Blakeshields Limited

St Margarets Nursing Home

Inspection report

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Date of inspection visit:
05 December 2017

Date of publication:
08 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 5 December 2017. The last two inspections, which took place on 17 May 2016 and 20 October 2016 found the service to be in breach of the legal requirements. The service was rated as Requires Improvement at the last inspection. At both inspections we identified very hot water running from the taps in people's ensuite bathrooms and communally used toilets, posing a scalding risk to people using the hot water. In May 2016 one person's bedroom door closed shut very quickly and heavily posing a risk of injury to the person using this room. In May and October 2016 we identified there were a number of fire doors to people's bedrooms that were propped open with door wedges. This placed people at risk in the event of a fire near to their bedroom. We advised the service to fit devices to the fire doors which allow the doors to be held open when needed but close when the fire alarm sounds. In October 2016 we identified that staff were not supported with regular supervision, appraisal, staff meetings and regular training updates in mandatory subjects such as infection control and health and safety.

Following the last inspection the service sent us an action plan stating what action it was taking to meet the requirements of the regulations. This inspection visit was planned to check on the action the service had taken to meet the requirements of the regulations.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. St Margarets is a care home which offers care and support for up to 28 predominantly older people. At the time of the inspection there were 26 people living at the service. Some of these people were living with dementia. The service uses a detached house over two floors with a passenger lift for people to access the upper floor.

At this inspection we again found very hot water coming from the taps in the ensuite bathrooms of two people who used the hot water in their rooms independently. We also found very hot water coming from the taps in a communally used bathroom. Signs throughout the service stated the water was very hot and in a shower the sign stated the hot water posed a scald risk.

At this inspection we identified a person's bedroom door was slamming shut quickly and heavily. The door closure device was faulty. This was the same bedroom door identified as a concern at the May 2016 inspection. This door was not being held open by the device which was connected to the fire alarm system, which closed in the event of a fire, but by an ornament which would not allow the door to close in an emergency. This put the disabled person in this bedroom at risk.

At this inspection we found people's bedroom doors continued to be held open by items other than fire system devices. One person, whose door was wedged open by furniture, was using oxygen in their room, there was no door guard on the door and no sign on their door to alert people to the use and storage of oxygen in their room. This meant the person was at considerable risk in the event of a fire.

Staff told us there were not sufficient numbers of appropriate sized moving and handling slings for all the people who needed them at St Margarets. Nine people were sharing slings. Some people required large sized slings which were not available to them. This meant people were at risk of not being moved safely and appropriately. Sharing slings does not protect people's dignity and is a cross infection risk.

Slings were hung together on hooks in the corridor. Staff hung their outside coats, scarves and jumpers on these same hooks. This increased the risk of cross infection. Open bins, without lids, were used for food waste in the dining room. Staff also used this bin for their soiled gloves and aprons. Open bins without lids were also found in toilets, overflowing with used paper towels.This also posed a risk of cross infection.

Sluice rooms were found open and containing substances hazardous to people's health. The medicines room was found open and unattended. There were people living at the service who were independently mobile and living with dementia, this meant they were at risk of accessing items which could pose a risk to them.

Recruitment checks for new staff were not robust. One member of staff, who had been working at the service for six months, had not had all the appropriate recruitment checks carried out by the previous registered manager. There was no current Disclosure and Barring Check held by the service to ensure the person was safe to work with vulnerable people.

Some people living at St Margarets were living with dementia. Some were able to walk around the service independently. However, there was no pictorial signage at the service to support people who may require additional support with recognising their surroundings. One communally used toilet did not have a lock on the door. This meant people's privacy was not protected.

There were systems in place for the management and administration of medicines. People had received their medicine as prescribed. Regular medicines audits were being carried out on specific areas of medicines administration and these were effectively identifying if any error occurred such as gaps in medicine administration records (MAR).

The premises, equipment and services were regularly checked and maintained by a maintenance person or other competent people. However, the hot water and door closure concerns found at this inspection had not been highlighted by these checks.

