

St Marys Lodge Care Home Ltd

St Mary's Lodge Residential Care Home For The Elderly

Inspection report

81-83 Cheam Road
Sutton
Surrey
SM1 2BD

Tel: 02086616215

Date of inspection visit:
05 December 2017
14 December 2017

Date of publication:
16 April 2018

Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

This inspection took place on the 5 and 14 December 2017 and was unannounced. This is the first inspection of the service under this provider. The provider was registered with the CQC on 9 November 2017. The service was previously registered under a different provider. You can read our inspection reports for the service under the previous provider by visiting our website www.cqc.org.uk. The same registered manager remained in post.

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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also one of the provider's directors.

St Mary's Lodge Residential Care Home for the Elderly is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 Lodge Residential Care Home for the Elderly accommodates up to 40 people across two adapted buildings that are joined together. Accommodation is provided on two floors with lift access between them. The service provides care and support for older people who are living with dementia. There were 33 people using the service at the time of our inspection.

This inspection was prompted following receipt of information from the local authority which raised concerns for the safety and welfare of people living at the service. These concerns related to a lack of heating and access to hot water. We looked at these concerns as part of this comprehensive inspection.

The registered manager had not provided evidence that they were fit to undertake their duties and had not learnt from previous CQC inspections they had been involved with under a different provider. There lacked management oversight of the service and there were insufficient processes in place to review and monitor the quality of the service. The registered manager had not consistently adhered to the requirements of their CQC registration and had not submitted notifications about key events as required.

Staff were unclear about their roles and responsibilities and there was not a clear vision or values in place regarding service delivery. The registered manager did not use feedback from people and/or their relatives to improve the quality of the service.

People were not provided with a safe and well maintained environment. People had gone a number of weeks without access to appropriate heating and hot water due to a boiler breakdown. The registered manager had not appropriately identified and managed environmental risks. The premises were not sufficiently maintained and effective systems were not in place to monitor and reduce the risk of infection. The design and layout of the premises did not fully promote people's independence and consider the needs

of people living with dementia.

Whilst the majority of medicines were stored securely and appropriately administered, recorded and disposed of, we saw safe practices were not followed regarding the storage and application of topical creams. The provider did not appropriately follow safeguarding adults' procedures to protect people from harm.

Staff recruitment checks were not fully completed and therefore there was a risk that people were supported by unsuitable staff. The provider's training matrix showed significant gaps and inconsistencies in staff's completion of these courses and did not correlate with staff training certificates that we were shown. We could therefore not be fully assured that people were supported by suitably trained staff who had the appropriate skills and knowledge to support their needs. We found staff were not always adequately supported. Our inspection of supervision records demonstrated a lack of appropriately structured staff supervision and staff had not received an appraisal of their work since 2016.

Relatives told us people on the whole had built caring relationships with staff. Staff had asked relatives for information about people's likes, interests and life histories. However, we saw inconsistencies in the recording of this information and did not see many examples of where this information was used to provide people with meaningful engagement and interactions.

The activities coordinator provided a programme of activities. However where people chose not to engage with activities we saw there was little alternative stimulation and engagement provided for people. An example of this was where people were living with dementia. We recommend the provider consults and implements best practice regarding the stimulation and engagement of people living with dementia.

Staff supported people to make choices and took account of people's communication and sensory limitations when supporting people to make decisions. Staff respected people's privacy and maintained their dignity. There were no restrictions in place regarding visitors and relatives told us they felt welcomed by staff to visit their family members.

There were sufficient staff to meet people's needs and risks to people's individual clinical needs had been identified and managed. The care records we sampled contained detailed information about people's assessed needs and how support was to be delivered. However, we received information from the local authority that this was not consistently available. They found care records were not always updated in a timely manner to ensure they reflected people's current needs.

People were provided with adequate support to ensure their nutritional, hydration and health needs were met. The provider participated in the NHS England vanguard 'red bag' initiative to improve consistency of care when people required hospital admission. Staff supported people in line with the principles of the Mental Capacity Act 2005, including application of the Deprivation of Liberty Safeguards (DoLS).

A complaints process was in place to ensure any concerns raised were recorded and investigated.

