathered verbal feedback from people during their day to day activities. The 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 established some procedures to check the quality of care people received, and to identify where areas needed to be improved. The provider was updating quality assurance processes, to develop more effective recording systems. We saw information was used to identify any patterns or trends and to make improvements to the service.

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?

Good

The service was safe.

People told us they felt safe living at St Martins. Staff knew how to safeguard people from harm. People were protected from the risk of abuse as the provider took appropriate action to protect people. Medicines were managed safely, and people were supported to take their medicines as prescribed. Staff were available to assist people if they needed support.

### Is the service effective?

Requires Improvement

The service was not consistently effective.

The rights of people who were not able to make decisions about their health or wellbeing were not always protected. People were supported by staff who had received training to help them undertake their work effectively. People were supported to access healthcare services to maintain their health and wellbeing. However, advice from nutritional health professionals was not consistently followed by staff, and fluids were not monitored consistently.

### Is the service caring?

Good

The service was caring.

People told us they were happy at the home and felt staff were caring and respectful. Care and support was provided by staff who had a good knowledge of how people wanted their care and support to be provided. Staff understood how to promote people's rights to dignity and privacy at all times. 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 need and wishes. Overall care records were up to date. People and their relatives knew how to

make complaints if they needed to, and the provider acted on complaints to improve the service provided.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

People, relatives, staff and health care professionals felt able to speak to managers at the home when they needed to. Managers supported staff to provide care which focussed on the needs of the individual and staff told us they were supported by the managers. The provider had some systems in place to monitor the quality of the service provided but had not ensured these were always effective.

# 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 30 November 2015 and was unannounced. The inspection was undertaken by two inspectors.

Before our inspection we reviewed information we held about the service, for example, 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 commissioners of the service. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

Seven of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their diagnoses. 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 observed care and support being delivered in communal areas of the home, and we observed how people were supported to eat and drink at meal times. We observed medicines being administered.

During our inspection we spoke with seven people living at the home, one relative of a person who lived at the home, two senior care workers, four care workers, a nurse and a visiting best interest assessor (BIA). A BIA assessor is a qualified person who decides whether people who lack the capacity to consent to their care are being deprived of their liberty and if so, if this is in their best interests, to prevent harm to them and proportionate to the risk or likelihood of that harm. We also spoke with the floor manager and the provider. As part of our inspection process, after the visit, we spoke with the manager when they returned from leave.

We looked at a range of records about people's care including seven care files, daily records, food and fluid

charts and medication administration records (MAR) for seven people. We looked at various records the manager kept to check the quality of service provided

Good

# Is the service safe?

## Our findings

People told us they felt safe living at St Martins. One person said, "I know I'm safe because I feel safe." Another person told us, "Knowing staff are available night and day makes me feel safe." A relative said, "I know [name] is safe, I feel at peace."

Staff knew how to safeguard people from abuse and were clear about their responsibilities to report incidents to the manager. For example, we asked staff what they would do if they witnessed an incident of a safeguarding nature. All responded that they would intervene directly to prevent further abuse, and immediately report the incident to more senior staff. Staff told us it was their responsibility to make sure people were kept safe. One staff member said, "It's their home. I feel safe in my home so they have the right to feel safe in theirs."

The manager notified us when they made referrals to the local authority safeguarding team where an investigation was required to safeguard people from harm. The manager followed the local authority procedures to ensure people were safe whilst safeguarding concerns were investigated.

Records showed staff were recruited safely. For example, prior to staff working at the service, the provider checked their character by contacting their previous employers to obtain references, and 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 associated with people's care and treatment and care plans had been written to instruct staff how to manage and reduce potential risks to each person. Risk assessments were detailed, up to date, and reviewed regularly. Risk assessments gave staff clear instructions on how to minimise risks to people's health and wellbeing. For example, one person was at risk of falling, and could injure themselves. There were plans for staff to follow in how the person should be assisted to move around, and what equipment should be in place to minimise the risk of them falling. We saw staff used the identified equipment whilst assisting them.