We walked around the service which was comfortable and appeared clean with no odours. People's bedrooms were personalised to reflect their individual tastes. People were treated with kindness and compassion.

Staff were supported by a system of induction training, supervision and appraisals. People were supported by staff who knew how to recognise abuse and how to respond to concerns. The service held appropriate policies to support staff with current guidance. Mandatory training was provided to all staff with regular updates provided. The manager had a record which provided them with an overview of staff training needs.

The service had identified the minimum numbers of staff required to meet people's needs and these were being met. The service had no staff vacancies at the time of this inspection.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005. The principles of the Deprivation of Liberty Safeguards were understood and applied correctly.

Meals were appetising and people were offered a choice in line with their dietary requirements and preferences. However, pureed meals were not presented in an appetising way. All the meal was mixed up together to a brown consistency instead of each component of the meal being pureed separately. Staff were available to support people to eat if required. We noted that some people had their clothes protectors left on throughout the morning, and for some time after breakfast. This did not protect their dignity.

Care plans were well organised and contained accurate and up to date information. Care planning was reviewed regularly and people's changing needs were recorded. Daily notes were completed by staff.

People had access to activities. An activity co-ordinator was not in post but care staff co-ordinated activities. On the day of this inspection school children came to entertain people. People were supported to go out on trips in to the local community.

The day to day running of the service was overseen by a deputy manager, who was supported by the registered manager and an administrator. The registered manager visited the service regularly as they were also the registered manager for another service. The service had a team of happy, motivated and many long standing staff.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 safe.There were infection risks where staff hung their clothing along with communally shared moving and handling slings. Bins without lids contained food waste, used gloves and aprons an used paper towels.

There were not sufficient numbers of the correct size moving and handling slings to meet people's needs.

Recruitment processes were not robust. One member of staff had been working for six months without appropriate recruitment checks having been carried out.

There were sufficient numbers of suitably qualified staff to meet the needs of people who used the service.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not effective. There was very hot water coming from taps used by people in their en suite bedrooms. Fire doors were not held open by effective fire system linked devices. Fire doors were wedged open by furniture and would not close in the event of a fire.

Staff were well trained and supported with regular supervision and appraisals.

The management had a clear understanding of the Mental Capacity Act 2005 and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected.

Is the service caring?

Good

The service was caring. People who used the service, relatives and healthcare professionals were positive about the service and the way staff treated the people they supported.

Staff were kind and compassionate. However, people had to share moving and handling slings communally and this did not

respect their dignity. Some people did not have the correct size sling for their comfort and safety.

Staff respected people's wishes and provided care and support in line with those wishes.

Is the service responsive?

Good

The service was responsive. People received personalised care and support which was responsive to their changing needs.

People were able to make choices and have control over the care and support they received.

People knew how to make a complaint and were confident if they raised any concerns these would be listened to.

People were consulted and involved in the running of the service, their views were sought and acted upon.

Is the service well-led?

Requires Improvement

The service was not well-led. Repeated concerns found at the last two inspections remained at this inspection. Governance checks had not been effectively implemented and monitored to address the concerns found at the last two inspections.

Maintenance checks were not robust.

Recruitment checks were not robust.

People were asked for their views on the service.

Staff were supported by the management team.

St Margarets 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 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.

The inspection took place on 5 December 2017. The inspection was carried out by one adult social care inspector and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service. Their area of expertise was in older people's care.

Before the inspection the provider completed a Provider Information Return (PIR). This 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 reviewed the PIR and other information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with eight people living at the service. Not everyone we met who was living at St Margarets was able to give us their verbal views of the care and support they received due to their health needs. We looked around the premises and observed care practices. We spoke with six staff. We spoke with four visitors and an external healthcare professional.

We used the Short Observational Framework Inspection (SOFI) over the lunch time period. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at care documentation for two people living at the service, medicine records for 26 people, four staff files, training records and other records relating to the management of the service.

Following the inspection we spoke with one family of a person living at the service, one member of staff and an external healthcare professional.