The provider was in breach of legal requirements relating to safe care and treatment, safeguarding, staffing, fit and proper persons employed, good governance, premises, requirements relating to the registered manager and the submission of statutory notifications.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe. People were not provided with a safe and well maintained environment. People had gone a number of weeks without access to appropriate heating and hot water due to a boiler breakdown. The registered manager had not appropriately identified and managed environmental risks. The premises were not sufficiently maintained and effective systems were not in place to monitor and reduce the risk of infection. Safe practices were not followed regarding the storage and application of topical creams.

Staff recruitment checks were not fully completed and therefore there was a risk that people were supported by unsuitable staff. The provider did not appropriately follow safeguarding adults' procedures to protect people from harm.

There were sufficient numbers of staff to meet people's needs and risks to people's individual clinical needs had been identified and managed.

Is the service effective?

Requires Improvement ●

Some aspects of the service were not effective. The design and layout of the premises did not fully promote people's independence and consider the needs of people living with dementia.

The provider's training matrix showed significant gaps and inconsistencies in staff's completion of these courses. We were therefore not assured that people were supported by suitably trained staff who had the appropriate skills and knowledge to support their needs. We also found staff were not adequately supported and there was a lack of staff supervision and appraisal.

People were provided with adequate support to ensure their nutritional, hydration and health needs were met. The provider participated in the NHS England vanguard 'red bag' initiative to improve consistency of care when people required hospital admission. Staff supported people in line with the principles of the Mental Capacity Act 2005, including application of the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Some aspects of the service were not caring. Relatives told us people on the whole had built caring relationships with staff. Staff had asked relatives for information about people's likes, interests and life histories. However, we saw inconsistencies in the recording of this information and did not see many examples of where this information was used to provide people with meaningful engagement and interactions.

Staff supported people to make choices and took account of people's communication and sensory limitations when supporting people to make decisions. Staff respected people's privacy and maintained their dignity. There were no restrictions in place regarding visitors and relatives told us they felt welcomed by staff to visit their family members.

Requires Improvement ●

Is the service responsive?

Some aspects of the service were not responsive. Whilst the care records we sampled contained detailed information about people's assessed needs and how support was to be delivered, we received information from the local authority that this was not consistently available. They found care records were not always updated in a timely manner to ensure they reflected people's current needs.

The activities coordinator provided a programme of activities. However, outside of the group activity programme we saw there was little stimulation and engagement provided to people and a lack of resources to engage people living with dementia. We recommend the provider consults and implements best practice regarding the stimulation and engagement of people living with dementia.

A complaints process was in place to ensure any concerns raised were recorded and investigated.

Requires Improvement ●

Is the service well-led?

The service was not well-led. The registered manager had not provided evidence that they were fit to undertake their duties and had not learnt from previous CQC inspections they had been involved with under a different provider. There lacked management oversight of the service and there were insufficient processes in place to review and monitor the quality of the service. The registered manager had not consistently adhered to the requirements of their CQC registration and had not submitted notifications about key events as required.

Inadequate ●

Staff were unclear about their roles and responsibilities and there was not a clear vision or values in place regarding service delivery. The registered manager did not use feedback from people and/or their relatives to improve the quality of the service.

St Mary's Lodge Residential Care Home For The Elderly

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 the 5 and 14 December 2017 and was unannounced. The inspection was carried out by three inspectors over the course of the two days.

Prior to our visit we reviewed the information we held about the service. This included the inspection history, information and feedback we received from the local authority and notifications that the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law. The provider had not been asked by us to complete a Provider Information Return (PIR) as we undertook this inspection in response to concerns we received. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 10 people using the service, four visiting relatives, the registered manager, seven members of staff and one visiting health care professional. Due to their needs, some people living at the home were unable to share their direct views. We therefore spent time observing how care and support was provided to people. Along with general observation, 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 with us.

We reviewed care records for 10 people, checked recruitment records for four members of staff and the records kept for staff allocation, training and supervision. We inspected the premises, all of the bedrooms and checked how the premises and equipment were maintained. We checked records for the management

of the service including health and safety records. We reviewed how the provider managed complaints and checked the safety and quality of the service. We also looked at how medicines were managed and the records relating to this.

Following our inspection we reviewed information provided by the local authority, commissioners and other professionals supporting people at the service. This included further concerns which they raised with us about the service.

Is the service safe?

