Mr & Mrs H J Medland

St Anne's Residential Home

Inspection report

Whitstone
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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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This was an unannounced inspection on 8 July 2015 and 9 July 2015. St Anne's Residential Home provides accommodation for up to 36 older people who require support in their later life or are living with dementia.

There were 25 people living at the home at the time of our inspection.

The home is on two floors, with access to the upper floors via a passenger lift, chair lifts, or wheel chair lift. All bedrooms have en-suite facilities which have a toilet and wash basin. There are shared bathrooms, shower facilities and toilets. Communal areas include four sitting areas, a conservatory and a dining room. The home is in a rural location, with country views and outside courtyard space.

After our last inspection in March 2015 we took enforcement action. We told the provider to take action to make improvements to how risks to people's care was managed and reviewed, how people's consent to their care was obtained, and how people's care plans were reviewed and updated. We also told the provider to take action in relation to how people's medicines were

Summary of findings

managed, to address the dignity and respect of people and review staffing numbers. The provider was also asked to make improvements to how the quality of the service was monitored.

The provider sent us an action plan on 8 June 2015 and confirmed on 25 June 2015 all the improvements had been made. During this inspection we looked to see if these improvements had been made. We found some improvements had been made, however further action was required.

People told us staff were kind and caring. People told us there were sufficient numbers of staff to meet their needs and we found staff had time to speak with people. People had call bells which they could use to ask for assistance. However, people told us their call bell was not always answered quickly which meant they could be waiting for a long time for assistance. Staff told us the position of the call bell system meant they may not always hear the call bell ringing which caused delay.

There was a clear management structure in place and staff received training and supervision to carry out their role. However, some staff had not completed the required training to ensure they had the skills and knowledge to effectively care for and support people. Staff told us they felt supported by the registered manager. Staff, were able to explain what action they would take if they suspected abuse was taking place. People were protected by safe recruitment procedures as all employees were subject to necessary checks which determined they were suitable to work with vulnerable people. People told us, if they had any concerns or complaints, they would speak with the registered manager, staff or their relatives. People told us they felt confident that their complaints would be listened to. There was a complaints policy which outlined the procedure which was to be followed and complaints were recorded so themes could be identified and action and improvements taken.

People told us they lacked confidence in the laundry service, because their clothes had been lost or damaged. People's privacy and dignity was not always protected as there were no locks on people's bedroom doors and some bathroom locks did not work.

The registered manager and staff did not fully understand how the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) protected people to ensure their freedom to make decisions and choices was supported and respected. This meant decisions were being made for people without proper consultation.

People's independence and social life were promoted. People told us there were enough social activities. People's end of life wishes were not documented or communicated. People's care planning documentation was not reflective of their wishes. This meant people were at risk of not having their choices and wishes for the end of their life met, because there was no written information for staff to follow.

People's individual nutritional needs were known and taken into consideration and associated risks were monitored. People were supported to eat and drink, but at times staff were not always focused on the person they were helping, which resulted in the person loosing interest and not eating all of their meal. People had access to health care services. However, services were not always contacted in a timely manner because of communication difficulties between the staff team and the registered manager. People's medicines were managed to help ensure they received them safely; however, documentation was not always accurate or robust.

People and their families were involved in their care plans to help ensure their care plan included their wishes and desires for later life. Care plans and risk assessments were in place, reviewed and updated. However, they did not always give clear direction to staff about how to meet a person's needs. This meant the care being provided was inconsistent between staff. People had personal evacuation plans in place which meant in an emergency, peoples individual care needs, could be shared with emergency services.

Falls and accidents were monitored and were used effectively to identify required changes. The quality monitoring systems in place did not help to identify concerns and ensure continuous improvement. People's confidential records were stored securely. The Commission was notified appropriately, for example in the event of a person dying or experiencing injury.

Summary of findings

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 always safe.

There were enough staff to meet people's basic needs. However, people told us staff did not always answer their call bells promptly.

Ordering and administering of people's medicines were managed effectively to ensure they received them at the prescribed time. However, documentation was not always completed accurately.

People were protected from risks associated with their care and documentation relating to this was reflective of people's individual needs.

People told us they felt safe. Staff knew what action they would take if they suspected abuse was taking place. Safe recruitment practices were in place.

Is the service effective?

Requires improvement

The service was not always effective.

People's changing care needs were not always referred to relevant health services in a timely manner.