Requires Improvement

Is the service safe?

Our findings

In a corridor of the service, staff hung their coats, and other clothing on hooks which were also used to hold people's moving and handling slings. When we raised this risk of cross infection with the staff this clothing was removed and put in a cupboard. However, when the next shift arrived they hung their clothing on the same hooks again. This meant it was common practice for staff to use these hooks for their coats and the concern we raised had not been effectively communicated to the next shift when they arrived at 2 pm on the day of this inspection and the infection risk persisted.

Some people had their own named slings, however a number of slings, used by staff to move people, were not named for individual use and staff confirmed nine people shared slings communally. Staff told us they did not have sufficient suitable slings for every one living at the service. Staff told us they had people who required large size slings which the service did not have access to. Another member of staff had carried out an audit of the slings available and raised the need for different sized slings to suit everyone at the service. There was no evidence slings were correctly assessed for individuals use to ensure they were moved safely and in comfort.

There were bins in use at the service which did not have lids. One bin in the dining room, which was used for food waste, was also used by staff for soiled aprons and gloves. Other bins were seen overflowing with paper towels, in communally used bathrooms and toilets, which did not have lids. This posed an increased risk of cross contamination and infection.

The medicine room was found unlocked and unattended for several minutes during the inspection. Two sluice rooms were unlocked throughout the inspection, one contained a product which contained a substance hazardous to health. This meant people who were living with dementia and moving around the service independently could access items that posed a risk to them.

Recruitment systems were mostly effective and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and the provision of two references. However, one member of staff, who had been working at the service for six months, did not have an appropriate DBS check in place and had to be suspended from work until this had been carried out. All other staff were appropriately recruited.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service held an appropriate medicines management policy. There were medicine administration records (MAR) for each person. Staff completed these records at each dose given. From these records it could be seen that people received their medicines as prescribed. We saw staff had transcribed medicines for people, on to the MAR following advice from medical staff. These handwritten entries were signed and had been witnessed by a second member of staff. This meant that the risk of potential errors was reduced and helped ensure people always received their medicines safely. Some people had been prescribed creams and these had been dated upon opening. This meant staff were not aware of when the item would no longer

be safe to use. The service was holding medicines that required stricter controls. The records held tallied with the stock held at the service. Records of people's medicines went with them when they went to hospital.

St Margarets were storing medicines that required cold storage and there was a medicine refrigerator at the service for this purpose. There were records that showed medicine refrigerator temperatures were monitored regularly to ensure the safe storage of these medicines could be assured.

Where people required to have their medicines crushed before administration the GP had given written and signed agreement for this to be done.

The service had suitable ordering, storage and disposal arrangements for medicines. Regular internal and external audits helped ensure the medicines management was safe and effective.

Some people required medicines to be given as necessary or occasionally. There were clear records to show when such medicine might be indicated and if it had been effective.

Staff training records showed all staff who supported people with medicines had received appropriate training. Staff were aware of the need to report any incidents, errors or concerns and felt that their concerns would be listened to and action would be taken.

Equipment used in the service such as moving and handling aids and passenger lifts, were regularly checked and serviced by professionals to ensure they were always safe to use. The necessary safety checks and tests had been completed by appropriately skilled external contractors.

All the people we spoke with told us they felt safe living at St Margarets. Comments included, "I feel safe because they make sure I have my call bell by my side," "I feel very happy and safe living here" and "Staff pop in to make sure I'm okay." Relatives told us, "The staff are so helpful to my husband" and " My relative never looks worried about anything."

The service held an appropriate safeguarding adults policy. Staff were aware of the safeguarding policies and procedures. Safeguarding was regularly discussed at staff meetings. Staff were confident of the action to take within the service, if they had any concerns or suspected abuse was taking place. Staff had received recent training updates on Safeguarding Adults and were aware that the local authority were the lead organisation for investigating safeguarding concerns in the county. There were "Say no to abuse" leaflets displayed in the service containing the phone number for the safeguarding unit at Cornwall Council. This provided information to people, their visitors and staff on how to report any concerns they may have. People were asked for their views about if they felt safe at the service. If people were involved in safeguarding enquires or investigations they would be offered an advocate if appropriate or required.