Our findings

People were at risk of harm because the provider had not ensured people lived in a safe, clean environment and that equipment was safe to use. Prior to our inspection, we received information that people had been without central heating and hot water for over two weeks in parts of the premises. This had occurred as a result of a boiler breakdown in one of the two houses where 16 people were living. We found the provider had failed to take proactive and timely action to address this. In addition, they had not identified and properly managed other hazards that may pose a risk to people's safety. These related to risks associated with water hygiene and the use of oil filled radiators while the boiler was out of action.

During our inspection, various radiators were still not working properly and portable radiators were in use to provide people with additional heating. Prior to our visit we had asked the provider to complete a risk assessment concerning their use. The assessment was generic and insufficient as risks to people's individual safety were not considered. Alongside a list of people's names the provider had recorded the risk to a person's needs as "dementia" and either "able to recognise hot surfaces" or "not able to recognise hot surfaces." There was no other information about people's individual needs or what support they may require from staff to reduce risks.

Due to the boiler not reaching the required temperature and issues with the hot and cold water supply over a period of time, there was an increased risk of Legionella disease. We found the provider was not complying with Health and Safety Executive (HSE) guidance or relevant legislation about managing this and relied on intervention from the local authority to take the necessary action to keep people safe. There was also no contingency plan for unforeseen events such as a utility failure. This meant staff did not have information about actions to take in the event of an emergency situation.

We found equipment had not been maintained and serviced as needed. The gas safety certificate was dated 2015 and records showed there had been problems with hot water in people's bedrooms since 12 November 2017. On 14 November 2017, a contractor was called out as the boiler was not working. Their report identified essential work was required to fix the boiler. There was no record of a further visit or evidence this was addressed. The registered manager confirmed they were still in the process of arranging for another company to carry out the work. Whilst they were waiting for this work to be completed there was a risk that people would not have consistent access to hot water and heating.

The provider had not ensured that all equipment was regularly serviced to ensure it was safe to use. We found there were three hoists in use which had not been serviced within the agreed timescale. This put people at risk of unsafe care. However, we did see evidence of other safety checks on fire equipment and alarms, the lift, portable electrical appliances and electrical safety.

During our first visit, we saw fire doors blocked by equipment and other furniture which may have delayed escape through those exits if there was a fire. Staff took several minutes to open the main front door which was also a fire exit. At our second visit, we saw three bedroom fire doors propped open with rubber wedges. Although the provider took immediate action to address these issues when we brought it to their attention,

they had not identified these fire safety risks through their own checks which may have impacted on people's safety in the event of a fire.

People were not provided with a clean, hygienic environment. In a number of people's bedrooms, toilets and bathrooms there was no liquid soap, hand sanitizer or paper towels for people or staff to use when supporting individuals with their personal care. Without appropriate hygiene facilities we were not assured that people using the service and staff were adequately protected from the risk of cross infection. There was malodour in one of the bedrooms and the registered manager told us this was due to a person's continence needs at night. There had not been sufficient thought given to this person's needs to ensure a clean and hygienic environment was provided.

The management of medicines in the service was not always safe. We found prescribed topical medicines were not stored securely. Some of the creams had expired, the labels were not legible and they did not have opening dates recorded on them to indicate how long they had been in use. Charts to record the application of topical creams (TMAR) were blank or not always completed and there were no body map charts to inform staff where cream should be applied. Front sheet summaries which included the person's name, any known allergies, room number and photograph for identification for five people were missing. This meant there was a risk of people being given the wrong medicine.

There were limited systems to check that medicines practice was safe and people had received their medicines as prescribed. Although staff had completed training the registered manager had not assessed their competency to administer medicines. Staff completed weekly stock checks of medicines but did not review people's administration records consistently.

The above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not provided with a well maintained environment because areas of the home required repair and refurbishment. Parts of the premises had not been cleaned or maintained sufficiently. The paintwork around doors and in corridors was damaged. In some of the en-suite bathrooms we saw torn lino flooring, cracked tiles and a rusted radiator. In one bedroom paintwork was damaged due to a leak from the bedroom above and the sink had a blockage. There was damaged woodwork, broken tiles and an extractor fan not working in one of the bathrooms. We saw blistering paint in part of the premises. This all impacted on the ability to maintain a clean environment and did not provide a pleasant homely environment for people to live.