People's consent and mental capacity was not always fully assessed and documented. This meant decisions were made for people without proper consultation.

Staff had not always completed training, to ensure they had the necessary skills and knowledge to care and support people effectively.

People were supported to eat and drink and maintain a balanced diet.

Is the service caring?

Requires improvement

Aspects of the service were not always caring.

People told us they lacked confidence in the laundry service.

People's choices and wishes for the end of their life had not been considered or communicated to staff. This meant staff did not know how to meet people's individual needs.

People's privacy and dignity was not always respected.

People told us staff were kind and caring.

People told us they felt involved in their care.

Summary of findings

People's personal records were kept confidential.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care plans did not always provide guidance and direction to staff about how to meet people's care needs.

People's care plans did not always help to ensure people's needs were being met and a lack of communication between staff, resulted in action not always being taken.

People told us there was a choice of social activities.

People were involved in the design and implementation of their own care plans.

People told us if they had a complaint they would speak with the registered manager, member of staff or their relative.

Is the service well-led?

Requires improvement

Aspects of the service were not always well led.

People did not receive a high standard of care because the provider's systems and processes for quality monitoring were ineffective in helping to ensure people's needs were met.

The registered manager monitored incidents and risks.

There was a management structure in place and staff told us they felt supported by the registered manager.

The registered manager worked with external professionals to help ensure people's health care needs were met.

St Anne's Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This 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.

We visited the home unannounced on 8 July 2015 and 9 July 2015. The inspection team consisted of three adult social care inspectors, a pharmacy inspector and an expert by experience – this is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection, we spoke with sixteen people living at the home, six relatives, eight members of care staff, the chef, and the receptionist. We spoke with the registered manager, the registered provider and a district nurse. We carried out a Short Observational Framework Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how people spent their morning in the main lounge and watched how staff interacted with people during this time.

We observed care and support in communal areas, spoke with people in private and looked at nine care plans and associated care documentation. We also looked at records that related to medicines as well as documentation relating to the management of the service. We looked at policies and procedures, staffing rotas, the accident book, six staff recruitment and training files and quality assurance and monitoring paperwork.

Before our inspection we reviewed the information we held about the home and spoke with the local authority. We reviewed notifications of incidents that the provider had sent us since the last inspection and previous inspection reports. A notification is information about important events, which the service is required to send us by law. After the inspection we contacted the local authority service improvement team. We also contacted six health and social care professionals who supported people who lived at St Anne's Residential Home to obtain their views. We spoke with two district nurses, and contacted a psychiatric nurse, and three GPs.

Requires improvement

Is the service safe?

Our findings

At our last inspection in March 2015 we found people's medicines were not being effectively managed, people told us there were not enough staff and the assessment and management of risks to people's health, safety and welfare was not always effective. The provider sent us an action plan detailing how they would make improvements. At this inspection we found some improvements had been made, however further improvements were necessary.

People's medicines were managed to help ensure they received them safely and they were stored securely. However, documentation was not always accurate or robust. For example, medicine administration records (MARS) recorded the application of topical medicine, however; people's care plans and daily records showed this had not always been signed for. Hand written entries on the MARS records had not been double signed to help ensure prescribing and administering errors did not take place. The registered manager had introduced an audit tool to identify where improvements could be made; however, the audit tool had failed to identify this.

People were supported to take their medicine and staff provided this support in a discrete and caring manner. One person told us, staff competence varied in how well their inhaler was administered, and explained, "It just depends who administers it…a lot of difference in the people".

People told us there were enough staff to meet their needs and relatives told us, "when I visit there always seems to be enough staff…they work very hard, too", "There always seems to be enough staff to look after everyone. I've never seen anyone treated badly" and "The staff are very patient, nothing is rushed, I have never seen any unkind treatment".

People had access to a call bell to request assistance, however, people told us their call bells were not always answered promptly. This was because of where the call bell system was positioned in the care home. People's comments included, "It varies at different times of the day", "If you buzz it takes them ages to come", and "There is a call bell over the bed. No point…they don't answer it. I've got a telephone if I have an emergency but there is no-one in the office during the morning to answer it". People in the lounge did not have access to a call bell and although staff walked through the lounge frequently, there was one occasion when one person wanted assistance and the Inspector went to find a member of staff.

