St Mary's Nursing Home

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Inspection report

Montilo Lane
Harborough Magna
Rugby
Warwickshire
CV23 0HF

Tel: 01788832589

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected St Mary's Nursing Home on 16 & 17 November 2015. The first day of our visit was unannounced.

St Mary's Nursing Home is divided into two separate floors and provides personal and nursing care for up to 56 older people, including people living with dementia. There were 53 people living at St Mary's Nursing Home when we inspected the service.

A requirement of the service's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection. We refer to the registered manager as the manager in the body of this report.

People were protected against the risk of abuse as the provider took steps to recruit staff of good character, and staff knew how to protect people from harm. The provider had appropriate policies and procedures so staff understood how to report allegations of abuse. However, there were not always enough staff to care for people effectively and safely, or to meet people's individual needs. People were not always engaged in activities and interests that met their individual needs.

A full record of each person's individual care and support needs was not maintained. People's care records did not reflect the care and support they received from staff on a daily basis. However, permanent staff knew people well and could describe the care people received.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Decisions were made in people's 'best interests' where they could not make decisions for themselves.

Care staff treated people with respect and dignity, and supported people to maintain their privacy and independence. People made choices about who visited them at the home which helped them maintain personal relationships.

People received medicines to maintain their health and wellbeing and were supported to access healthcare from a range of professionals inside and outside the home. People were offered nutrition that assisted them to maintain their health. However, the monitoring of records to record the amount of fluid people received required improvement.

People knew how to make a complaint if they needed to. Complaints were fully investigated and analysed so that the provider could learn from them. People who used the service and their relatives were given the

opportunity to share their views on how the service was run. Quality assurance procedures identified where the service needed to make improvements, and where issues had been identified the manager took action to continuously improve the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People felt safe living at the home. People were protected from the risk of abuse, as staff knew how to safeguard people from abuse. The provider recruited staff of good character to support people at the home. Medicine administration procedures and medicine records required improvement to ensure people received their prescribed medicines. Improvements were required to risk management plans, to ensure people were cared for safely. There were not always enough staff available at all times to care for people safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff completed induction and training so they had the skills they needed to effectively meet the needs of people at the home. Where people could not make decisions for themselves, people's rights were protected; important decisions were made in their 'best interests' in consultation with health professionals. People received food and drink that supported them to maintain their health. However, monitoring records required improvement to reflect the actual amount of fluid people consumed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff treated people with respect and kindness. Staff knew people well, and respected people's privacy and dignity. Staff supported people to maintain their independence. End of life care planning needed improvement to reflect the wishes of people and their relatives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported to take part in activities and interests that met their needs. People did not always have an up

to date record of their care and support needs, or of the care they received each day, to ensure care was delivered consistently by staff. People were able to raise complaints and provide feedback about the service. Complaints were analysed to identify any trends and patterns, so that action could be taken to make improvements.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The records relating to people's care needed, and the care delivered to them were not consistently updated to provide a full and contemporaneous records of people's care. The manager was accessible to people who used the service, their relatives, and members of staff. People were asked for their feedback on how the service could be improved. Quality assurance procedures identified areas where the service could improve, and the manager took action to improve the service.

St Mary's Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 16 & 17 November 2015. The first day of the inspection was unannounced. This inspection was conducted by three inspectors, a specialist advisor, and an expert-by-experience. An expert-by-experience is someone who has personal experience of using, or caring for someone who has used this type of service. The specialist advisor had specialist experience of nursing people in this type of service.

We asked the provider to send to us a Provider's Information Return (PIR). The document allows the provider to give us key information about the service, what it does well and what improvements they plan to make. We were able to review the information as part of our evidence when conducting our inspection.

We reviewed the information we held about the service. We looked at information received from statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law.

Some people had limited verbal communication skills, and so we spent time observing how they were cared for and how staff interacted with them so we could get a view of the care they received. 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 spoke with nine people who lived at the home and nine visitors or relatives of people at the home. We spoke with several members of staff including three nurses, two members of care staff, the activities co-ordinator, and three members of additional staff including a member of the domestic staff. We also spoke with the manager, the training advisor, and the clinical lead nurse at the home.

We looked at a range of records about people's care including six care files, and other records relating to

people's care, for example, medicines records and fluid charts. This was to assess whether the information needed and the care offered to each person was available.

We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service.

We looked at personnel files for three members of staff to check that suitable recruitment procedures were in operation, and that staff received appropriate support to continue their professional development.

Requires Improvement

Is the service safe?

Our findings

Most of the people we spoke with and their relatives, told us they felt there were enough staff available to care for people safely. However, staff told us they felt there were not always enough staff available. One staff member told us, "I have a concern about the night time staffing numbers." They explained how this impacted on people's care, "At night there are not enough staff. There are only two staff on each floor. If two people are supporting someone in their room, then this leaves the floor with no care staff available to support anyone else."