Staff used a maintenance book to record when repairs were needed. However, we found that timely action was not taken to address the concerns raised and ensure the building was adequately maintained. There were various entries in the maintenance book between June and October 2017 identifying problems with the hot water supply. This showed the provider had failed to act promptly and arrange for appropriate maintenance.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who use the service were not fully protected from the risk of abuse. Records showed that safeguarding concerns were not always correctly identified and reported appropriately. In July 2017 there had been a near miss incident where a person using the service choked on their food. During day 2 of our inspection one person shared concerns with us about the conduct of a member of staff. We asked the

registered manager to address the concerns and follow safeguarding procedures as necessary. Following the inspection the registered manager told us she planned to start her own investigation. However, we were not assured the registered manager had followed safeguarding procedures correctly. She had not recognised the two incidents as possible abuse or reported externally to allow the local authority to consider if they needed to investigate.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff recruitment and selection processes were not protecting people living in the home. The staff records we checked showed that staff had not always been recruited safely. Although there was confirmation of a criminal record check, we found incomplete application forms with no information about the applicant's previous employment and no photograph identification. There was a lack of evidence to support whether employment references had been sent to previous employers or to the applicant's personal contacts. References were not always stamped to confirm the authenticity of the referee or confirm whether the applicant had worked previously in a registered care setting. During the first day's inspection the maintenance man was being assisted by another person. There was no record available of pre-employment checks or a contractor's permit to work at the service. This meant the provider did not have complete information to assess whether these staff members were suitable to work with people using the service.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects around medicines management were safe. Care plans were in place for people who were prescribed 'as required' (PRN) medicines. These provided staff with information about the circumstances when a person can take a certain medicine so that it can be administered safely and consistently. Where people received covert medicine, appropriate action had been taken to support the decision making process. (Covert is the term used when medicine is administered in a disguised way that is in the person's best interest and when they don't have the capacity to consent). There were details about the reasons why covert medicines were required and how they should be administered.

Apart from the topical creams, medicines were stored securely and disposed of appropriately. The provider's policies and procedures for ordering, storage, administering and recording medicines were up to date and in line with latest guidance. We observed staff demonstrating safe practice when administering medicines. Staff had access to advice from a pharmacist who also carried out training at the service.

We observed staff followed effective hygiene practice when supporting people with their personal care and at mealtimes. Staff wore gloves and aprons when necessary. Arrangements were in place for the safe storage and disposal of clinical waste. Staff understood their responsibilities in respect of food safety. The kitchen area and equipment was clean, food items were stored appropriately and had been labelled after opening. Staff maintained records of food and fridge/freezer temperatures. However, we noted that colour coded chopping boards were badly scored and the last food hygiene inspection was undertaken in March 2014.

People and relatives we spoke with felt there were enough staff to support their needs. Their comments included, "Yes there's enough, they come quickly if you press your bell." A relative told us, "They (staff) are always around, someone is always allocated to that room (lounge area)." At the time of our inspection we saw sufficient numbers of staff on duty to meet people's needs. Staff were deployed appropriately between the two houses. We saw staff present in the various lounges and they provided support promptly when

people needed or requested it.

People's care records included assessments where potential risks associated with their individual needs had been identified. These were used to develop risk plans to promote people's safety. The plans provided staff with information about the support people required to minimise risks and where appropriate using the correct equipment. This included risks associated with nutrition and hydration, falls, medicines, moving and handling, continence and skin integrity. Records we saw confirmed risk assessments were reviewed every six months. However, the local authority had identified that some risk assessments had not been updated in a timely fashion when people's needs had changed. We confirmed with the local authority that the provider had implemented an improvement plan to address this.

Is the service effective?

Our findings

The design and layout of the premises did not fully promote people's independence and consider the needs of people living with dementia, and were not suitable for their intended use. Accommodation was provided across two adapted buildings that were joined together. There were many steps throughout the service and therefore some people relied on staff to support them to mobilise and did not therefore have as much freedom to move around as they could have. The provider had building work planned to address accessibility concerns at the service however, they were unable to confirm when this work would be completed.