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 was easily accessible 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 when they needed them. One person said, "My medicines are there every day." We saw medicines were given to people safely. We looked at seven medication administration charts and found that medicines had been administered and signed for at the specified time. Six records contained people's photographs to ensure staff could correctly identify the person to receive the medicine. The provider told us a photograph for the other record was in the process of being printed.

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 regularly to ensure they had the skills they needed to administer medicines to people safely. One staff member said, "If the manager thinks you need more training, then you have to do this before you can continue to give medicines to people."

Medicines were stored securely and disposed of safely when they were no longer required. 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 about when and why the medicine was needed, and staff knew when the medicine should be given. One person told us, "The girls [staff] always check if I'm in pain so I can have my medicine." We saw staff discreetly and sensitively asking people if they needed "as required" medicine. This ensured people did not receive too much, or too little medicine when it was prescribed on an "as required" basis.

We found there were adequate numbers of staff available during the day to care for people safely, including dedicated staff to cover housekeeping roles such as cooking and cleaning. There were staff present in communal areas of the home throughout our inspection, ready and available to assist people if they needed support. One staff member said, "Yes there are enough staff at the moment. Staffing numbers depend on the amount of residents we have. The manager and the floor manager are also extra staff if we need them."

The provider told us that the home did not use agency staff. This was confirmed by staff. One staff member said, "If a shift needs covering one of us will do it, we don't use agency because we know our residents and understand how they want to be looked after. Agency staff wouldn't have time to know about the little things that are important to them [people]." This meant that people received care and support from staff who understood their preferences and needs.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The floor manager and provider were unable to explain to us the principles of MCA and DoLS, which showed they did not have a good understanding of the legislation.

People had not been asked to sign they consented to their care and support being delivered by the home, where people did not have the capacity to make these decisions. We saw where people did have the ability to be involved in decisions about their care and support needs, their involvement had been recorded. However, in one person's care records we saw a relative had signed 'consent' for care and support to be delivered in a specific way. This 'consent' was instead of a 'best interests' decision being made by an appropriate person. This demonstrated that the provider was not acting in accordance with the principles of the MCA.

Mental capacity assessments were not always completed when people could not make decisions for themselves. In addition, where mental capacity assessments had been completed, records detailing people's capacity to make decisions was not decision specific, which meant staff were not given instructions on which decisions people could make for themselves, and which decisions needed to be made in their 'best interests'.

The manager reviewed each person's care needs to assess whether people were being deprived of their liberties. No-one had a DoLS in place at the time of our inspection. However, the manager had made applications to the local authority for all people living at the home.

We saw one person had a DoLS application to restrict their movements, and prevent them from leaving the home because of the risk of them injuring themselves if they fell outside the home. However, the person had capacity to make their own decisions, and indicated that they would like to leave the home and do more outside activities on their own. We spoke to the floor manager as we were concerned that the person was not being supported to make their own decisions. They told us, they were concerned that the person may fall but they understood that the person had capacity to make decisions which the home's staff would respect. The floor manager was not able to explain why a DoLS application had been submitted to restrict the movement of a person who has capacity. The provider told us, they followed the advice of the local authority to make applications for DoLS assessments for each person who lived at the home.

We observed the home had a CCTV system, and had previously recorded people in the communal areas of the home. The provider confirmed that the system had not been working for several months. However, people had not been consulted regarding the CCTV system, and people had not given their consent, where they had the capacity to do so, for the system to record their movements. The provider told us, "One person has actually refused their consent for us to photograph them." This demonstrated the provider did not understand the requirements of the Data Protection Act 1998 and the principles of the MCA.
We found this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

However, care staff demonstrated they understood the principles of the MCA and DoLS. They gave examples of applying these principles to protect people's rights, for example, asking people for their consent and respecting people's decisions to refuse care where they had the capacity to do so. One staff member told us, "If someone had capacity, and they wanted to leave the home or refuse our support, they can do this. We need to respect their decisions."

