

English Dominican Congregation Trust

St Mary's Nursing Home

Margaret Street Stone

Inspection report







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Stone
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31 May 2018

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Ratings

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|---------------------------------|---|
| 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? | Good  |
| Is the service well-led? | Requires Improvement  |

Summary of findings

Overall summary

We completed an unannounced inspection at St. Mary's Nursing Home on 30 May 2018 and 31 May 2018. When we completed our previous inspection on 12 January 2017, we found a breach in Regulation 12, because the provider did not have safe medicine management systems in place. Improvements were also needed to ensure that people were treated with dignity, their choices were respected and the systems in place to manage the service were effective. The service was rated as Requires Improvement overall. We asked the provider to take action to make improvements to the standard of care provided. At this inspection we found that the provider continued to be in breach of Regulation 12 as sufficient improvements had not been made and we found a new breach in Regulation. You can see what action we told the provider to take at the back of the full version of the report.

St. Mary's Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St. Mary's Nursing Home accommodates up to 58 people in one adapted building. There was a specific unit that provided care to people at the end of their life. At the time of the inspection there were 50 people using the service.

The service did not have a registered manager. The last manager de-registered with us on 9 April 2018. The provider had appointed a new manager in May 2018 who planned to register with us. 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.

We found that medicines were not always managed safely to protect people from potential harm.

Improvements were needed to ensure people received the least restrictive care and treatment to keep them safe in line with the Mental Capacity Act 2005.

Improvements were needed to ensure the systems in place to monitor the service people received were imbedded and sustained.

Risks to people's health and wellbeing were managed and followed by staff who knew people well, which ensured people were supported safely.

There were enough suitability recruited and skilled staff to provide support to people. Staff had received training to ensure they had sufficient knowledge to carry out their role effectively.

People were protected from the risk of infection because the provider had policies and systems in place to control infection risks at the service.

The environment had been adapted in a way that promoted people's safety.

People enjoyed the food provided and were supported with their nutritional needs. Action was taken to ensure people at high risk of malnutrition were supported effectively.

Advice was sought from health and social care professionals when people were unwell, which was followed by staff.

There were systems in place to ensure people received consistent care from staff within the service and also from staff from external agencies.

People received support from staff that were kind and compassionate. People's dignity was respected and their right to privacy upheld.

People were supported with their communication needs and information was provided in a format people understood which meant that people were supported to make informed choices.

People received care that met their preferences. People's past lives, cultural and diverse needs were assessed and considered to enable individualised care that met all aspects of people's needs. People had opportunities to participate in social activities, interests and hobbies.

People were supported to have a comfortable, pain free death in line with their preferences because their wishes had been considered and planned.

People and their relatives knew how to complain. Complaints received had been investigated and responded to in line with the provider's policy.

People, relatives and staff felt able to approach the registered manager and feedback had been gained from people about their care.

The provider had recognised that improvements were needed and action had been taken to plan and implement changes to ensure people received a good standard of care. People, relatives and staff stated that some improvements had been made at the service by the new manager. The provider understood their responsibilities of their registration and worked in partnership with other agencies.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Medicines were not managed safely.

People were safeguarded from abuse because staff understood how to recognise and report suspected abuse. There were enough suitably recruited staff available to meet people's needs in a safe and timely manner. Infection control risks had been mitigated to protect people from harm.

The provider had identified when things went wrong and there was a newly implemented system in place to ensure lessons were learnt from this.

Requires Improvement ●

Is the service effective?

The service was not consistently effective.

The provider was not always working in line with the principles of the Mental Capacity Act 2005 and improvements were needed to ensure that decisions were made in people's best interests and in the least restrictive way.

People's diverse needs were assessed and planned. People enjoyed the food and were supported with their nutritional needs. People received support from staff who were sufficiently trained. People's health was monitored and health professionals input was sought where needed. There were systems in place to ensure that people received consistent care from staff and external services. The environment was suitable to promote people's independence and safety.

Requires Improvement ●

Is the service caring?

The service was caring.

Staff were caring and kind and showed patience and compassion when they supported people. Staff treated people with privacy, dignity and respect. Staff understood people's individual ways of communication which ensured people were enabled to make choices to the way their care was delivered.

Good ●

Is the service responsive?

Good ●

The service was responsive.