The registered manager had made some improvement to create a more suitable environment for people living with dementia although we found further work was needed. For example, some people had pictures on their doors to help them find their room but this provision was inconsistent. Other bedroom doors were numbered with no names or features to help people distinguish one room from another. There were heavily patterned carpets which can cause perception problems for people living with dementia. We did see bathrooms and toilets doors had picture signage and had been painted with contrasting colours to help people find them. The lounge and dining areas were homely but quite plain in appearance lacking points of interest and pictures or photographs reflecting the lives of the people using the service.

During our walk round the premises we saw wheelchairs, walking frames, portable screens, portable radiators, mattresses, pads, portable fans and chairs in bedrooms, doorways and lounges impacting on people's accessibility of the service.

The evidence above adds to the breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified in the key question 'safe'.

New staff were supported through an induction into their role. Staff said this had been effective in preparing them for the work they would be doing. Staff thought the training was good and accessible. One staff member said, "The training is good here and I like that most of it is done here and is face to face. I have done training on lots of things including the safe use of hoists, safeguarding and medication." The registered manager used an electronic training matrix to monitor the training staff received and ensure they were up to date. Following our visit, the registered manager sent us information about completed staff training for 2017 and planned training for 2018. Whilst staff told us they had good access to training, the provider's training matrix showed significant gaps and inconsistencies in staff's completion of these courses and did not correlate with staff training certificates that we were shown. We could therefore not be fully assured that people were supported by suitably trained staff who had the appropriate skills and knowledge to support their needs. Staff had not refreshed their training in areas such as manual handling, infection control, food safety, safeguarding, MCA and DoLS since the beginning of 2016. Newer members of staff who joined in May 2017 had not completed training in safeguarding, MCA and DoLS and one had not undertaken fire safety training. Of the 23 members of staff working in 2017, only four had undertaken training in person centred care in July 2016.

Staff records included some evidence of additional training in topics that were relevant to the needs of the people using the service. This included dignity in care, understanding dementia, challenging behaviour, equalities and diversity, loss and bereavement. However, the overall training record showed significant gaps and inconsistencies in completion of these courses. We were therefore not assured that people were supported by suitably trained staff who had the appropriate skills and knowledge to support their needs.

Staff we spoke with found the registered manager to be supportive and said they could always ask if they had a problem or issue they wanted to discuss. Although staff spoke positively about their support, we found minutes of the supervision meetings were a duplicate record of the previous minutes and there was a risk that staff were not being adequately supported with all aspects of their roles and responsibilities. The registered manager had a planner record for all staff supervisions and yearly appraisals and told us this helped them to keep on track with supervising staff. However we saw staff had not received an appraisal during 2017.

Although there were plans to improve staff training and supervision, we found that staff training and development had not been adequately managed. There was a risk that people may not receive effective care and support as staff had not been supported to stay up to date with current practice and legislation.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the main people spoke positively about the meals provided and some told us they had a choice. One person however told us meals were "repetitive". When we checked food supplies in the home we found choice was limited for people. The food products were all from a supermarket saver range and indicated that people were not given as much choice as they could be. During our first visit, there was no milk in the fridge and the chef advised staff were due to go shopping.

People's nutritional needs were assessed and monitored. The support people required with eating and drinking was detailed in their care plans. Where people required adapted or specialised diets the chef was able to describe their individual requirements. Monitoring charts were used where people experienced appetite or weight changes and staff involved other professionals if there were concerns. One person chose to eat specific foods and refused main meals. Staff had consulted with a dietician to ensure they were eating a suitable diet which included higher calorie foods and nutritional drinks. Staff maintained records about people's meal choices and quantities eaten.

People felt their health needs were met, they told us staff took prompt action when they were unwell and said they saw the GP as and when required. Relatives we spoke with told us the home took timely action if their family member needed further healthcare support. People had hospital passports. This document provided healthcare staff with important information about the person and their health if they were admitted to hospital.

Arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. An example of this included use of the NHS England Vanguard 'red bag' initiative introduced by the local Clinical Commissioning Group. The red bag contained important information about a person's healthcare needs should they need to go into hospital in an emergency. This helped ambulance and hospital staff determine the person's needs and provide effective treatment promptly.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS is a lawful process whereby a person could be deprived of their liberty because it was in their best interests. 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.