Peoples told us the food served at St Martins was good and there was lots of choice. One person said, "The food is always nice and warm. I love my food and I get to eat lots of nice things to eat."

We observed a mealtime at the home. People told us they enjoyed their meal. The dining room tables were set with cutlery and condiments, flowers and drinks. People sat down to eat their meal where they preferred, and with people they wished to spend time with. People helped themselves to drinks and condiments during the meal. This made the dining experience enjoyable for people at the home, as it provided social interaction whilst they ate their meal.

People made choices about what they wanted to eat. Some people were eating breakfast when we arrived at the home, and were eating cereals or porridge. Other people ate breakfast later, and had a cooked breakfast which was their preference. One person told us, "I had a cooked breakfast today, which was what I really wanted. The staff are great, and make you what you like."

We saw people were offered drinks throughout the day. Staff encouraged people to have a drink which they liked as people were offered a selection of drinks. Staff prepared what people wanted. One person told us, "You can get a drink whenever you like, you just ask."

Staff made sure people had the specialised equipment they needed for eating and drinking, without being prompted, such as adapted cutlery and crockery. This helped people to maintain their independence, and demonstrated staff knew people well.

Where people needed to receive a specific amount of food or fluid to maintain their health each day, people had their food and fluid intakes monitored and recorded. We found the fluid and food charts were not audited each day to check people received the amount of food and fluid they needed to maintain their health. For example, one person was restricted in the amount of fluid they should consume following the advice of a nutritional health professional. The charts did not contain information on the restricted amount of fluid for the person; instead it stated the individual should be given at least 1280ml per day which was incorrect. The charts documented that the person was receiving more than the recommended 900mls per day. This may impact on their health. On the 25 November 2015 it was recorded the person received 1150ml, on the 26 November 2015 it was recorded the person received 1050ml. We spoke to the floor manager about the person, because we were concerned about their level of hydration. The floor manager could not explain to us what had happened in response to people receiving too much fluid.

We found the fluid and food charts were not consistently completed by staff, or audited each day to check people received enough or too much fluid. For example, in one person's charts it showed that they only consumed 500mls fluid on the 25 November 2015. On another day in November they showed the person had only consumed 1050mls of fluid. The floor manager told us, "People are having more fluids probably than is recorded, it's just poor recording."

We discussed our findings with the provider who told us these issues had been identified during an internal audit and a new system for the recording and monitoring of fluids had been agreed, to ensure people only received the recommended fluid to maintain their health.

People and professional visitors expressed confidence in the knowledge and skills of staff members who worked at the home. One person said, "The staff know what I need and what I like. I like to do things myself and they [staff] are good because they don't rush me." A district nurse who regularly visited the home told us staff had a good understanding of people's needs and always sought advice if they had any concerns or needed guidance about a person's health."

Staff told us they received an induction when they started working at the home which included working alongside an experienced member of staff, and completing training courses tailored to meet the needs of people who lived there. One staff member told us how important the induction had been as it ensured they understood people needs and how they liked their care and support to be provided. The induction training was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care workers in the UK. Staff told us in addition to completing the induction programme; they had a probationary period to check they had the right skills and attitudes for the people they supported.

Staff told us the manager encouraged them to keep their training and skills up to date, and maintained a record of staff training. One staff member told us, "We get all the training we need." We saw staff put into practice the training they received. For example, staff used appropriate moving and handling equipment and techniques to assist people safely. We saw one person being supported to move using a hoist and handling belt. Staff explained to the person what they were intending to do, and offered the person reassurance. The transfer was completed safely. One person told us, "The staff are wonderful, they help me move around. I need help because I struggle to walk."

Staff told us they were updated about any changes to people's health or care needs because they had a verbal 'handover' at the start of each shift. The handover provided them with information about any changes since they were last on shift. One member of staff said, "It's everything we need to know to catch up." Staff explained the handover was recorded, so that staff who missed the meeting could review the records to update themselves.