People received care that met their individual needs and preferences and had opportunities to be involved in social activities, interests and hobbies. People's care was reviewed and updated to ensure they received care that met their changing needs. There was a complaints procedure available for people and their relatives to access if required and there was a system to respond and log any complaints received. The provider gained information to ensure people were supported in a way that met their needs at the end of their life.

Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

Improvements were needed to the systems in place to monitor and mitigate risks to people. Improvements plans had not been fully implemented, which needed to be imbedded into the service and sustained.

People, relatives and staff felt the manager was approachable and had seen improvements to the way the service was led. Feedback was gained from people to help inform service delivery. Staff felt supported to carry out their role and had received a supervision to discuss their role and raise any issues.

The provider understood their responsibilities of their registration with us and had notified us of any events that had occurred at the service. The rating from the previous inspection was displayed.

St Mary's Nursing Home Margaret Street Stone

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 checked whether the provider was 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 May 2018 and 31 May 2018 and was unannounced. The inspection team consisted of two inspectors.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, caring and well led to at least good. We found that some improvements had been made to these areas. However, further improvements were needed.

We used the information we held about the service to formulate our planning tool. This included notifications about events that had happened at the service, which the provider was required to send us by law. For example, safeguarding concerns, serious injuries and deaths. We received information from local authority commissioners to gain their experiences of the service provided.

We spoke with seven people and three relatives/visitors. We also spoke with two nurses, three care staff, the deputy manager, the home manager and the consultant. We also spoke with a visiting professional.

We observed how staff supported people throughout the day and how staff interacted with people who used the service. We also 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 with us.

We viewed five records about people's care and eight people's medicine records. We also viewed records that showed how the service was managed, which included quality assurance records, improvement plans

and three staff recruitment and training records.

Is the service safe?

Our findings

At our last inspection, we found that there were risks to people's safety medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the provider continued to be in breach of this regulation.

People were not always supported with their medicines safely. For example; one person was prescribed a medicine for their blood pressure. The Medicine Administration Records (MARs) stated that this person's blood pressure needed to be between 70 – 80 bpm. We saw that there was one day where their bpm was 68 below the safe assessed range. The deputy manager was unaware of this issue and was unable to explain whether this person had received their medicine or not. This meant the person was at risk of harm as they had not had their medicine administered. Another person was prescribed a time sensitive medicine. We saw that this person was administered their medicine at 1.40p.m instead of the specific time as stated on the MAR of 1.00p.m. We saw the nurse on duty record a signature against the 1p.m record and no changes were made to the MAR to show that this medicine had been given late. This meant people were at risk of harm because medicines were not administered as prescribed.

Some people required their medicines to be administered covertly. Covert medication is the administration of any medical treatment in disguised form. We found there was not always a plan in place to ensure people were being administered covert medicine safely. For example; the plan stated that people were to have their medicine in their drink or food. However, there was no specific guidance from the GP to ensure staff were mixing the medicine with food/fluid that was suitable and the effect of the medicine was not compromised. This meant that we could not be assured that these medicines were effective because there was no guidance available for staff when administering medicines covertly.

We saw that Topical Medicine Administration Records (TMARs) were in place for people who required creams administered by care staff. We found that there was some information about the cream to be administered, this was not specific to ensure carers understood how, why, where and when to apply people's prescribed creams. For example, one person was prescribed cream with the instructions "apply when required, three times a week". We saw the TMAR had been signed as applied five times one week, once another week and seven times another week. This meant we could not be assured that this person had been supported with their creams as required. Another person was prescribed a cream and the TMAR stated "apply daily to protect skin integrity". The TMAR's showed that this cream had been applied inconsistently and we could not be assured that this person had received their cream as prescribed. This person did not have a body map in place to give staff guidance on where the cream needed to be applied. The manager was unable to confirm whether these people had been supported with their prescribed creams. The manager told us that they had plans in place to check the TMARS were signed by staff to ensure that people had received their creams. At the time of the inspection this system had not been implemented and people were at risk of harm because we could not be assured they were receiving their creams as prescribed.

We found that protocols were in place for people's 'as required' medicines. We found that these protocols gave details of the amount of medicine required and why this medicine was required. However, we found

that the protocols lacked details of how staff would recognise that people needed these medicines. For example; protocols did not always detail at what stage a person needed 'as required' medicine for their agitation or how a person who was unable to communicate displayed signs that they were in pain. The MARs did not contain details of the amount of pain medicine people had received or the time this was administered, which meant that we could not be assured that people had received their medicines with a suitable time lapse between doses. This meant that improvements were needed to ensure staff had sufficient information to support people with their medicines safely.