Records of staffing rotas we reviewed confirmed there were only two members of staff on each floor of the home during the night, which included nursing staff. There were 53 people living at the home when we inspected St Mary's, with around half on each floor. Twelve people at the home were cared for in bed and needed two staff members to assist them with moving around. More than half of the people at the home were living with dementia. This meant that if two staff members were assisting one person with their personal care needs, there were no staff available to assist other people. A member of staff explained the impact on people at the home if people were noisy and called out during the night. They said, "We need more staff at night. Some residents disturb other people. Staff sometimes are too busy to assist other people who need it." They added, "Other people can react to the noise and become agitated, and one person becomes abusive."

We found there were not always adequate numbers of staff available during the day to prevent people from becoming distressed and anxious. We saw one person at the home called out continually throughout the day, on both days of our inspection visit. They looked anxious and distressed when calling for help. We observed the person was left calling out for more than half an hour on one occasion, until a staff member went into their room to calm them. One member of staff told us, "Staff try to sit with them when they are agitated. When the activities co-ordinator was here it was much better as they spent time with them." They added, "I don't feel there is enough time to spend with people, the only time we really spend with people is when we are assisting them to eat."

On another occasion we observed people in the early evening at the home when staff were busy assisting people in their bedrooms. One person came out of their room looking for staff to help them. The person was only partially clothed and looked confused. It was several minutes before a member of staff was available to assist them.

A lack of staff during the day meant staff focussed on tasks rather than spend time with people in the communal areas of the home. We observed a lounge area on the ground floor where some people were sitting for more than an hour. During that time only one member of staff entered the room. They switched on the television and then left the room. We noticed there was no interaction between the four people in the room and the staff member. On another occasion we saw one person trying to stand and use their walking frame. They struggled to stand, and were at risk of falling over. We observed two members of staff who did not stop to assist the person, but continued with the tasks they were involved in.

Staff told us the home employed a number of temporary or agency staff to cover staff rotas. One member of staff said, "The weekend is the worst for not having enough staff, I find it's exhausting." A second member of staff said, "We try to get the same agency staff, so that they know the home and the people here. There are staff shortages at the weekends though, and this can lead us to use up to four agency people." We asked staff why the use of agency staff impacted on the care people received. One staff member said, "We work a lot with agency staff which can be difficult at times as they don't know the residents, and can't respond to people promptly." Another member of staff said, "Agency nurses don't always fill in all the paperwork. Last week two agency staff arrived late, and had never worked in this type of environment before. This meant other staff needed to support them in their work." We spoke to the manager about agency staff not always being suitably experienced in the home; they said they had spoken with the agency company to rectify this happening in the future.

Staff members also told us there were not always enough staff on duty to consistently cover all the domestic tasks at the home. One staff member said, "Sometimes there is only one member of staff doing the cleaning. There should be one on each floor. We have a vacancy in the kitchen, and sometimes one of the domestic staff are called in to help there." Another member of staff told us, "The dementia floor suffers a bit, because it doesn't have regular cleaning staff at the moment." They added, "Staff morale is low at the moment."

We asked the manager how they ensured there were enough staff to meet people's needs safely. They told us staffing levels were determined by feedback from staff. They did not assess people's needs or abilities when making a decision on the number of staff required to support people. The manager had listened to the feedback from staff, and had identified a number of vacancies within the home. Recruitment to some vacancies would reduce the use of agency staff, and additional recruitment was planned to offer more staff provision at night. The manager told us, "In the event of staff shortages we use agency staff to maintain staff levels. We have requested regular staff from agencies to promote continuity." They added, "We are actively recruiting to fill six support worker vacancies to reduce agency use, and to improve the numbers of staff on duty. We are also actively recruiting to fill an activities co-ordinator vacancy and weekend vacancies for domestic staff." The manager told us one of the challenges of running the service was recruiting staff with the right skills and values to work at the home, as the home was situated in a rural location. We saw that in addition to nurses and care staff the manager and the clinical lead nurse were available to cover care duties at the home.

We found this was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing

All the people we spoke with told us they felt safe at the home. One person said, "Of course I feel safe." Another person commented, "I feel as safe as the rock of Gibraltar!"

The provider protected people against the risk of abuse and safeguarded people from harm. Staff attended safeguarding training regularly which included information on how staff could raise issues with the provider. Staff told us the training assisted them to identify different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone. They were confident the manager would act appropriately to protect people from harm. All the staff knew and understood their responsibilities to keep people safe and protect them from harm. The provider notified us when they made referrals to the local authority safeguarding team where an investigation was required to safeguard people from harm. They kept us informed with the outcome of the referral and actions they had taken.