A member of staff told us, "If we are right down the other end we don't hear the call bells. The call box is in the office so if you are a long way away you don't hear it. It can take 15 minutes to answer a call. If we had walkie talkies or mobile phones it might be better." We spoke with the registered manager about this; they were not aware of how people felt, and told us walkie talkies had failed to work in the past because of the design of the building. The registered manager was unable to provide any other solutions.

During our inspection staff did not appear rushed; they had time to engage with people. For one person who liked reassurance, staff had time to sit with the person to reduce their anxieties. Staffing arrangements at lunch time meant some people were not always adequately supported to eat their meal and attention by staff was not always given. For example, one person who required assistance to eat their meal stopped eating, because of continued interruptions and staff did not notice that another person used the table cloth to wipe their mouth. The registered manager told us they would speak with staff about this.

The manager had a staffing dependency tool which was used to review and assess the staffing ratios for the care home. This helped to ensure there were enough staff to meet people's individual care needs. Since our previous inspection, management hours had increased and there were plans in place to make further improvements. For example, the deputy manager was going to be employed full time, and a manager would be working alternate weekends.

People had the freedom to spend each day as they choose, and were encouraged to continue to take balanced risks to maintain independence. For example, the risks of going out into the community were balanced by reporting to staff about their intended plans, and an estimated time of return. If they had any difficulty in getting back to St Anne's Residential Home, people told us staff would support them, and tell the management about it.

People told us they felt safe living at St Anne's Residential Home, comments included, "you know that you have the

Requires improvement

Is the service safe?

freedom to do what you want but there is always someone to help if you need it" and "I've been here a few months now, I feel much safer. At home I kept falling over. I was worried all by myself…here I'm safe".

People's risk assessments, that gave guidance to staff about how to minimise associated risks related to people's individual care needs, were in place, updated and reviewed. For example, people who displayed behaviour which was unpredictable and challenged staff had risk assessments in place which gave staff clear instructions about how to manage the risks. People who were at risk of falling had risk assessments in place to provide guidance to staff about how to minimise the person from falling. For example, staff, were observant and made sure people had their walking aids with them at all times.

People's nutritional risks were being recorded, monitored and reviewed. For example, when a person was at risk of losing weight, the frequency of monitoring had increased and action had been taken. Risks had been minimised for one person, because food and fluid charts had been introduced and action taken to contact the GP for nutritional supplements. A health care professional told us there had been an improvement in the recording and completion of documentation.

People's falls, accidents and incidents were recorded and information was used to identify themes and necessary action which may be required. For example, the manager had visited unannounced one night because she was concerned staff were not regularly checking one person who had been falling. Since the introduction of the new audit, the registered manager told us, and documentation confirmed, there had been a significant reduction in falls.

People had personal evacuation plans (PEPS) in place which meant, in an evacuation, emergency services would know what level of care and support people would need.

Staff spoke confidently about how they would recognise signs of possible abuse. Staff were able to tell us about what action they would take if they suspected abuse was taking place. Staff told us they would have no hesitation in reporting it to the registered manager or registered provider and told us they felt their concerns would be dealt with.

People were protected by safe recruitment procedures. The provider followed their policy which ensured all employees and volunteers were subject to necessary checks to determine they were suitable to work with vulnerable people.

Requires improvement

Is the service effective?

Our findings

At our last inspection in March 2015 we found people were not always protected from the risks of unsafe or inappropriate care because accurate and appropriate records were not maintained regarding their nutrition. People's consent was not always obtained in respect of their care and the Mental Capacity Act was not being implemented to empower people to make decisions and protect those who lacked capacity to make decisions for themselves. At this inspection we found some improvements had been made, however further improvements were necessary.

People had access to health care services to receive ongoing health care support; however referrals to relevant health services when people's needs changed did not always happen quickly. For example, for one person their behaviour had changed. Staff had shared their concerns with the registered manager so that a GP would be called. However, the person's care records did not record this, and the registered manager told us a referral had not taken place.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), designed to protect people's human rights, with the registered manager. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager and staff demonstrated a limited understanding and knowledge of the requirements of the legislation. Applications for deprivation of liberty safeguards (DoLS) should be made in line with the requirements of the legislation. However, DoLS applications had been made for everyone that used the service though some people did have mental capacity. The registered manager told us she was due to attend a training course in September 2015.

The legislative framework of the MCA was not always being followed. For example, it was not detailed in people's care plans, how people who lived with dementia were to be supported by staff. If there is reason to question an adult's capacity there is a set procedure to be followed to establish if they are able to make their own decisions about important matters.