The service had a whistleblowing policy so if staff had concerns they could report these and be confident of their concerns being listened to. Where concerns had been expressed about the service, if complaints had been made, or if there had been safeguarding investigations the management said they investigated these issue to help ensure people were safeguarded from the risk of abuse.

The service held a policy on equality and diversity, this was in the process of being introduced to the staff so that they were aware of this legislation. Staff were not yet provided with training on equality and diversity but this was planned in the near future. This would help ensure that staff were aware of how to protect people from any type of discrimination. Staff were able to tell us how they helped people living at the service

to ensure they were not disadvantaged in any way due to their beliefs, abilities, wishes or choices. For example, if people were poorly sighted staff would read things out to them or support them to recognise where they were in the service. One person's family had been provided with information on how to access talking books, as they enjoyed reading but could no longer do this due to their healthcare needs.

The management understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these as necessary. Staff told us if they had concerns management would listen and take suitable action. If the service had concerns about people's welfare they liaised with external professionals as necessary, and had submitted safeguarding referrals when it was felt to be appropriate. Staff were clear about people's rights and ensured any necessary restrictions were the least restrictive.

Accidents and incidents that took place in the service were recorded by staff in people's records. Such events were audited by the manager. This meant that any patterns or trends would be recognised, addressed and the risk of re-occurrence was reduced.

Risk assessments were in place for each person for a range of circumstances including moving and handling, nutritional needs and the risk of falls. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately in order to minimise risk and keep people safe whilst maintaining as much independence as possible. Assessments also helped determine what equipment was required and how many staff were needed to support a person safely.

Care records were stored securely but accessible to staff and visiting professionals when required. They were accurate, complete, legible and contained details of people's current needs and wishes.

The staff shared information with other agencies when necessary. For example, when a person was admitted to hospital a copy of their contact sheet and medicine records was sent with them. The service did not routinely send copies of care plans to the hospital when admissions were unplanned as there was not time to prepare these. However, when admissions were planned the service ensured the hospital were provided with the necessary information.

We looked around the building and found the environment was clean and there were no unpleasant odours. The service had arrangements in place to ensure the service was kept clean. Staff received suitable training about infection control, and records showed all staff had received this. Staff understood the need to wear protective clothing (PPE) such as aprons and gloves, where this was necessary. We saw staff were able to access aprons, hand gel and gloves and these were used appropriately throughout the inspection visits. However, these were not always appropriately disposed of.

Relevant staff had completed food hygiene training. Suitable procedures were in place to ensure food preparation and storage met national guidance. The Food Standards Agency awarded the service a four star rating. Actions required had been completed and the service were awaiting a further inspection from this agency.

Each person had information held at the service which identified the action to be taken for each person in the event of an emergency evacuation of the premises. Firefighting equipment had been regularly serviced. Fire safety drills had been regularly completed by staff who were familiar with the emergency procedure at the service.

People's needs were reviewed regularly and this informed dependency scores for each person. This helped ensure there were sufficient staff planned to be on duty to meet people's needs. The staff team had an

appropriate mix of skills and experience to meet people's needs. During the inspection we saw people's needs were usually met quickly. We heard bells ringing during the inspection and these were responded to effectively. We saw from the staff rota there were four care staff, a senior and a nurse on duty supported by a member of the management team on each shift. Staff told us they felt they were a good team and worked well together, morale was good and staff felt the management was very supportive.

The management was open and transparent. We were told management was always available for people, relatives, staff and healthcare professionals to approach them at any time. The management understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these as necessary. Staff told us if they had concerns the management team would listen and take appropriate action. The manager said if they had concerns about people's welfare they liaised with external professionals as necessary, and would submit safeguarding referrals if it was felt to be appropriate

Requires Improvement

Is the service effective?