The above evidence shows that people were at risk because medicines were not managed safely. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us staff supported them to move safely and they felt safe when staff helped them. Another person told us that staff had helped them to maintain their skin. One person said, "The staff are very good, they make sure I am safe. They help me to move and walk with me to make sure I don't fall". Staff we spoke with explained people's risks and had a good understanding of how they needed to support people to remain safe from harm. We saw that risk assessments had been completed that contained management plans to ensure people were supported safely. However, although staff knew how to support people with their risks some of the records we viewed did not always provide detailed information. For example; we saw that one person displayed behaviours that may challenge. Staff we spoke with explained how they supported this person when they became anxious. This included how music helped this person and how staff diverted this person by talking to them calmly and supported them with activities. However, this was not included in the person's records. We saw that agency staff were employed when there were staff shortages and this placed people at potential harm when receiving support from new or unfamiliar staff. This meant some improvements were needed to ensure that plans contained detailed individualised guidance for staff to follow to mitigate people's known risks.

People who used the service told us they felt safe. One person said, "I feel very safe here. The staff are very good and treat me in a very gentle way". Relatives we spoke with were happy with the treatment their relative's received and told us they had no concerns with the safety of their relatives. Staff we spoke with were aware of the various signs of abuse and understood the actions they needed to take if they suspected abuse. One staff member said, "I would not hesitate to take action if I thought someone was being abused. I would report any concerns to my manager and document this too. I know that if I was unhappy with the response I could go directly to other professionals such as the safeguarding team and CQC". The records we viewed showed that any concerns had been reported to the local safeguarding authority and an investigation had been carried out. This showed that people were protected from suspected abuse.

People told us that there were enough staff available to meet their needs. One person said, "The staff are all very good and they come when I need them to help me". Another person said, "I have never been left waiting as there are always staff about for me to call on". During the inspection we saw that there were enough staff available to provide support in a patient and unrushed manner. People were able to stay in their rooms or access the communal areas and the staff were deployed across the building to ensure that staff were available to people. Staff told us that any shortages in staff were covered with existing staff where possible or regular agency staff to ensure that people received consistent support. One staff member said, "There has been an improvement in the staffing levels and the agency staff has reduced which means that people know the staff who support them". The manager showed us a dependency tool that they used to ensure there were enough staff available, which was reviewed regularly to ensure the staffing levels were in line with people's changing needs. This meant there were enough staff available to meet people's needs.

Staff had been employed using safe recruitment procedures. Staff told us and we saw that they had received checks of their character and references from previous employers which ensured they were suitable to provide support to vulnerable people. This meant people were supported by staff that were of suitable character and had been recruited safely.

People and relatives told us that the service was always clean. We saw that the environment and equipment were all clean and there was a cleaning schedule in place. We saw domestic staff cleaning all areas of the service throughout inspection. We observed staff wearing gloves and aprons when they supported people and staff told us that these were always available for them to use. The registered manager explained how they ensured that staff prevented the risk of cross contamination. We saw an infection control audit was in place to ensure that any risks to people were mitigated. This meant people were protected from the risk of infection and cross contamination.

People, relatives and staff felt involved in the service and told us they felt the management were approachable and acted on issues if things went wrong. The manager told us that the provider had appointed a consultant at the service to undertake an independent review of the service before they were appointed. The consultant had identified areas that needed improvement and had been requested to remain at the service to assist the newly appointed manager with the improvements needed. We found the provider had acted on the feedback received and the manager was in the process of introducing systems to ensure lessons were learnt where issues had been identified.

Is the service effective?

Our findings

At our previous inspection we found no concerns and rated the effectiveness of the service as good. At this inspection improvements were now needed in this area and it was rated as requires improvement.

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.