People were protected from the risk of abuse because the provider checked the character and suitability of candidates prior to them being recruited to work at the home. The PIR sent to us before our inspection confirmed this, and as did the manager and staff. For example, criminal record checks, identification checks

and references were sought before staff were employed to support people.

We observed medicines being administered to people. Staff who administered medication were trained nurses, and had received specialised training in how to administer medicines safely. Nurses confirmed their training included checks on their competency before they could administer medicines to people. Each person at the home had a medication administration record (MAR) that documented the medicines they were prescribed and how and when they should be taken. We reviewed the MAR of five people. MAR records contained a photograph of the person so that staff could ensure the right person received their medicines. This was important as the home used temporary or agency staff to administer medicines who might not know the people they administered medicines to. Daily checks were undertaken by nurses to check people received their medicines. Medicines were stored safely.

We found however that MAR records were not always up to date, and did not accurately document the medicines people received. For example, one person's MAR did not list all the medication they were being given. This was because the MAR was handwritten and had not been updated correctly. This posed a risk to the person, as temporary or agency staff may not understand which medicine needed to be given to the person. We brought this to the attention of the manager during our inspection who immediately implemented a system, so that MAR were produced by the pharmacy in the future to prevent mistakes occurring.

We saw one person was being given some of their medicines covertly, with the agreement of their doctor. This is a term used to describe the administering of medicines without the person's knowledge or consent and can often be disguised in food or fluids. The medicine was given in this way because the person frequently refused to take their medicine, and they lacked the capacity to make an informed decision about how this would affect their health. All of the medicines that were being given to the person were not documented as being approved by the doctor to be given covertly. An additional medicine had been added to their prescription, without a decision being recorded by the doctor. A nurse told us, "We are giving the person the medicine in liquid form. The person just isn't informed that this is medicine." This meant the person was being given medicine covertly, without up to date paperwork being in place.

Some people received medicines that were prescribed on an 'as required' (PRN) basis, such as pain relief. This meant the medicines should only be given to the person when they were in pain. We saw the MAR and care records did not describe the signs of pain the person might display to ensure staff knew when to give them their medicine. The person was unable to speak, and so could not inform staff when they were in pain and needed their medicine. We spoke to a nurse who told us, "I recognise when the person is in pain by their facial expressions." However, the signs of when the person was in pain had not been written down for other staff to follow. There was a risk that the person might be left in pain, if all staff did not understand their visual signs of pain accurately.

Staff closely monitored one person who lived with dementia to ensure they did not become ill with constipation. A chart was used to monitor the person to help staff decide whether 'as required' medicines were needed, and what dose was required. We noted the chart had not been completed by staff from 1 November 2015 to 15 November 2015, however staff told us they had been monitoring the person visually to determine whether the medicine was required. This meant that staff who did not know the person's daily habits, may not know when to give the person their medicine, especially if the person became confused and could not tell them if they needed their medicine.

Creams to protect people's skin were administered to people by care staff. Each person who had cream administered to them had a MAR which care staff were asked to complete when they administered the

cream. We found that MAR sheets were not being completed consistently. For example, we saw one person had cream prescribed for their legs and feet, to be administered daily. On 11 November 2015 the MAR was not completed to show whether cream had been administered. We asked staff whether this was a recording error, and if people had their prescribed cream. Staff reassured us that people were having their cream administered, they told us, "People have the care they need, it's just not everything is recorded on the paperwork."

People we could speak with told us they received their prescribed medicines safely. One person told us, "I don't like the calcium tablets but they persuade me to take them, and do the best they can."

The manager had identified potential risks relating to each person who used the service, and care plans had been written to instruct staff how to manage and reduce potential risks to each person. Most of the risk assessments we reviewed were detailed and up to date. The up to date risk assessments gave staff clear instructions on how to minimise risks to people's health and wellbeing. For example, one person was at risk of falling, and could injure themselves. There were plans for staff to follow in how the person should be assisted to move around, and what equipment should be in place to minimise the risk of them falling. One relative told us "The staff are aware of the risk of them [Name] falling, and they have put all possible measures in place, such as mats and bedrails to mitigate the risks."

Some risk assessments and care records which documented the care people received and their care and support needs, were not up to date. For example, one person's risk assessment documented how risks to their health should be managed by staff to reduce the risk of them falling and injuring themselves. Records showed their room should have no 'clutter', to minimise the risk of them tripping and falling. We looked in the bedroom of the person. There were loose cables trailing from the side of their bed and from a recliner chair next to their bed. The room was full of furniture such as a wardrobe, bed, a large recliner chair, a bed table and a dressing table. There was little space for them to move freely around the room. This placed the person at risk of falling. We brought this to the attention of the manager. The manager stated the person objected to the furniture being moved and other measures were being put in place to reduce the risk. This meant their risk assessment did not provide staff with the correct information they needed to minimise the risks to the person.