The registered manager had assessed where a person may be deprived of their liberty and made applications to the local authority. For example, where people were unable to go out independently and needed constant staff supervision to keep them safe. The manager kept a monitoring record to track when authorisations were approved and when they should be reviewed. Staff supported people in line with the principles of the MCA and asked for people's consent before supporting them. Where people did not have the capacity to make decisions about their care and support staff followed appropriate procedures in line with the Act.

Is the service caring?

Our findings

People who were able to speak with us described staff as "patient", "very friendly" and "kind hearted." A person who had recently moved in told us, "I'm happy so far." Comments from visiting relatives included, "The care is very good", "My relative is happy here" and "All are looked after. (My relative) appears clean and dressed in a different outfit every time. Staff are patient, caring. I trust staff, the owner and the care."

We spent time in communal areas and observed the care provided to people and their interactions with staff. We saw staff were respectful, attentive and generally knew people well. Relatives confirmed they were asked for information about people's likes, dislikes, life history and things that were important to people. We saw some people's care records included a completed 'This is me' document which contained this information. However, other people's care records were generic and did not contain this level of information impacting on the delivery of person centred care.

From our observations we saw staff speaking clearly and explaining what they were doing when supporting people with their care needs for example when assisting people to walk or supporting individuals to eat their lunch. However, we observed a number of times throughout both days that staff interactions were brief and task orientated and did not positively impact on people's wellbeing. For example, in the afternoons we saw staff standing in the lounge areas but there was little engagement or conversation with people. We saw people sleeping or dozing in their chairs and at times a lack of interaction from staff. Staff were not consistently using the information gathered about people's interests and life histories to converse with people and provide them with meaningful activities and engagement.

After our first inspection, we received information from the local authority that following an unannounced visit, the majority of people were awake and sitting in the lounges by 8.00am. We therefore asked people if they were given a choice about what time they got up in the mornings and we received inconsistencies in the answers provided. One person told us, "I get up early, 5.30 or 6.00am, have to fit in with the routine" and another person said, "Staff knock on the doors in the morning but you don't have to get up though." Care plans lacked information about people's daily routines and their preferences in regards to their morning and evening routines. We spoke with the registered manager about this who said they would ensure care records would be updated to further reflect people's preferences in regards to their daily routine.

Relatives and visitors we spoke with felt they were involved with their family members' care. They said they were always made to feel welcome by staff and we saw examples of this. There were no restrictions in place regarding family and friends visiting their loved ones. Relatives told us they were invited to social events such as parties and other celebrations and records confirmed that staff supported people to maintain relationships and social links with those close to them.

People were encouraged and supported to make daily choices and this was confirmed through discussions with staff. Staff told us they supported people to choose which clothes they wanted to wear (whilst being conscious of appropriate choices for the weather and to maintain people's dignity), what they wanted to eat and what activities they wanted to participate in. People had freedom in regards to where they chose to

spend their day and where they wanted to sit in communal areas and during mealtimes. Staff were aware of people's limitations in regards to decision making and supported them appropriately. For people who found it more difficult to understand verbal information due to cognitive limitations or who were unable to verbally express their choices, staff visually showed people the options available to help them make informed choices.

Staff understood the need to maintain people's privacy and dignity and were able to tell us the action they took to ensure this. They told us they always knocked on doors and waited for a response before entering people's rooms, unless they had concerns about people's health or welfare. Staff explained how they upheld individuals' dignity. This included making sure people were offered an apron or napkin when eating to protect their clothes and that doors were kept closed when people required personal care.

Is the service responsive?

Our findings

Staff were knowledgeable about people's care and support needs, and people received support in line with their current care needs. The care records we viewed detailed people's support needs. The care staff assessed people's needs when they first came to the service as well as at regular intervals. Care and support plans were written in response to each identified needs including the associated care and support objectives and outcomes the person wanted to achieve. Care records detailed the level of support people required and how this was to be delivered, including how many staff they needed support from in order to receive person centred care safely. A summary document was displayed in people's bedrooms with 'at a glance' information for staff to refer to about people's needs and how support was to be delivered.

Whilst the care records we sampled and reviewed were up to date, we received information from the local authority that some people's care plans were incomplete and did not always reflect their care and support needs. We confirmed with the local authority that the provider had implemented an improvement plan to address this.