Some people were unable to understand some decisions about their care and we checked that the provider was meeting their responsibilities under the Mental Capacity Act 2005. We saw that some mental capacity assessments had been carried out, which included when people were unable to consent to personal care in a 24 hour care environment. However, we found that there were not always assessments of people's ability to consent to specific decisions such as bed rails, lap belts and covert medication. For example; one person required bed rails and lap belts to keep them safe from the risk of falling. There was no best interest assessment in place to ensure that this was in the person's best interests and the least restrictive method. We saw that this person's relative had consented to the bed rails and lap belts. However, the relative did not have the legal authority to consent on this person's behalf. Another person required their medicine to be administered covertly. Covert medication is the administration of any medical treatment in disguised form. We found that this person did not have a best interest assessment in place that included other professionals' advice to ensure that this was in the person's best interests. This meant that the provider was not consistently meeting the requirements of the MCA.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that a number of applications for DoLS had been applied for by the manager but these had not yet been processed by the local authority. We saw one person had a DoLS authorised prior to the new manager's appointment. We found that the DoLS was subject to six conditions, which meant actions needed to be taken to ensure that this was the least restrictive method to support the person. We found that two of the six conditions had been met. The manager was unaware of these conditions in place and told us they were in the process of analysing all records within the home to ensure people were receiving the care required. However, they had not analysed the DoLS documents at the time of the inspection as the manager had only been in post for two weeks. The manager stated they would look at this person's DoLS as a matter of urgency to ensure the DoLS in place was lawful. This meant that the provider was not always following the requirements of the MCA to ensure people were supported in the least restrictive way.

The above evidence shows that the provider was not consistently acting in accordance with the MCA. This

was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People who were able to understand decisions about their care told us their consent was gained by staff before they provided support. One person said, "The staff always ask me what I would like help with. They are very good as they always ask me and never do anything without asking". We observed staff asked people if they could provide support and gave people time to respond to questions they asked about how they preferred their care to be provided in a way that they understood. For example; we saw people showed people pictures if they were unable to understand the question, which enabled them to consent to the care provided.

People told us they enjoyed the food at mealtimes. One person said, "The food is good here, I like it a lot". Another person said, "The food is lovely we have lots of choice". One person told us that staff had helped them to get their appetite back as they were offered different meals to ensure they liked what was on offer. We saw plans were in place that detailed the individual support people needed to ensure their nutritional needs were met. For example, people who had been assessed as a high risk of malnutrition had a support plan in place that detailed the actions required by staff. We saw that these people were encouraged and assisted throughout mealtimes as stated in their plans of care. Staff completed food and fluid intake charts to monitor the amount that people ate and drank which ensured people received sufficient amounts to meet their nutritional needs to keep them healthy. This meant people were supported to eat and drink sufficient amounts in line with their assessed needs.

People told us they were able to see health professionals when they needed to. One person said, "I can see a doctor when I need to. The staff are good at recognising when I am unwell and make sure I get the help I need". The records we viewed showed that people had accessed health professionals such as; dieticians, opticians, chiropodists and consultants. We also saw that guidance was sought from health professionals and this had been acted upon so that people were supported to maintain their health and wellbeing. For example, one person was at risk seizures and referrals had been completed for advice from the GP and CPN to ensure staff were supporting the person effectively. Another person had been referred to the Speech and Language Team because staff had noted that this person was having difficulties eating. This meant that people were supported to access health professionals to maintain their health and wellbeing and advice sought was followed by staff.

Before a person used the service an assessment of their needs was undertaken by to ensure that the person's needs could met at the service. We saw that information was gathered from the person themselves, family members and any other representatives that were involved in the person's life. This information included details such as; the person's past medical history, physical and emotional needs, people's likes and dislikes and any diverse needs that needed to be considered. We saw that the information gathered such as preferred religion had been used to form a care plan that stated how important the people's religion was to them and how staff needed to support people to maintain this part of their lives. This meant that people's diverse needs were assessed and planned for.

Staff told us they had received an induction when they were first employed at the service, which included training and shadowing experienced staff. One member of staff said, "I had a good induction. It really helped me to understand people and the way the service was run. I completed training and there is opportunity to complete refresher training". The records we viewed confirmed staff were trained to carry out their role effectively and updates in training were carried out regularly. We saw that there were some gaps in training such as dementia awareness. However, the manager had plans in place to ensure this training was scheduled and made available to all staff including the ancillary staff. The manager told us it was important all staff receive dementia awareness as people come in to contact with all the staff in the service and this will

help staff to have a good understanding of people's needs. Dementia learning had also been extended out to relatives of people to give relatives an opportunity to learn and understand the effects of dementia. This meant staff were trained to provide care to people who used the service.

Staff told us that they attended a handover session at the beginning of each shift, which ensured that they were able to provide a safe and consistent level of care to people. The handovers ensured that any risks were highlighted and any changes in people's needs and how staff needed to be deployed across the service to ensure people's needs were consistently met. We saw that the manager liaised with external services to ensure people received consistent care across services. This showed that the service ensured that people received consistent care within the service and across other services.