Staff and people told us the home's staff worked in partnership with other health and social care professionals to support people. Care records included a section to record when people were visited, or attended visits, with healthcare professionals. For example, people were able to see their GP, speech and language therapist, district nurse practitioner, dietician and dentist where a need had been identified. One person told us, "The physiotherapist comes here to see me now. They, and the home have really helped me with my mobility. I used to be in a wheelchair, but now I can walk again."

Good

# Is the service caring?

## Our findings

People told us they were happy living at the home. One person said, "I'm very happy here. The staff are wonderful. They really do care for us." Another person told us, "What I like is it's a nice atmosphere, it's friendly and clean and the girls are nice to me. It's home from home, really."

A relative told us, "I am very, very happy with the care staff. They really do care and I know [name] is in safe hands." A district nurse also shared positive views about the staff, they told us, "The staff are wonderful. They are very pleasant. I would recommend the home to anyone without any doubt."

We observed people had a good rapport with staff, and spoke to them with confidence. Staff sat with people and chatted to them. People laughed and seemed pleased with the way staff interacted with them. Staff took time to listen to people and supported them to express themselves according to their abilities to communicate. For example, we saw staff crouching down when people were sitting, to hold a conversation with them on the same level. This demonstrated people were supported by staff with kindness, in a way that they could understand.

Staff asked people how they were feeling, and if they needed anything. One staff member approached people in the lounge area and asked if they were warm enough. One person stated they could be warmer, and a member of staff immediately produced a blanket to wrap around their legs.

People were able to spend their time where they wished, and were encouraged to make choices about their day to day lives. Staff respected the decisions people made. For example, we saw some people were up when we arrived, and other people were still in bed. Some people were eating breakfast in the dining room, and other people were eating breakfast in their room, which was their preference.

People told us their dignity and privacy was respected by staff. One person told us, "The girls always ask me if they can go in my room even if I'm in here [lounge]." Staff knocked on people's doors before entering, and announced themselves when they entered people's rooms. We heard staff speak discreetly and quietly to people regarding personal care routines, to respect people's privacy. Whilst using specialist equipment for transferring people, we saw staff covered people in order to maintain their modesty.

Staff told us they understood the importance of treating people with dignity and respect. One staff member said, "It's important to respect people's dignity and privacy. We make sure we knock doors and close curtains, this is very important, particularly, in the shared room. We ensure people are covered with a towel when helping them to wash and we make sure we ask permission before we start to help them [people]."

Staff told us they thought people received good quality care at the home. One member of staff said, "They [people] can have anything they want and it's our job to make sure they get it. Sometimes it's difficult because we have to do laundry and other things, but they [people] always come first. If the laundry doesn't get done we just hand it over to the next shift." A second staff member told us, "Everything we do is for them [people]. Even when we go home we are thinking about them." This demonstrated staff were person centred

in their approach to providing care rather than being task focussed.

People told us staff treated them with respect and supported them to maintain their independence where possible. One person said, "I do some things by myself. I always tell the staff what I want to do, and they support me." Another person told us about how staff supported them to maintain their personal preferences. They said, "I prefer my own chair as this helps me feel comfortable, and it's higher than the chairs here, so it's easier for me to stand up. The manager helped me organise things so I could bring my own chair from home." We saw the person used the chair in the communal lounge area to sit in.

People made choices about who visited them at the home. One person said, "It's open visiting here, people can come and visit me here whenever they like." We saw people had visitors join them at the home during our inspection. Visitors were offered drinks and snacks and made to feel welcome, and used the communal areas of the home as well as people's bedrooms to meet. This helped people maintain links with family and friends.

People were supported to access advocacy services. Most people had a relative they could ask for support from, however, where people did not the manager provided access to advocacy services. An advocate is a designated person who works as an independent advisor in another's best interest. Advocacy services support people in making decisions, for example, about their finances which could help people maintain their independence.