We found the legislative framework of the Mental Capacity Act 2005 was not always being followed. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's treatment escalation plans (TEP) were contradictory to care plans. For one person, it stated on their TEP form that they lacked capacity; however their care plan stated they had capacity. There was no documentation within the person's care plan to indicate if the person agreed and consented with the recorded decision on the TEP form. This meant the decision regarding resuscitation may not be in line with the person's wishes. The registered manager explained to us that since our last inspection, she had requested TEP forms to be updated by GPs, but told us she would make further efforts to ensure this happened.

People told us the meals were nice and there was choice available, one person told us, "I can choose what I want. Sometimes I have a cooked breakfast, sometimes just scrambled egg. They are very good with the food". Other comments included, "for breakfast I can have whatever I want. I like melon, bread and butter and honey. For lunch we have a set meal, but you can always choose something else if you don't fancy it", "'I don't snack…I wait for the main meals…lovely…no-one goes hungry here" and "Food is wonderful…You couldn't ask for better". A relative told us, "I come here during lunchtime, the food always looks lovely. If they have something they don't like, they will always find you something else".

A member of staff told us, "There is a set meal every day. There is a menu on the table and it is written on the board. If anyone doesn't want that, they can choose something else. With breakfast it is an individual choice, they can have anything they want."

People had care plans in place regarding their nutrition so staff were aware of how to meet people's individual needs. For one person, their care plan recorded their favourite meal and the chef confirmed the meal was cooked for the person once a month. The chef was knowledgeable about people's likes and dislikes. Choices were flexible and although there was a menu in place, the chef told us, "the

Requires improvement

Is the service effective?

carers know what is on the menu and if someone says they don't want something then they can have something else. They can tell me and within reason I can whip up something….yesterday […] asked for a poached egg on toast for lunch."

People could choose if they wanted to eat their meals in the dining room or elsewhere. People were offered a choice of drinks, which included an alcoholic option. People who required different levels of support at lunch time were assisted by staff. Staff, however were not always focused on the person. For example, a member of staff frequently left the person they were assisting and as a result of this, the person ate only a small amount of their lunch.

People who were partially sighted were given support by staff. For example, explanations were given about what was on the person's plate and plate guards were fitted to stop the meal from sliding off the plate. However, staff were not always observant when a person was in need of additional support. For example, staff put one person's hand on their glass to show them were it was, but then the person could not find it again on the table, this was not recognised by the member of staff who had walked away.

People who had not eaten their meal were offered alternatives, for one person who had been losing weight, the chef gave many different options to the person to try and tempt them.

People's weight was being monitored to help ensure concerns were identified quickly so action could be taken. As a result of this, some people had been prescribed nutritional supplements and the chef had been advised of meals which required enriching with higher calories.

Staff said they felt well supported by the registered manager and received relevant training to help ensure they had the knowledge to meet people's needs. However, the providers training records showed that not all staff had completed the required training, for example, in respect of end of life care, dementia, moving and handling, safeguarding and infection control. A health care professional told us they felt staffing competence varied within the staff team.

Staff received an induction when they first started working at the home. Staff completed the "Skills for Care" induction which is a nationally recognised programme for health and social care staff. Staff received ongoing supervision in the form of one to one meetings with their line manager, and annual appraisals of their work. Staff told us supervision gave them an opportunity to discuss good practice as well as any issues or concerns. Team meetings were held to provide staff with the opportunity to highlight areas where support was needed or where improvements to the service could be made.

The environment was suitable for people who had mobility difficulties, and for those who used equipment, such as wheel chairs and stand aids. Areas were spacious and people's bedrooms were of a good size. The home was clean and free from malodours. A relative told us, 'It's kept spotless here. It's lovely and clean, the rooms are lovely'.

Requires improvement

Is the service caring?

Our findings

At our last inspection in March 2015 we found that people's privacy, dignity and independence were not respected and people's views and experiences had not been taken into consideration in relation to their care. The provider sent us an action plan detailing how they would make improvements. At this inspection we found some improvements had been made, however further improvements were necessary.

People's privacy may not always be respected because people did not have locks on their bedroom doors and some bathroom door locks did not work. The registered manager explained people were asked before they moved in whether they wanted a lock on their bedroom door. However, this was not always recorded in people's care plan, and had not been reviewed with people. The registered manager told us she would take immediate action.