People's end of life wishes had been discussed and advanced care plans were developed detailing people's preferences and how they wished to be cared for when this type of support was required. Care records showed that discussions had been held with either the person or their relatives in regards to the level of care and support they received, whether they wanted to receive active treatment and whether or not they would like to be resuscitated should this support be required. We saw for people who did not want to be resuscitated that appropriate processes had been completed and 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms had been signed and were available in the event of a medical emergency.

A programme of activities was available and delivered at the service to provide people with stimulation. The provider employed an activities coordinator who worked weekdays who arranged a variety of activities for people to join in with. The programme of activities included arts and crafts, quizzes, relaxation and reminiscence sessions. People who were able to comment told us they enjoyed the activities. One person told us they liked dancing and a musician visited regularly to play the piano. Another person told us they liked reading and went out independently twice a week. During our inspection people and staff told us they were looking forward to the activities and celebrations planned for the festive period.

Whilst people enjoyed the activities on offer and delivered by the activities coordinator, we saw that when they were not at the service or for those that did not want to join in the group activities there was little stimulation and engagement taking place, leaving people at risk of boredom and social isolation. We observed that care staff did not always provide people with interactions above that associated with their clinical care and support needs. We saw there was a lack of resources available for care staff to use with people or for people and/or relatives to help themselves to, particularly for people living with dementia. There was a lack of reminiscence or sensory objects for people to interact with.

We recommend the provider consults and implements best practice regarding the stimulation and engagement of people living with dementia.

People and relatives we spoke with felt confident to raise a concern or complaint should the need arise. There was a complaints policy and records showed that none were received by the service in the last twelve months. The policy included clear guidelines, in a format that people could understand, on how and by when issues should be resolved. It also contained the contact details of relevant external agencies if people wanted to raise a concern outside of the home. The registered manager and the staff explained that complaints were welcomed and would be used as a tool to improve the service for everyone.

During our inspection we saw a number of compliments from people about the service. They included, "Thanks so much for the excellent care, my [family member] could not have lived as well as they did without their loving care" and "We are really happy with the care and the service our [family member] gets from the manager and staff at St Mary's."

Is the service well-led?

Our findings

The provider did not regularly assess and manage risks relating to the health, welfare and safety of people living at the home. Health and safety checks including equipment checks and observations of the quality and safety of the premises had not been consistently undertaken. The latest environmental audit was dated June to September 2016 and there was no evidence of any further checks or action plans to improve the environment. In response to the boiler failure the provider had failed to adequately assess the impact on people, other equipment and areas of service delivery, for example the Legionella risk. The registered manager had not kept her skills and training up to date and lacked understanding about health and safety legislation, including managing the risk of Legionella disease. They were also not aware of the key code for the fire exits meaning there was a risk that they may not be able to adequately support people to leave the service safely in the event of a fire. The business continuity plan was written after the event and was not in place at time of the boiler breakdown meaning there was a risk that people would not be adequately cared for in the event of utility failure.

The arrangements for ensuring that people were provided with a clean hygienic environment were insufficient. Areas of the home had not been adequately cleaned and there was no maintenance plan to show how the premises were being kept in a good state of repair or when the planned improvements would be completed. The home's infection control audit was last completed in April 2016 and was not appropriate for the service as it referred to nursing care activities such as checking suction equipment, tubing and oxygen cylinders.

The registered manager did not have an effective system in place to analyse incidents which resulted in, or had the potential to harm people. It was not clear what preventative measures were in place to reduce or prevent repeat occurrences. This meant that risks to people were at risk of recurring. For example, the registered manager had not reviewed accidents or incidents collectively to look for trends and themes such as falls. We also found that certain policies were not kept up to date. For example, there was no policy related to visitors and contractors.

Staff records and other records relevant to the management of the services were not always accurate and fit for purpose. Whilst staff said they felt supported, we identified that supervision records were not detailed and covered the same topics at each session. The registered manager did not have effective oversight of staff members' individual performance, training and development needs. The system for auditing and monitoring staff training and competence was not robust and there was a risk that this would impact on the quality of people's care.

The registered manager told us they did not know how to access the electronic care records system. There were insufficient systems to monitor the quality of care records which may explain why the local authority had found discrepancies in the quality and completeness of people's care records. We also saw that the list about people's dietary needs was out of date. This meant catering staff did not have accurate information about the foods people required.