People's needs were met by the adaptation of the service. We saw that the corridors of the service aided people's mobility as they were large and spacious with no trip hazards, which meant people's risk of falling was lowered. We found that there were adapted facilities available which included bathrooms with equipment to ensure people were supported safely when bathing. There were private spaces on each unit which people could access if they wanted some time in a quiet environment or to use when relatives visited. Rooms had people's names on to help people identify their own private spaces. The manager told us the environment was constantly being maintained by the internal maintenance worker to ensure that people were safe. The manager also told us that they planned to look at how the environment may be improved to aid orientation for people with dementia.

Is the service caring?

Our findings

At our previous inspection we found people's choices and dignity were not always respected and rated this area as requires improvement. At this inspection improvements had been made and this area was rated as good.

People told us that the staff were kind and caring towards them. One person said, "The staff are wonderful, they are all so nice". Another person said, "I like chatting with staff. They all come and have a little chat, even the manager who I know well". Relatives we spoke with also told us that staff showed compassion towards their relatives. Relative's told us that they were able to visit their relatives at the service and staff were always warm and welcoming towards them. One relative said, "There is a lovely caring and happy atmosphere here". Another relative said, "I think my relative gets absolutely fantastic care here, I was very lucky to find this place".

We observed staff interaction with people and found that staff were caring and compassionate when they provided support. For example; we heard one staff member take a drink into a person and said, "Hello, how are you today? I've got your favourite a nice cup of tea. Is that nice? Have I made it how you like it?" The person responded, "Oh thank you, that's lovely just what I needed". We saw another person started to cough and staff immediately went to ask if they were okay and rubbed their back to help them. Staff took time and patience to ensure that this person was supported to move when they were ready and felt cared for by responding to their questions in a calm and caring way. We saw staff were given time to provide caring support for people in an unrushed manner and staff were able to sit and talk with people. This showed that staff treated people with care, kindness and compassion.

We viewed a number of compliments from people and their relatives about the standard of care that was provided. The comments we viewed included; 'Attentive professional care given by staff', 'Loving kindness received', 'The attitude of the staff is excellent. They are all very caring' and, 'Thank you for the care and compassion you have shown'.

People told us that they were given choices in how and when their care was carried out. One person said, "I have lots of choice. The staff help me to choose my clothes by showing me what I have in my wardrobe. We chat about what would look nice on. There is lots of choice around meals, when I want to go to bed. Everything really". Another person said, "The staff listen to what I want. I like to stay in my own room because I can look at the gardens and see the children at the school. Staff respect that I like my own company and don't wish to go to the lounges". We saw that people were given choices throughout the day by staff who were patient and listened to what people wanted. We heard staff asking people in a way that promoted their understanding and repeated questions if people hadn't heard or understood the question. People responded well to the way staff interacted and staff had a good understanding of people's ways of communicating their needs. For example; some people were unable to communicate effectively and we saw staff were patient and gave people possible answers to the question to help people make choices. One person was asked what they would like for their lunch but they were unable to understand. The staff member used the pictorial menu available to show the person who was able to make their choice of meal

independently. This meant people were supported to make choices in line with their individual needs.

People told us that they were treated with dignity and respect when they were being supported by staff. One person said, "The staff are very respectful when they help me. They do things discreetly so I don't feel embarrassed". We saw that staff spoke with people in a way that respected their dignity, for example; staff were discreet when they asked people what they needed help with. We observed a staff member supporting a resident with their meal. The staff member talked with the person and wiped their mouth which enabled them to maintain their dignity. People were supported with personal care in privacy and were able to access private bedrooms and quiet areas when they wanted some time alone. We heard staff spoke with people using their preferred names, some people liked their Christian names to be used and others like staff to call them by Mr or Mrs in a more formal manner. Staff we spoke with were aware of the importance of dignity and were able to explain how they supported people to feel dignified. This meant that people were treated with dignity and their right to privacy was upheld.

Is the service responsive?

Our findings

At our previous inspection we found no concerns and rated the responsiveness of the service as good. At this inspection this area remains good.