People's decisions regarding their end of life care was not always recorded. Since our previous inspection the registered manager had introduced new paperwork, however, care plans had not been completed. This meant the people were at risk of not having their choices and wishes for the end of their life met because there was no written information for staff to follow.

People told us the laundry service was not effective. Some people explained they had lost clothes or their clothes had been damaged. Comments included, "the laundry…there's a weakness there. My clothes have been ruined. They put a dark jumper in with the towels…now I do my own washing and hang it in the shower room. They do the bedding though" and "I have lost some of my clothes". The registered manager told us she would look at different ways to make improvements.

People told us they felt well cared for, their comments included, "The staff are absolutely marvellous, helpful. Obliging. I can't say a bad word about any of them", "I am very happy here, the staff are very caring. I am pleased with all the care I receive. They help me to bath once a week and anything I need they will help me with" and "I'm very well treated. I'm very happy here. I would recommend it to anybody. You can have a good laugh, it can be hilarious".

People told us they were involved in their care, comments included, "the staff ask me what I would like, whether I get up early or late. It's all choices and they ask our opinion about what care we need, and they leave us to do our own thing" and "I have all the care I need, but the staff don't tell me what to do and what not to do. They help me to manage to do the things I want to do". A barbeque had been held to bring people and their relatives together to look at their care plans. This helped ensure they felt involved in the creation of their care plan. One relative told us, they had seen their […] care plan, they explained, "I was really pleased with it and all the little details in it".

Relatives told us, "I think that this is a lovely Home. The staff are lovely, really helpful. Visitors are always welcomed, offered tea, sometimes sandwiches. The atmosphere is very relaxed and the staff are caring. I'd be happy to come here myself "and "The care is good. Whenever I visit I see my […] comfortable, he looks clean, tidy. The staff treat him with respect. I am very satisfied with the care he gets…..I've never seen anyone treated badly".

Staff showed kindness and acknowledged people as individuals. For example, care, support and humour was adapted depending on who they were supporting. Staff were conscious of their actions when communicating with people. For example, they crouched down next to people so they could speak to them at their level and they held people's hands in a tender manner to provide calmness and re-assurance to people.

People's personal records were kept secure to maintain confidentiality. However, the office door which stored people's confidential personal information was frequently left open. The registered manager told us a lock would be fitted.

Requires improvement

Is the service responsive?

Our findings

At our last inspection in March 2015 we found people's care plans were not always updated and reviewed effectively. This meant staff did not always have the guidance and direction about how to meet people's health and social care needs. At this inspection we found some improvements had been made, however further improvements were necessary.

People's care plans had been re-designed, updated and reviewed. This helped to ensure care plans were reflective of the care being delivered and enabled staff to have guidance and direction about how to support and meet people's individual needs. However, some care plans were still not always reflective of the care being delivered. For example, one person had fallen at the beginning of June 2015. Information had been documented in the falls records, which said that the person should be checked at a different time to reduce prevent the re-occurrence of a fall. However, when the person's care plan had been reviewed at the end of June 2015 this information had not been included. For one person, their care plan detailed the person had short term memory loss and became confused, but there were no details about how this person should be supported.

People's care plans did not always help to ensure people's needs were being met and a lack of communication between staff and management, resulted in action not always being taken. For example, for one person their records recorded a request by the district nurse team; however, this action had not been followed through. One external health professional told us they lacked confidence about whether the information they wrote in people's records was always passed on and shared. Another health professional told us they felt the recording of people's care and documentation had significantly improved.

People had body maps in place when there were concerns regarding bruising or the condition of their skin. Body maps are a tool which staff may use to identify and monitor any concerns with a person's skin.

People had been involved in planning their own care to ensure they received the care they needed, in the way they wanted it provided. People's comments included, "I get up around 8.00.a.m. I like to eat in the dining room. I can choose whatever I want for breakfast. There's a newspaper available to read. I like to read my books. A few of us sit around and knit squares, or do a crossword. It's all very relaxed….we choose how we spend our day. The staff know us enough to treat us as individuals", and one relative told us, they were pleased with their […] care plan and told us, "I thought if I hadn't known her and read it, I would know what to do and how to look after her".

People's care plans included a personal history section so staff were aware of what a person achieved in life prior to getting older and moving into the home. One person talked fondly of memories of their previous career, and the information had been recorded in their care plan. A person's history helps to enable staff to have meaningful conversations with people and tailor social activities to people's past interests and memories.