Requires Improvement

# Is the service responsive?

## Our findings

People told us they received care and support from staff who responded in a timely way when they needed support. We saw call bells were answered promptly throughout our visit. People told us this was usually the case. One person said, "You just call and they appear."

We saw a bathing schedule was in place, where each person was allocated a weekly time to have a bath or shower, according to their personal preferences. We were concerned that this might restrict people to only having a shower or bath once a week. However, one person we spoke with told us, "Yes, we have a schedule, and a bath or shower day each week. We can have one whenever we want though." This demonstrated staff responded to individuals preferences.

People were offered support to take part in a range of different events and activities each day to help them form social relationships with other people at the home, and to provide them with activities they may find enjoyable and stimulating. We asked people whether they enjoyed the activities arranged. We received mixed responses from people. One person told us, "I can't sit here all day with nothing to do. I sit in the lounge for some time, and then in my room, but there's not a lot going on I find interesting." Another person told us, "I go out about twice a week with friends. I'd like to go out more often, but there's no one to go with me here at the moment. I'm not allowed to go out on my own."

We saw a sing-a-long and colouring competition had been organised in the afternoon. Staff had also put up Christmas decorations with people in the morning. One person told us, "I enjoy the colouring. It's a nice time of year, and the tree is lovely." Another person said, "Christmas was nice here last year."

Activities were advertised on a noticeboard in the lounge area, and showed what was due to happen each day. For example, Monday activities were described as 'What's in the news.' We found that the activities advertised were not on offer during the day, but other activities had been arranged instead. We brought this to the attention of the floor manager and the provider during our inspection, as we found this was confusing to some people at the home. The provider told us advertising social activities was an area "we are not good at yet." We were told an "interactive display screen" had been purchased to ensure information about activities was up to date and publicised. This had not been installed at the time of our inspection.

The provider had not appointed a staff member designated to offer people support with their interests and hobbies, inside and outside the home. We spoke with the provider who told us the intention was to appoint an "activity coordinator" to offer people activities that met their preferences.

People and their relatives were involved in planning their care and support needs. One visitor told us they were involved in planning the care of their relative and were invited to meetings to discuss the care and support being provided. They said "I know about the care plans and I can access them at any time. I read them when I go to reviews."

Care records contained information on people's religious beliefs and their personal preferences about how

they wanted to be supported to maintain their faith. We saw people's preferences were respected, as people met with ministers when they wanted to.

We reviewed the care records for seven people. Care records were up to date with the exception of one. Care records had a section called 'this is my life' which was not filled in for one person. We asked a member of staff why the records had not been completed. They stated, "There's no reason for this, the person has been with us since August, and they and their relatives could have assisted us to complete this." They added, "Their relatives do visit them here". We brought this to the attention of the floor manager who agreed that the file would be updated straight away.

The provider's complaints procedure was on display in the reception area of the home which gave people advice on how to raise concerns and informed them of what they could expect if they did so. The procedure included details of other relevant organisations, including the local authority and the Care Quality Commission. However, information about how to make a complaint or provide feedback was not on display in the communal areas of the home, or in an easy to read format for everyone at the home to access. For example, easy to read documents may be prepared using large print and pictures to make them accessible to people with limited communication. Documents provided in this way would give more people the opportunity to provide feedback to the provider, and could help people to maintain their involvement and independence. We brought this to the attention of the provider during our inspection.

People and relatives told us they knew how to make a complaint and felt able to do so. One person said, "I have no complaints. If I was worried I would talk to [Name]." A relative told us, "If I had any issues at all I would speak to the floor manager. I would be straight in there. They are very good and always oblige me." The provider told us complaints were taken seriously. No written complaints had been received in the home in the last 12 months. However, a verbal complaint had been made by a relative and the provider had managed this in line with their complaints procedure. The provider said there was an 'open door' policy at the home and the floor manager was always available should anyone want to make a complaint or raise their concern. The provider analysed complaints to continuously improve the service.