Our findings

At the May 2016 inspection we identified very hot water running from the taps in people's ensuite bathrooms and the basin in a separate toilet in the upstairs corridor. There were signs above each sink stating, "Caution very hot water." At the October 2016 inspection we were told regular checks of the hot water temperatures throughout the service were carried out. However, we again found very hot water continuing to run from taps used by people who were at risk of being scalded. On the second day of that inspection visit the maintenance person had addressed the concern and the temperature of the water had reduced a little.

At this inspection we again found very hot water running from the taps in people's ensuite bathrooms and communal bathrooms. We used the thermometer, which staff used to check the temperature of the hot water, and it was above the recordable levels of this device, which was over 50 degrees centigrade. Some people used their ensuite bathrooms independently. These people were living with a varying degree of physical and mental impairment which meant they were at increased risk from being scalded by very hot water. There was a typed red sign in a communal shower room which stated the hot water posed a scald risk. We raised this concern with the administrator at the feedback session of this inspection. They contacted us two days after the inspection visit and told us, "We found that a zone valve was faulty, it was staying open and not shutting the hot water down which would account for the water being over temperature. We obviously do not know when this fault occurred. This has been replaced and also cylinder stats renewed just in case of any further faults." This meant that regular checks of the hot water system were not being carried out effectively, as the service told us they did not know when the fault had occurred.

At the May 2016 inspection we identified a fire door to a person's bedroom slammed shut very quickly and loudly. This posed a risk of injury to people using this door. In October 2016 we found this concern had been addressed .

At this inspection we identified the same bedroom door was again slamming shut quickly and heavily. The person using this room was at potential risk of injury. The door guard fitted to this door was not working effectively. The door was not being held open by the device connected to the fire alarm system which closed in the event of a fire. Staff were using an ornament to hold the door open. The maintenance person told us the door guards were regularly checked but they were not aware this one was not functioning correctly. We raised this concern with the service at the time of this visit. Two days later the service told us that a replacement door closure had been fitted and that the door now closed slowly and safely.

At the May 2016 inspection we found a number of fire doors to people's bedrooms were wedged open. We advised the service this was not safe. Following the May 2016 inspection the service sought the advice of the fire service and commissioned a private fire prevention consultant. Both agencies produced reports clearly stating that all the door wedges should be removed immediately and replaced by an automatic closing device linked to the fire alarm. At the October 2016 inspection we identified a number of fire doors to people's bedrooms continued to be propped open with door wedges. These rooms were occupied by vulnerable people who were confined to bed due to their healthcare needs. Following the October 2016 inspection the provider assured us that a further risk assessment was to be carried out to identify how many

bedroom doors were required to be held open most of the time. We were given assurances that doors that were required to be held open at times would be fitted with door guards.

At this inspection we found people's bedroom doors continued to be held open by ornaments and furniture. One person was having oxygen therapy in their room, their healthcare needs meant they would not be able to independently raise the alarm or leave their room unsupported in the event of an emergency. The fire door to their bedroom was held open by a piece of furniture. There was no door guard on this bedroom door and no sign on their door to alert people to the use and storage of oxygen in their room. This meant the person was at considerable risk in the event of a fire.

The registered persons had not taken effective action to address the risks to people's safety. The registered persons not carried out the action they had assured us they would following the last two inspections.

There was an upstairs corridor fire exit opening out on to a fire escape with open stairs down to the street, was marked 'Please Keep Locked' but the door was unlocked. People living on this corridor could walk independently and were able to leave the building via this door unnoticed. We reported our concerns to the local fire service.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we have told the provider to take at the end of this report.

People's needs and choices were assessed before moving to the service. This helped ensure people's needs and expectations could be met by the service. People were asked how they would like their care to be provided. This information was the basis for their care plan which was created during the first few days of them living at the service.

The use of technology to support the effective delivery of care and support and promote independence was limited. People had call bells in their rooms which they used to call for assistance from staff. We were told there was one pressure alarm mat at the service which was not being used.