We observed one person who shouted out frequently and who had displayed signs of anxiety and distress during our inspection. Care staff knew the person well, and could describe the actions they would take to calm the person, such as spending time with them. However, the care records for the person did not document that the person shouted when anxious or distressed and how they should support them to reduce the risk of this occurring.

Fire risk assessments were in place, and fire safety equipment was regularly tested. However, fire evacuation procedures did not contain person emergency evacuation plans to ensure each person's individual support needs in an emergency were detailed. The procedures in the event of a fire were not displayed prominently in the home. We were concerned that agency staff may not know how to react in an emergency without this information being on display and quickly accessible. We brought this to the attention of the manager during our inspection who immediately compiled personal emergency evacuations plans for each person who lived at the home, and placed these on display.

We found there had been a coroner's investigation relating to the death of a person at St Mary's the previous year. The coroner had asked the home to respond to the concerns raised at the inquest, and had directed the provider to implement a number of actions to minimise the risk of incidents re-occurring at the home. The manager had implemented the following actions in response to the coroner's report. Nurses had

received training to enable them to recognise the signs of acutely unwell residents. An 'on-call' procedure had been introduced to support staff when the manager was not at the home. The home planned to provide training to nurses in how they should respond to emergency situations annually. The provider also planned to introduce mandatory clinical training for nurses in 2016, and observations on nursing skills. This was to ensure nurses were supported to keep their skills up to date, to enable them to respond confidently in emergency situations.

Requires Improvement

Is the service effective?

Our findings

We spent time with people during the lunchtime period. Most people enjoyed the food on offer. Relatives told us people were offered a choice of meal, and had individualised food that met people's preferences and dietary options. One relative said, "I can't fault the food." Another relative told us, "I come every day, and I come at lunchtime so I can assist [Name] to have their meal. The food is wholesome and well cooked. Residents are well fed, well looked after."

Kitchen staff knew the dietary needs of people who lived at the home and ensured they were given meals with met those needs. For example, people on a soft food diet and gluten free diets.

Staff told us people were provided with a menu, and ordered their food before each mealtime. We were concerned that people who lived with dementia may not be able to read and understand the menu. For example, one person asked us what the menu said, and asked us to explain what was on offer, as they were unable to read it. When the meals arrived they were already plated ready to be served to people. People were not shown the food options, but were presented with what they had previously ordered. This meant people had no options for choices about what side orders they wanted to have. One person said, "I have steak and kidney pie, but I don't like kidney." We saw the person did not eat this part of their meal.

We saw some people were given a choice of a different meal if they did not like what was on offer. One person was reluctant to eat the main meal staff had provided. The person was then offered semolina and a plate of sandwiches which they ate. We saw another person did not eat much of their lunch. A staff member explained the person had eaten five Weetabix and a slice of toast that morning. The care worker told the person. "Don't worry, if you get hungry later tell me and I'll get you something else to eat."

People who could eat independently in the dining room did not have a pleasant meal time experience. Staff queued to collect meals for people at the kitchen doorway inside the dining room area. We observed a lunchtime meal in the dining room where three people ate, all three people ate at separate tables. People were given their meals at separate times. There was a gap of at least 25 minutes from when the first person received their meal, to when the third person received their meal. This meant people were waiting for their meal whilst watching others eat around them. Although tables had table clothes, these were plastic covers which were ill fitting. There were no condiments or cutlery out on the tables for people to use to promote people's independence. The dining room did not have a relaxed atmosphere, and did not encourage people to socialise with each other.

Most people who lived at the home needed assistance with eating and drinking. The provider employed specific staff to assist people with this. Nutritional support workers offered people drinks throughout the day, which helped people maintain their health. Staff offered people a range of drinks, such as tea, water and juice. Staff waited for a response from people regarding their preference before preparing their drink. We saw one person wanted to have Horlicks, as a drink. The staff member didn't know how to prepare the drink, and so the person showed them how they liked this making.

Staff made sure people had the specialised equipment they needed for eating and drinking, without being prompted. This helped people to maintain their independence, and demonstrated staff knew people well. Staff encouraged people to eat at their own pace and waited for clear signals that people had finished their main meal before offering them dessert. One member of staff said, "[Name] opens their mouth when they are ready for the next spoonful." Staff spent time with people encouraging them to eat.