People told us that they participated in activities within the service. One person said they had talked with an activity co-ordinator about what they liked to do and what was available at the home. They had been encouraged to take part in activities with other people and they enjoyed going to the hairdresser once a week, playing bingo in a communal lounge and sitting in the garden. A relative told us on a sunny day staff spent time with people in the gardens and took drinks out for them. We saw that the dedicated activity member of staff supported people with painting and a quiz, interacting with people in a way that met their needs and providing praise when a person had answered a question or completed a good painting. People appeared happy and settled and told us that they had enjoyed the activities on offer. People who preferred to stay in their rooms told us that staff visited them regularly and chatted with them. This meant people were supported to access a variety of interests and hobbies that met people's preferences.

People told us that they received care in a way that they preferred and they were involved in the planning of their care. One person said, "The staff know me well. Myself and my family discussed what I wanted before I came to live here". Another person said, "The staff are wonderful, they know exactly how I like things done and they often ask me about my past life. We talk and chat about the things I used to do". Staff supported people throughout the day in line with their preferences and staff knew people well and understood how people preferred their support to be carried out. We saw that people's preferences and interests were detailed throughout the support plans, which showed people's lifestyle history, people's cultural needs and people's current physical and emotional wellbeing needs. The information we viewed gave a clear picture of each individual person and ensured that people's preferences were met in all areas of their care. We saw records of reviews that had been undertaken which showed involvement of people and contained details of any changes to their needs. For example; one person had suffered a fall and their care plan had been reviewed and updated to ensure staff reminded this person to use their walking aid.

People we spoke with knew how to complain and felt able to approach staff if they were unhappy with the service they received. One person said, "If I had any worries I would chat with [manager's name] they are lovely and very approachable too". A relative said, "I have no concerns I am very happy, but I know if I raised anything with the manager it would be acted on. They are always about at the service and have made sure we know who they are". The provider had a complaints policy in place which was available to people who used the service, relatives and visitors. At the time of the inspection there had been no recent formal complaints received. However, the manager had ensured there was a system in place to deal with complaints and log the outcomes for people.

We saw that a quiet area of the home had been set aside and was used to care for people at the end of their life. Two staff were allocated to care for up to six people and other staff were encouraged not to use the corridor as a route. A small lounge was available for relatives to use when they visited. People and their relatives were invited to discuss their preferences for music, spiritual needs, food and drink as well as direct

care planning. Relatives were encouraged to visit the day before a person was admitted for palliative care, to meet the staff and help prepare the bedroom with photographs and ornaments that the person would benefit from seeing. We saw that one person who had been admitted the day before we visited had a full and detailed care plan in place. Anticipatory medication had been prescribed and was available if or when the person required it to manage their symptoms. Staff we spoke with knew people's needs and told us they involved people and their families by talking with them and encouraging them to ask questions. There was a catholic religious sister available to visit and talk or pray with people for whom this was important. Staff told us that there were also links with other religions if people had different religious preferences. This meant that people were supported to receive a pain free, dignified and comfortable death in line with their wishes.

Is the service well-led?

Our findings

At our previous inspection we found some concerns and rated the well led area of the service as requires improvement. At this inspection we found improvements were still needed and this area continued to be rated as requires improvement.

Prior to the inspection visit the provider had identified concerns with the quality of the service provided. The provider had employed a consultant in March 2018 to undertake an external audit of the service to ensure that they were providing a good standard of care to people. The audit had identified areas of concern with regards to medicines management, records, lack of monitoring systems, and lack of direction for staff which had affected morale. A new manager had been recruited in May 2018 to enable improvements to be made to the quality of the service. We saw that the manager had implemented daily walk rounds, infection control audits and supervision for staff. The manager had clear actions for all staff to undertake such as weekly audits to be completed by nurses, which will be checked by the manager and deputy manager to ensure staff had supported people as required. The manager was aware of the issues raised at inspection and was in the process of implementing changes. For example; the manager was aware that there were concerns with medicines management and had contacted the local pharmacy to discuss medicines. This included discussions about 'as required' protocols. There was a clear plan in place to ensure that the provider had an oversight of the service, which involved the manager meeting with the Board of Trustees and the consultant undertaking regular audits to ensure that the manager is undertaking their responsibilities and improvements are being implemented and sustained. This showed that the provider had recognised that improvements were needed and had plans in place to ensure people had an improved quality of care. We will assess the improvements at the next inspection to ensure these actions have been completed and sustained.