Training records showed most staff were provided with mandatory training and regular updates. Staff had also undertaken a variety of further training related to people's specific care needs such as dementia care. Three nurses did not have any training recorded regarding the Mental Capacity Act and associated Deprivation of Liberty Safeguards. We were told this was due to be addressed in the near future.

Staff demonstrated a good knowledge of people's needs and told us how they cared for each individual to ensure they received effective care and support. Staff told us the training they received was good. One commented, "We have a good skill mix here, we are a good team."

Newly employed staff were required to complete an induction when they started work. This included training identified as necessary for the service and familiarisation with the organisation's policies and procedures. The induction was in line with the Care Certificate is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone.

Staff received support from the management team in the form of supervision and annual appraisals. They told us they felt well supported by the manager and were able to ask for additional support if they needed it. Staff meetings were held to provide staff with an opportunity to share information and voice any ideas or

concerns regarding the running of the service.

People told us they did not feel they had been subject to any discrimination, for example on the grounds of their gender, race, sexuality or age. The service had an equality and diversity policy in place. However, staff were not being provided with training on the legislation at the time of this inspection. We were told us this would be reviewed to ensure staff had the necessary awareness to help protect people who lived at the service from the risk of discrimination.

Staff regularly monitored people's food and drink intake to ensure all residents received sufficient each day. People's weight was regularly checked to ensure they had sufficient food. People told us, "The chef is a good cook," "The food is more than adequate " and "There's always something I like on the menu." A relative told us, "Although my relative doesn't have a big appetite, he enjoys what he has."

We spoke with the chef who was knowledgeable about people's individual needs and likes and dislikes. They made a point of meeting people in order to identify their dietary requirements and preferences. Where possible they tried to cater for individuals' specific preferences. Some people had been assessed as needing pureed food due to their healthcare needs. On the day of this inspection meals were provided all mixed together as one colour. It was not presented as separate foods and colours on the plate to help the meal look appealing and to help people to see what they were eating.

The service had a good working relationship with the local GP practices and district nursing teams. Other healthcare professionals visited to see people living at St Margarets when required. We saw people had seen their optician and podiatrist as necessary. The dentist was visiting to treat people during this inspection visit.

People were encouraged to be involved in their own healthcare management. Some people were encouraged to be independent in their own use of prescribed inhalers. When people were visiting hospital the service ensured that records of people medicines went with them along with the front page contact sheet from their care plan.

The service had a maintenance person. The décor and floor coverings were mostly in good condition. Some people living at St Margarets were living with dementia and were independently mobile around the building. They required additional support to recognise their surroundings. There was little pictorial signage which clearly identified specific rooms such as toilets and shower rooms. Most bedrooms only had a number on them, this did not help people with dementia to find and recognise their own rooms independently.

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. The service held an appropriate MCA policy and most staff had been provided with training in this legislation.

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). 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 service had applied for some people to have authorised restricted care plans. However, there were no capacity assessments held on people's care files to demonstrate that a formal capacity assessment had always been carried out before the DoLS application was made. We were assured this

would be addressed by the registered person and they would make arrangements for such assessments to be completed immediately. No DoLS authorisations were in place at the time of this inspection.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People chose when they got up and went to bed, what and then they ate and how they spent their time. People were able to go out in the grounds and local area as they chose. Some people required support to do this and this was provided by staff. There was also secure outside spaces that people could enjoy.

The management were not aware which people living at St Margarets had appointed lasting powers of attorney to act on their behalf when they did not have the capacity to do this for themselves. We were told that one person had a solicitor acting for them. There were no details of who may have legal powers to act on behalf of people living at the service recorded in their care files. There was little evidence of people, or if appropriate their family, being involved in their own care plan reviews. Consent forms were not always signed. In one instance a nurse had signed consent on behalf of a person who could not sign for themselves, which is not legal.

We recommend the service seek appropriate guidance from the Mental Capacity Act 2005 Code of Practice.

Good

Is the service caring?