Where people needed to receive a specific amount of food or fluid to maintain their health each day, people had their food and fluid intakes monitored by staff using a chart system. We found the fluid and food charts were not consistently completed by staff, or audited each day to check people received the amount of food and fluid they needed to maintain their health. The charts did not contain any information as to what the target fluid intake was each day, for staff to check against. For example, in one person's charts it showed that they only consumed 200mls fluid on the 1 November 2015. On another day in November there were no entries on the fluid charts. A third day showed the person had only consumed 250mls of fluid. We spoke to a member of staff about the person, because we were concerned about their level of hydration. The member of staff told us, "The person drinks fluids all day." The manager confirmed, "People are having their food and fluids, it's just poor recording." The manager explained that a review of care records was planned to address inadequate recording of fluids.

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 an assessment shows a person lacks mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the 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 manager was able to explain to us the principles of MCA and DoLS, which showed they had a good understanding of the legislation. Mental capacity assessments were completed when people could not make decisions for themselves. Records detailing people's capacity to make decisions was not decision specific, and staff were not given instructions on which decisions people could make for themselves, and which decisions needed to be made in their 'best interests'. However, staff demonstrated they understood the principles of the MCA and DoLS. They gave examples of applying these principles to protect people's rights, for example, asking people for their consent and respecting people's decisions to refuse care where they had the capacity to do so. Where people could not make decisions for themselves, records confirmed important decisions had been made in their 'best interests' in consultation with health professionals.

The manager reviewed each person's care needs to assess whether people were being deprived of their liberties. No-one had a DoLS in place at the time of our inspection. The manager had made several applications to the local authority for a DoLS; however we found that other applications where people required a DoLS had not been made. The manager was working with the local authority guidance in submitting these applications to them.

People told us staff had the skills they needed to meet their needs. One person said, "The staff seem to know what they're doing." One relative told us, "Personally, I think the staff have skills on how to engage people with dementia, but more training wouldn't hurt." One person said, "They seem knowledgeable. It beats the hell out of doing things yourself!"

Staff told us they received an induction when they started work which included working alongside an experienced member of staff, and training courses tailored to meet the needs of people who lived at the home. The induction training was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care workers in the UK. Staff told us in addition to completing the induction programme; they had a lengthy probationary period to check they had the right skills and attitudes for the people they supported. We spoke with the training advisor who explained that some members of staff who were employed by the home before the introduction of the 'Care Certificate' were being offered additional support to complete all the elements of the current induction standards, to make sure they had all the skills they needed to support people effectively.

Staff told us the manager encouraged them to keep their training and skills up to date. The provider employed a specialist training advisor to monitor and develop staff training for care staff. The training advisor maintained a record of staff training. They told us the provider was investing in training, and a new training schedule was being developed. New training courses would be implemented in the next few months to include updates in moving people safely, to ensure staff had knowledge of the latest techniques and equipment. This demonstrated the provider was developing staff training to improve the quality of care at the home.

Whilst the provider was updating staff in moving people safely, we saw staff used their existing knowledge to assist people to move safely. For example, staff used appropriate moving and handling equipment and techniques when they assisted people during our inspection. We saw one person being moved using a hoist and handling belt. Staff explained to the person what they were intending to do, and offered the person reassurance. The transfer was completed safely.

The provider also employed a clinical lead nurse to monitor the performance and training of nursing staff at the home. Staff told us that each member of staff received an individual training programme tailored to their specific job role. For example, nursing staff received specialist training in dementia and medicine administration. Nursing staff had their skills checked through supervised observation following training in medicine administration. One member of staff told us, "Yes, the training is good and we have the skills we need." Another member of staff told us, "If we want any further training in something we just ask, and it's organised for us." Staff told us the provider also invested in their personal development, as they were supported to achieve nationally recognised qualifications.

Staff were supported with meetings with a manager, or the training advisor, and yearly appraisals. Staff told us regular meetings with the training advisor provided an opportunity for them to discuss personal development and training requirements. Regular meetings with their manager enabled the manager to monitor the performance of staff, and discuss performance issues. The manager gathered feedback from colleagues, and senior care workers on the performance of staff members, to input into the appraisal process. Feedback was discussed with staff so that they could continuously improve their skills.

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

Staff and people told us the home worked in partnership with other health and social care professionals to support people. A relative told us, "When [Name] needed to go to hospital they called me straight away, I

came and was able to go with them." Care records included a section to record when people were visited, or attended visits, with healthcare professionals. For example, people were able to see their GP, speech and language therapist, mental health practitioner, dietician and dentist where a need had been identified. The manager told us the doctor and other health professionals visited the home each week, for example, the physiotherapist. One person told us, "The optician and dentist have been here to see me." Another person said, "I am supported to go my own private dentist." Information and advice from medical professionals was transferred to people's care and support records, and changes were made to people's care and support plans following their advice.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us staff treated them with respect and kindness. One person said, "I am H-A-P-P-Y!" A relative told us, "Staff are so caring. They do a commendable job and make me feel extremely humble because of their humanity and dedication." Another relative told us, "It's like coming home, it's like a family."