People were encouraged to participate in social activities, but they did not have to participate if they did not want to. One person told us, "I prefer to stay in my room, I avoid the activities. I read my paper, cover to cover, and I like to have a rest twice a day. I don't go out much; I've got everything I need right here…no need to go out" and "I like to stay in my room, mostly, I avoid activities. They don't force you to join in…just help you to do what you want to do".

Staff took every opportunity to engage and socialise with people, and some activities were unplanned. For example, a member of staff started a throwing game to encourage movement of people's hands and arms. Within a short space of time lots of people joined in, people were seen to laugh, and joke with each other. Another member of staff created a quiz with two people. People were supported and encourage when they felt nervous about participating and their individual achievements were recognised. The games, however, came to an abrupt end when staff had to answer call bells, which left people waiting without an explanation. People then became vacant and disengaged.

There was a complaints policy which outlined the procedure which was to be followed. However, some people told us they were not aware of the formal procedure. Other people told us, if they had any concerns or complaints, they would speak with the registered manager, staff or their relatives. People's comments included, "I have no complaints. I have never seen any unkindness here. If I needed to complain I would tell the managers", and "If I had a complaint I would tell the manager. I'm pretty sure they would listen to me. I don't know of any formal complaints procedure".

Requires improvement

Is the service responsive?

Although, some people were not aware of the formal complaints procedure, evidence showed people's complaints were managed effectively. A relative told us, they had complained and the provider had personally written to them and apologised. Another relative commented "I am very satisfied with all the care that my […] is given. I have no complaints but If I did, I would tell the management'. One relative told us she had complained about the standard of cleaning in her […] bedroom. They explained they had been satisfied that their complaint had been listened to and a solution found. Complaints were being recorded so themes and trend could be analysed.

Requires improvement

Is the service well-led?

Our findings

At our last inspection in March 2015 we found the quality monitoring system was not effective in identifying areas that required improvement. At this inspection we found some improvements had been made, however further improvements were necessary.

People did not receive a high standard of care because the provider's systems and processes were ineffective. The provider had an auditing system which they used to identify improvements which could be made. However, the provider's auditing system had not ensured effective care planning, and the management of medicines. It had also not ensured that consent to care was obtained in line with the legislative framework of the Mental Capacity Act.

The registered manager monitored incidents and risks and these were used to help ensure care provided was safe, effective and responsive.

Staff knew what the management structure was. The management structure in place consisted of the registered manager, deputy manager and care supervisors. The management hours had increased since our last inspection, and the registered manager had recognised the importance of having a manager working at the weekends. The job description of the care supervisors was in the process of being re-designed to help ensure care supervisors understood their accountabilities and responsibilities. One person told us, 'the leadership here is very good'.

The registered manager told us she felt supported by the provider. The registered manager was in the process of undertaking training in management and leadership. She was also open to accepting our feedback about staff training. This demonstrated the registered manager recognised the importance of further improving their skills and knowledge with regards to the day to day management of running the care home.

The registered manager had made improvements since our last inspection and to address the concerns which had been raised. It was apparent from speaking with the registered manager that she was passionate about the welfare of the people who lived at St Anne's Residential Home. She had recognised the importance of delegating certain tasks to improve the running of the home and improve communication. However, there were still some communication difficulties as we have identified elsewhere in this report.

Staff told us the values and visions of the service were to "promote people's privacy and dignity and encourage people to be independent" and staff understood these values. Staff spoke highly of the support they received from the registered manager and felt able to speak to the registered manager if they had any concerns or if they were unsure about any aspect of their role. Staff described the staff team as "very supportive" and "a great team."

The whistle blowing policy which was in place assured staff if they were to report concerns it would be "without fear of reprisals". Staff told us they would not hesitate to report to the registered manager or provider concerns about abusive practices.

The registered manager told us and documentation showed the staff team worked in partnership with agencies, such as local authority commissioning and health care professionals. One external health professional told us she felt the registered manager had been working hard to make improvements and told us she thought they were doing really well. An external health professional told us she met with the registered manager on a monthly basis to discuss each person in detail, this helped the registered manager and staff team to have effective communication about people's individual care needs.

The registered manager had notified the Commission of significant events which had occurred in line with their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The legislative framework of the Mental Capacity Act 2005 was not always being followed.