Our findings

People's dignity and privacy was mostly respected. Staff provided people with privacy during personal care and support ensuring doors and curtains were closed. Staff were seen providing care in an un-rushed way, providing explanations to people before providing them with support and ensuring they were calm throughout. People and relatives told us staff were kind and caring. However, two people were seen throughout the morning sat in the lounge area with a clothes protector around their neck, they had finished their meal some time earlier. A communal toilet door did not have a lock on the door, therefore did not provide privacy and dignity for people using the toilet. Some people required the use of moving and handling slings. Slings are specifically assessed for each person by healthcare professionals. Slings were provided, but not all were named solely for individuals use and were shared. This did not protect people's dignity. Some people required larger slings than were available at the service. This has been covered in greater detail in the Safe section of this report.

People and their relatives were positive about the attitudes of the staff and management towards them. People were treated with kindness, respect and compassion. They told us, "The staff are not bad at all," "I can have a shower or a wash whenever I want," and "You can do anything you want here." Relatives were also positive, saying, "I can assure you there are no visiting restrictions, I can come at any time and stay as long as I want" and "The staff make us feel welcome."

People said they were involved in their care and decisions about their treatment. They told us staff always asked them before providing any care and support if they were happy for them to go ahead. People were encouraged to make decisions about their care, for example what they wished to wear, what they wanted to eat and how they wanted to spend their time.

During the day of the inspection we spent time in the communal areas of the service. Throughout the inspection people were comfortable in their surroundings with no signs of agitation or stress. People appeared clean and well cared for. Staff were kind, respectful and spoke with people considerately. We saw relationships between people were relaxed and friendly. People told us, "The staff are very friendly" and "Staff are quite entertaining."

When people came to live at the service, we were told the manager and staff asked people and their families about their past life and experiences. This way staff could have information about people's lives before they lived at the service. This is important as it helps care staff gain an understanding of what has made the person who they are today. Information in care plans about people's past lives was variable. Staff were able to tell us about people's backgrounds and past lives.

Care files and information related to people who used the service was stored securely and accessible by staff when needed. Care files and confidential information were stored in lockable cupboards and filing cabinets. This meant people's confidential information was protected appropriately in accordance with data protection guidelines. The office door lock was jammed in the open position which meant the office could not be secured when not in use. We were assured this would be addressed immediately.

Bedrooms were decorated and furnished to reflect people's personal tastes. People were encouraged to have things they felt were particularly important to them and reminiscent of their past around them in their rooms.

Visitors told us they visited regularly at different times and were always greeted by staff who were able to speak with them about their family member knowledgeably.

People and their families were involved in decisions about the running of the service as well as their care. Relatives were invited to attend meetings regularly. A survey had been sent out to families in September 2017. The responses to this survey were fairly positive.

The service had held residents meetings which provided people with an opportunity to raise any ideas or concerns they may have. We saw the minutes of these meetings. Activities and staffing were discussed along with meals. This meant the service sought the views and experiences of people who used the service, their families and friends.

Good

Is the service responsive?

Our findings

People had access to some activities both within the service and outside. There were little pre-planned activities. A poster only advertised 'Armchair Exercise' every Tuesday afternoon. On inspection of the activity record book a small amount of activities were recorded. In the month of August only one activity had been recorded. We were told bus trips were arranged on a fortnightly basis which appeared popular, although these were not always recorded.

On the day of this inspection a local school choir attended in the afternoon to sing Christmas Carols in the lounge.This was well attended by people who appeared to thoroughly enjoy it by singing along and clapping.

People told us, "I just like to sit and watch television in the lounge," "I would like it if there was more going on," "I enjoy going out on the bus trips" and "I can take or leave the activities." Relatives told us, "Theres not much to do but I don't think Dad minds " and "Dad enjoys his own company." The recent survey feedback showed a third of the people who responded were not very satisfied with the activities provided at St Margarets. An activities co-ordinator was not employed, but a member of the care staff organised some activities. They told us they came in on their day off to have the time to arrange activities. It was unclear how the service was planning to respond to people's views on activities provided at St Margarets.