One relative told us they had recently moved their relative into St Mary's. This was after looking for a suitable home for a number of weeks. They said, "I liked the attitude of staff and was assured [Name] would be alright here. [Name] liked the surroundings and being in the countryside."

Staff told us they enjoyed working at the home, because of the interaction they had with people who lived there. One member of staff said, "Staff are really caring. The care staff work very hard, and are very good. I would have my family members here."

People told us they chose how to spend their time, and staff respected their decisions. They explained they could spend time in the communal areas of the home, or in their bedroom. We saw most people spent time in their bedroom during the day. One person said, "I tell the staff what I want, and they support me."

People and their relatives were involved in care planning where possible, and made decisions about how they were cared for and supported. For example, people had information recorded in their records about their religious beliefs, and their personal history, so that staff could support people in accordance with their wishes. One person told us, "The owner takes me to my church group every week, which I enjoy."

Staff we spoke with knew people's preferred name, and spoke of people in respectful and positive ways. People told us staff treated them with respect. One relative said, "Staff talk to people with respect and patience, they don't shout, they know what and how to say things." Staff told us they always explained to people the support they were offering before proceeding.

People told us staff supported them to maintain their independence where possible. One person said, "I do some things by myself. I always tell the staff what I want to do, and they support me."

People told us their dignity and privacy was respected by staff. Staff knocked on people's doors before entering, and announced themselves when they entered people's rooms. One member of staff explained how they respected people's dignity, and gave people privacy when they needed it. They said, "I know never to talk with anyone else about the care we provide to people here. We always knock on people's doors before entering, and close curtains and bathroom doors when we are assisting people with personal care. We also have a policy about not taking photographs of people without their consent."

We observed care staff respected people's privacy during our inspection. On one occasion a person was being hoisted into a chair, the member of staff made sure the persons legs were covered, so that they were not exposed to other people during the transfer. In another instance we heard a care worker ask someone

where they were going, they replied they were going to the toilet. The staff member made sure the door was closed for the person to maintain their privacy.

There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. People made choices about who visited them at the home. One visitor told us, "I can come every day if I want to." The PIR information confirmed that visiting was not restricted at the home. We saw people and their visitors being offered drinks and snacks throughout our inspection, and using communal areas of the home to meet. The manager told us, "Regular visitors are given a code so that they can enter the building whenever they choose and visit freely." This helped people maintain links with family and friends.

Some members of the staff team had been trained in the National Gold Standards Framework (GSF) on 'end of life care'. Staff told us this was to provide good quality care to people nearing the end of their life. We saw one person at the home during our inspection who was nearing the end of their life. We asked staff if the person had an 'end of life' care plan in place to identify their wishes at this critical time. Staff told us people did not have an up to date care plan in place for staff to follow at the end of their life. In common with most rooms their bedroom door had been left open, and the person was in their room unattended by staff. We brought this to the attention of staff at the home, as we were concerned people at the home may become distressed. Staff later closed the person's door to provide them dignity and respect.

We spoke to the manager regarding care plans to record the wishes of people approaching end of life, for example to have family with them. The manager told us, "End of life care plans which described people's wishes would be introduced for people throughout the home, early next year."

Requires Improvement

Is the service responsive?

Our findings

People told us staff were responsive to their needs. One person told us, "If I want something, I just ring the bell, and they come!" Relatives we spoke with confirmed that staff responded to people's needs. One relative said, "I rang the bell once by accident, despite the room being empty a member of staff came promptly to see if things were alright."

One relative gave us an example of when staff had responded to their relative's needs. They said, "[Name] was in a different room before, this was changed immediately when it was realised it was not suitable."

We observed how people were cared for, and how staff responded to people's individual needs. On some occasions we saw staff did not always respond to people straight away when they needed their support. For example, one person called out for support, and waited for more than 30 minutes before staff went to assist them. This was because staff were busy assisting other people at the home. The person showed anxiety and distress whilst they waited for staff to respond. On another occasion we saw one person trying to stand and use their walking frame. They struggled to stand, and were at risk of falling over. We observed two members of staff who did not stop to assist the person, but continued with other tasks they were involved in. We were concerned that staff seemed to be task focussed, rather than responsive to people's needs.

Staff recorded information from people or their relatives about people's preferences. People and their relatives told us they were involved in planning the care people received, and they were involved in regular reviews of the care provided. One relative told us. "I was involved in a formal review of my relative's care around three weeks ago; this also involved social services. I can look in care notes anytime, and also have had input when medication is changed." Another relative said, "If anything changes, or is needed, they let us know straight away."