Relatives were aware of family meetings and some told us they had received a satisfaction survey during 2017. We saw records that confirmed people and their relatives had opportunities to feedback about their experience of the service. However, there was no analysis of this feedback or how it was used to improve service delivery. This meant it was unclear how the service monitored its performance and made improvements based upon the views of people using the service, their relatives and other stakeholders involved with the home.

There was insufficient oversight and management of the service in order to review the quality and safety of the service and ensure continuous improvement.

The provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not demonstrate the knowledge and skills to ensure a culture of continuous learning and improvement. The same registered manager was in post under the previous provider and they were one of the partners of the previous provider. During our inspections of the previous provider in September 2016 we identified three breaches of regulation and rated the key question 'safe' as 'inadequate'. During an inspection in April 2017 the registered manager had made improvements and the service was no longer in breach of regulation, however they were still rated 'requires improvement' for the key question 'safe' and we identified some minor improvements were still required regarding risk management, recruitment procedures and regarding the suitability of the environment. The registered manager had not learnt from previous inspections and had not used this information to improve the quality and safety of service delivery. This demonstrated that the registered manager was unable to implement and sustain the changes necessary to meet these regulatory requirements.

The registered manager had also been in a partnership for another care home. This home was deregistered by the CQC in November 2017 due to significant concerns regarding the safety and quality of the service. The registered manager had not used learning from this experience to improve the quality and safety of this service.

Although the registered manager took immediate action to address some of the concerns we raised during this inspection, we found their approach to managing risk and quality improvement was reactive and they relied on other agencies such as the local authority to provide direction. We were concerned that the registered person has a history of not sustaining improvement and therefore lacked understanding of their responsibilities under the Health and Social Care Act 2008.

The provider was in breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered persons are required by law to notify CQC of certain events that occur at the service. This is so we can track and monitor whether the service had taken appropriate action in response to events that could have put people at risk of harm. Previously the registered manager had correctly notified us about reportable events. However they had not told us about a near miss incident where a person had choked and they did not notify us about the boiler breakdown which should have been reported as an event which stops the service running safely.

The failure to notify CQC of important events which affect people's health, safety and welfare was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Relatives shared positive comments about the registered manager and told us they could speak to them at any time. One relative said, "There's a homely feel, the owner is out on the floor and does extra bits for people." A member of staff told us the registered manager was supportive and told us they shared information about people using the service through daily shift handovers and team meetings although records showed meetings had been inconsistent.

One person using the service told us, "Nice staff but they don't seem to work together." We found the staff structure in the home was ineffective and not all staff were clear of their individual roles and responsibilities. There was no designated member of staff identified as being responsible for the key aspects of the service, including the quality assurance processes. The registered manager told us she had recently employed a full time administrator to support some of these activities but this was not fully integrated at the time of this inspection. There was no clear vision for the service and there were not clear values in place that underpinned service delivery, affecting the quality and management of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had not submitted notifications about potential serious injuries or events that stop a service. Regulation 18 (1) (2) (a) (g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. The registered persons had not ensured risks to service users' health and safety were adequately identified and managed, premises were not safe for their intended use, they had not assessed and controlled the risk of infections and did not consistently follow safe and proper management of medicines. Regulation 12 (1) (2) (a) (b) (d) (e) (g) (h)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered persons had not ensured systems and processes were established and consistently followed to protect service users from the risk of abuse. Regulation 13 (1) (2)
Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 15 HSCA RA Regulations 2014
Premises and equipment

The registered person had not ensured the premises were clean, properly maintained and suitable for their intended use.
Regulation 15 (1) (a) (c) (e)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

The registered persons had not ensured there were robust systems to review, monitor and improve the quality of service, to assess and mitigate risks, ensure accurate and complete records were maintained about service users' care or staff, and had not acted on feedback from service users' and/or their relatives.
Regulation 17 (1) (2) (a) (b) (c) (d) (e)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The registered person had not ensured staff were of good character as they had not obtained appropriate references.
Regulation 19 (1) (a)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 7 HSCA RA Regulations 2014
Requirements relating to registered managers

The registered manager was not fit to manage the regulated activities, and did not stay up to date with good practice to ensure they had the knowledge and skills to manage the delivery of the regulated activities.
Regulation 7 (1) (2) (b)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered person had not ensured staff

were suitably trained, supervised and appraised.

Regulation 18 (1) (2) (a)