Requires Improvement

# Is the service well-led?

## Our findings

All the people we spoke with were satisfied with the quality of the service and told us they liked living at St Martin's. One person told us the manager was "Very friendly". Staff told us the manager, floor manager and director were approachable and supported them if they needed it.

There was a clear management structure within St Martin's to support staff. The manager was part of a management team which included a floor manager and senior care workers. The manager was not available on the day of our visit, but we spoke with the floor manager for the home, and to the provider. As part of our inspection process, we spoke with the manager on their return from leave to gain clarification about information we had gathered during our visit.

We were told the 'day to day' running of the home was the responsibility of the floor manager with the registered manager overseeing more office based functions. The manager was also a director and was registered with us to manage other of the provider's services, so was not present at St Martins on a daily basis. However, the floor manager told us the manager or the provider was always available if there were any concerns or issues they required support with. The floor manager told us they felt supported by the manager and the provider.

We found that effective arrangements had not been made by the provider to manage the home whilst the manager was away. For example, the floor manager and provider were not familiar with the way the manager recorded and stored information about how the quality of the service was monitored. This meant some of our requests for information could not be met during the inspection.

For example, we found completed actions from some risk assessments had not been consistently recorded. For example, a fire risk assessment commissioned by the provider on the 21 May 2015 showed outstanding actions. The provider told us they believed the actions had been completed but, in the absence of the records and the manager they could not be sure. The manager has since confirmed that all required actions had been completed and these had been documented on a "quality log" located at the front of the home's health and safety file.

All people and staff we spoke with had a good rapport with the manager and floor manager who they described as approachable and supportive. One person said, "The manager is a very nice person". A staff member told us, "The floor manager is very good they deal with things when you raise them or, if they can't, they pass them on to manager." Staff told us there was always an 'on call' number they could call outside office hours to speak with a manager if they needed to. One staff member said, "A manager is always available if you need any support or advice."

A relative told us they felt the home was "running smoothly. They said," There is a very good line of communication between myself and the home. They always keep me informed about [Name] and I can speak to the floor manager at any time."

Staff said they had team meetings every three months. One staff member told us, "Meetings are really useful. We talk about lots of different things, like changes that are happening." Staff said that they had regular individual meetings with the manager or floor manager which they valued, as it was an opportunity to discuss any issues of concern and areas for self and service-development. One staff member said, "I asked the manager in my meeting if I could do extra training and just after my meeting they arranged it."

The manager and provider completed a number of checks to ensure they provided a good quality service. For example, weekly announced and unannounced visits to the home to speak with people, relatives and staff. We observed the floor manager and the provider engaging with people and staff in a familiar, friendly and warm manner. One person said, "The provider does come and visit here, they are very nice." We asked to see their visit reports, but were told they were not consistently recorded. We were later informed by the manager that any issues identified through internal audits were recorded on a log which was reviewed and updated each week to show actions completed and those which remain outstanding.

The provider explained quality assurance processes was an area they had identified for improvement and work had begun to develop more effective recording systems. The provider said they were updating their policies and developing additional procedures to ensure they reflected the requirements of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Some monthly audits and risk assessments had been undertaken, for example medicines, falls, incidents and accidents. We saw information was used to identify any patterns or trends and to make improvements. For example, new lighting had been fitted in corridors and some bathrooms, where there was no natural light, to ensure people were able to see clearly and reduced the risk of people falling. This meant the provider acted to continuously improve the service.

We found people's views were not always sought about the quality of the service or how things could be improved at the home. The provider told us the views of people, relatives and professional visitors were sought informally during weekly visits to the home. There was no formal system in place such as 'resident and relative' meetings or quality feedback surveys. When we asked people how they were supported to share their views about the service we received mixed responses. One person said," No, no one asks me what I think." A second person told us, "I chat with the staff and staff always ask me what I think." We could not establish how the provider acted on the feedback they received.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>11(1) The provider was not ensuring care of service users was only being provided with the consent of the relevant person. |