However, care records to guide staff to respond to people's individual support needs consistently, were not always kept up to date to demonstrate the care people received. In one person's care records we saw their wellbeing needed to be checked by staff hourly, but the charts were not consistently completed. For example, on 17 November 2015 the hourly checks had not been recorded at 10.00am, 12.00noon, or 2.00pm. On another day in November we saw hourly checks had not been recorded for a four hour period. Whilst there was no evidence the person had not received the care they needed, a lack of accurate recording could increase the risk of this happening.

In another person's care record we saw that they should be checked every 30 minutes during the night, as they were at high risk of falling and trying to get out of their bed at night. We saw the person had recently fallen during the night. Charts were in place in each person's room, which documented when people had checks on their wellbeing. Staff told us they did check on the person every 30 minutes, but forgot to write this down. They confirmed people were receiving the care they needed, but recording on charts was inconsistent.

In one person's care plan we saw they should be encouraged to mix with people in the communal areas of

the home, and be encouraged to take part in group activities. We saw the person was in their bedroom throughout the two days of our inspection. We asked staff about the person. They said, "The person does not like to mix with other people or go outside their room." The person was not able to verbally describe their wishes. Staff told us they knew the person's wishes about staying in their room through monitoring their facial expressions and behaviours. The permanent care staff knew the person's wishes but their care records did not reflect these. Records that were not up to date meant agency staff or temporary staff may care for people inconsistently, and not respond to people's needs correctly.

We asked people about the support they received to take part in activities and interests that stimulated them and they enjoyed. Some people told us they took part in group activities at the home arranged on the first floor by the activities co-ordinator. Relatives of people told us people usually spent time in their bedrooms, or in the communal lounges watching television and listening to music. One person said, "When it's fine outside staff sometimes take me out for a walk." Another person said, "The owner takes me to the garden centre sometimes, which I enjoy." We observed people sat in the lounge areas at the home, listening to the television and other people chatting with their relatives and friends which they enjoyed.

A list of activities available was displayed on the wall of the home which showed a range of things happened each day. Events included; group chat, arts and crafts, film afternoons, and movement to music. Three members of staff were responsible for arranging activities at the home, one staff member was on maternity leave at the time of our visit, another staff member was on sick leave, which meant there was one designated member of staff to organise and deliver activities across the whole home when we conducted our inspection visit. The activities co-ordinator told us, "I usually only work on the top floor of the home." People on the ground floor of the home therefore did not have an activities co-ordinator working with them.

We observed people who would have benefitted from further activities or stimulation. We saw one person who lived with dementia walked around the home banging on the doors and the walls. The person made noises that could disturb other people at the home. We discovered the person had been a builder, and they enjoyed DIY and building maintenance tasks, which could be why they banged on the doors and walls. Staff did not use this information to support the person responsively and minimise the disturbance for other people who lived at the home.

One member of staff told us about the shortage of staff to provide activities. They said, "People who could benefit from the activities are missing out." They added, "The lack of activities staff means pressure falls on other staff. The mornings are busy, staff only really have extra time to spend with people outside their work tasks in the afternoons." Another member of staff said, because of the shortage of staff, "I sometimes feel we are not delivering the best care, especially in the dementia unit." The manager told us they were planning to recruit an additional activities co-ordinator at the home, so that people could be offered more stimulation and activities they might enjoy.

People were not always consulted about what activities they wished to take part in, as there were no meetings to ask their views. Everyone at the home did not have an up to date personal activity plan in place that described the activities they might enjoy. The manager told us, "We are developing activities plans for people."

There was information about how to make a complaint and provide feedback on the quality of the service available in the reception area of the home. However, information about how to make a complaint or provide feedback was not on display in the communal areas of the home, or in an easy to read format for everyone at the home to access. For example, easy to read documents may be prepared using large print and pictures to make them accessible to people with limited communication. Documents provided in this

way would give more people the opportunity to provide feedback to the provider, and could help people to maintain their involvement and independence. We brought this to the attention of the manager during our inspection.

People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. Relatives told us they knew how to raise a formal complaint with the manager. In the complaints log we saw that previous complaints had been investigated and responded to in a timely way. The provider had also acted on the feedback they received in the complaints to improve the quality of their service. For example, a new cleaning schedule had been implemented following concerns about the cleanliness of one person's room. Complaints were analysed to identify any trends and patterns, so that action could be taken to improve the service provided.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager at the service who worked alongside the provider. The manager encouraged a culture of openness and transparency. People told us the manager was available to speak with 'most days.' The manager operated an 'open door policy', and people were confident in approaching the manager and the provider. One person told us, "You can say whatever you want." A relative told us, "They always listen and give it their best shot."

People told us they thought the home was well-led. One relative said, "My general impression is that things run very well. St Mary's is a very nice nursing home with amazing staff. I have nothing but praise for the management and staff at the home. St Mary's is the best home I have seen."