We found that improvements were needed to ensure that people's records were accurate and contained a true reflection of people's needs. For example; one person's records showed that they were unable to alert staff that they needed support by using the call bell system. The records did not show how this person alerted staff and what actions staff needed to take to ensure this person received the support they needed. Staff we spoke with knew this person's needs and how to support them, but there was a risk that unfamiliar staff would not know this important information. Another person displayed behaviour that may challenge. The records we viewed did not give staff guidance on how to support this person to effectively lower their anxieties. Staff knew this person and gave consistent explanations of how this person needed to be supported. However, there was a large use of agencies staff at the service and there was a risk that this person could receive inconsistent support because their records were not accurate and up to date. The manager told us and the action plan we received showed that care plan audits would be completed and records were scheduled to be updated and reviewed by the 11th June 2018. We will assess that this has been completed and sustained at our next inspection. This meant improvements were needed to ensure records were accurate and the system in place to review and audit records is sustained.

The consultant told us that the provider had asked them to remain as an external auditor and mentor for the new manager. Systems had been implemented for the consultant to visit the service on a monthly basis to

undertake an audit to check that the manager was undertaking their responsibilities and improvements were being made. The provider had learnt from the shortfalls in the previous management of the service and had strengthened the systems they had in place to ensure there was a more robust governance system. The new system will enable them to have oversight of the quality and safety of care and ensure improvements are sustained.

People and relatives told us that the manager was approachable and was available at the service if they needed them. One person told us that they had met the manager prior to their admission and the manager had visited them in hospital. They said, "I know the manager they visited me in hospital before I lived here. They pop in to see me. They are very nice". A relative said, "There has been a big improvement and the manager is very well liked, very approachable and very efficient." Another relative said, "The new manager introduced herself to me and they are visible across the service". People and relatives told us that they had attended resident/relatives meetings to discuss the care provided and to meet the new management team at the service. We were told that the meeting had been informative and a good opportunity for the manager to discuss the improvements to be made at the service. The manager told us that it was important to involve people and to ensure they knew the actions that were being taken to make improvements. They told us it was an opportunity for people and relatives to feedback any concerns and make suggestions. This meant that the manager had taken action to ensure they were available to people and feedback was gained to inform service delivery.

Staff we spoke with told us that the manager had arranged staff meetings and they were available and approachable. One staff member told us that improvements had been made to the service since the consultant and new manager had been employed. They said, "The new manager has started to make improvements. They have changed the care plans, which were easier to understand. The manager has really lifted morale. The office is always open, the manager is always available, approachable and supportive". Another member of staff said, "There have been so many improvements already and the manager has only been in post for a couple of weeks. We have a more structured working pattern now and discuss allocation of staff at the handover so we know where we need to provide support. The manager is very supportive and gives us encouragement when needed. I know they have lots more improvements planned too". Staff also told us that the manager had recently carried out supervisions. One member of staff said, "I hadn't had supervision for some time but had one recently and it was really helpful and gave me a chance to discuss any concerns. I feel confident that the manager will sort out any issues too". The manager told us that supervisions would normally be carried out by manager and nurses but they wanted to have an opportunity to talk with all staff on a one to one basis. They said this has enabled them to get a clear view of any issues so they can make improvements. This showed that improvements had been made to ensure staff felt supported in their role.

We found that accident and incident monitoring had been put in place by the manager. The accident log included details of the incident, any injuries sustained and the action needed to take reduce the risk of further occurrences. For example; one person had fallen. They used a frame and after the accident their records had been updated to ensure that staff reminded this person to use their frame as they often forgot to ensure that a further fall was prevented. Staff knew about this update in the person's support and we saw staff supporting this person in line with their plan of care. This meant there was a system in place to analyse accidents and incidents to ensure that the risk of further occurrences was mitigated to keep people safe from harm.

The provider understood their responsibilities in relation to their registration with us (CQC). We saw that the rating of the last inspection was on display and notifications were received as required by law, of incidents that occurred at the service. These may include incidents such as alleged abuse and serious injuries.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|--|--|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent |
| Diagnostic and screening procedures | The provider was not consistently acting in accordance with the Mental Capacity Act 2005. |
| Treatment of disease, disorder or injury | |

This section is primarily information for the provider

Enforcement actions

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

| Regulated activity | Regulation |
|--|--|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Diagnostic and screening procedures | People were at risk because medicines were not managed safely. |
| Treatment of disease, disorder or injury | |

The enforcement action we took:

We served a Warning Notice to ensure that action was taken within a specific timescale.