The manager completed regular checks of different aspects of the service. This was to highlight any issues in the quality of the care provided, and to drive forward improvements. For example the manager conducted regular checks in medication administration, care records, and infection control procedures. However, we found that people's care records were not always up to date and consistently completed by staff when they supported people. This included records relating to people's medicines, fluid and food monitoring charts, and the records of the care people needed. Auditing checks had highlighted the need to improve record keeping at the home. We spoke to the clinical lead nurse regarding the improvements they had planned for the next few months. They explained they were introducing more auditing procedures for care records, to include checks on food and fluid charts, and repositioning records.

A full care records review was planned for January 2016. This demonstrated the management team had already identified care records were not always kept up to date, and were acting to make changes.

We found there were not always enough staff at the home to care for people effectively and safely. We saw this impacted on the care people received. Staff were unable to respond promptly to people's individual needs. Staff had limited time to spend with people at the home. The provider did not have a system to identify how many staff may be required at the home to meet people's dependency needs. However, the manager had identified a number of vacancies, and was actively recruiting to fill the vacancies. They were recruiting new staff to fill six care staff vacancies, an activities co-ordinator and weekend vacancies for domestic staff. The manager told us the recruiting of more staff would fill vacancies that were currently being covered by agency staff, and also offer more flexibility to provide extra staff on some shifts. The manager told us one of the challenges of running the service was recruiting staff with the right skills and values to work at the home, as the home was situated in a rural location. This demonstrated the provider had already identified the need to increase staffing numbers, and was acting to improve staffing levels.

The management team were also planning other improvements at the home. New emergency plans were being developed to ensure staff had up to date information on how to respond to people becoming unwell, which included information on how staff could recognise the signs of strokes. The manager was also planning a full clinical audit of how nursing procedures were followed at the home. They explained they had also just updated their auditing procedures for medicines following advice from the pharmacist.

There was a clear management structure within St Mary's to support staff. The registered manager was part of a management team which included a clinical lead nurse and nurses who were available on each shift. Staff told us they received regular support and advice from managers and nurses to enable them to do their work. Staff told us there was always an 'on call' number they could call outside office hours to speak with a manager if they needed to. This information was confirmed in the PIR information we received before our inspection. One staff member said, "I feel supported in the role." Another member of staff added, "The registered manager is really helpful and supportive."

The manager told us the provider was supportive of the service, and offered regular feedback and assistance to support them in their role and their professional development. For example, the manager was supported to visit other services to gain information about the wider care sector and the latest views on how dementia care could be provided. The information was used to plan improvements to the service at St Mary's. The manager cascaded their learning to other members of their team in meetings and staff briefings. The manager said, "We have been to visit other local dementia care facilities, to see how we can introduce facilities to stimulate and interest our residents."

We spoke with staff about the culture of the home. We had mixed feedback from staff. One staff member told us, "We are providing good care to people. I feel supported in my role." Another staff member told us, "The communication between management and staff could be better." We spoke with the manager about these comments. They told us they were now conducting 'exit' interviews with staff if they decided to leave the home to discover their reasons for leaving, so that areas that might require improvement could be identified. The manager said, "Our senior nurses have also begun to meet weekly with the clinical lead nurse to improve communication and leadership."

Staff had regular meetings with the manager and other senior team members, to discuss how things could be improved. Staff meetings were planned each month, and included invitations for all staff at the home to attend. An agenda for each meeting was drawn up before the meeting, which staff could input into. One staff member told us, "We are asked to submit items we want to discuss at the team meetings." A recent meeting record showed staff had discussed the needs of people in their care, vacancies, and how to improve handover arrangements. Staff told us they had an opportunity to raise any concerns they had, or provide feedback and ideas about how the service could be improved. Where staff had made suggestions, the manager had acted to implement improvements.

People could provide feedback about how the service was run, which was acted on by the provider. The manager told us, and the PIR information confirmed, the manager encouraged feedback from people, visitors and relatives. The provider conducted annual surveys to gather feedback, there was a comments book in the reception area, and people were asked to complete regular feedback forms. We saw that feedback was analysed and where the provider could make improvements, things were acted upon. For example, recent feedback had generated a request for the type of fish living in the fish tank to be changed. People told us this was being implemented.

The provider had sent notifications to us about important events and incidents that occurred at the home. The manager also shared information with local authorities and other regulators when required, and kept us informed of the progress and the outcomes of any investigations. Where investigations had been required, for example in response to accidents, incidents or safeguarding alerts, the manager completed an investigation to learn from these incidents. The investigations showed the manager made improvements, to minimise the chance of them happening again.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing (1) The provider was not ensuring there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the needs of service users.