We recommend the service identify appropriate resources to ensure people are provided with planned meaningful activities.

Some people chose not to take part in organised activities and therefore could be at risk of becoming isolated. One person told us, "I don't want to join in the activities, I like my own company in my room." During the inspection we saw some people either chose to remain in their rooms or were confined to bed because of their health needs. We saw staff checked on people and responded promptly to any call bells.

Some people required specialist equipment to protect them from the risk of developing pressure damage to their skin. Air filled pressure relieving mattresses were provided. There were four mattresses which were checked at the time of this inspection. They were all set incorrectly for the person using them. We spoke with nurse about this who confirmed there was no regular check of these devices but that this would be put in place. No one at the service was experiencing any skin damage due to pressure. We judged this had not had any impact on people's well being at the time of this inspection.

We recommend that the service seek reputable guidance about the regular monitoring and management of pressure relieving mattresses.

Some people were unable to easily access written information due to their healthcare needs. Staff supported people with this, for example, menu choices were discussed each day with people, for the next days meals. Staff went through the menu to help people to make a choice. One person used to enjoy reading. They were unable to do this now so their family had been given information by staff about talking

books and how to obtain them. The family member told us they needed support to provide such items for the person and this had not been followed up. It was unclear if this assistance was going to be followed up. Another person who could not verbally communicate had a care plan which stated they used picture and word cards to ease communication. We were told the person did not use these but staff knew the person well and could work out what the person was trying to say.

Some people required to be re-positioned regularly by staff. Staff completed records each time this care and support was provided. Although there were some gaps in these records we judged people were receiving appropriate care but that staff were not always appropriately recording when they had provided care.

Some people told us they felt involved in their own care and the running of the service. Some people recalled attending residents meetings where their views and experiences were sought.

People who wished to move into the service had their needs assessed to ensure the service was able to meet their needs and expectations. Each person had a care plan that was tailored to meet their individual needs. Care plans contained information on a range of aspects of people's support needs including mobility, communication, nutrition and hydration and health. The care plans were regularly reviewed. District nurses visited some people living at St Margarets and told us they had no concerns about the care provided at the service.

Care plans provided staff with sufficient guidance and direction to meet individuals needs. One person was unable to verbally communicate, their care plan stated, "Ensure (person's name) has her call bell." Another person required a specific dietary regime and the details of this were clear and provided information for staff to ensure they had sufficient food.

Daily notes were consistently completed and enabled staff coming on duty to get a quick overview of any changes in people's needs and their general well-being. People had their health monitored to help ensure staff would be quickly aware if there was any decline in people's health which might necessitate a change in how their care was delivered. This meant people's changing needs were met.

Staff were able to tell us detailed information about people's current needs as well as their backgrounds and life history.

There was a staff handover meeting at each shift change this was built into the staff rota to ensure there was sufficient time to exchange any information. Handover information shared helped ensure there was a consistent approach between different staff and this meant that people's needs were met in an agreed way each time.

People were supported by staff to maintain their personal relationships. This was based on staff understanding who was important to the person, their life history, their cultural background and their sexual orientation. Visitors were always made welcome and were able to visit at any time.

People and families were provided with information on how to raise any concerns they may have. Details of the complaints procedure were contained in the complaints policy. People told us they had not had any reason to complain. We saw concerns that had been raised to the manager had been investigated fully and responded to in an appropriate time frame. All were resolved at the time of this inspection.

People were supported at the end of their lives to have a comfortable, dignified and pain free death. The service had in the past arranged for medicines to be held at the service to be used if necessary to keep

people comfortable. Where appropriate people had an end of life care plan which outlined their preferences and choices for their end of life care. The service consulted with the person and, where appropriate, their representatives about the development and review of this care plan.

The service had good links with GP's and the district nursing service to ensure people received suitable medical care during this period of their lives.

Requires Improvement

Is the service well-led?

Our findings

There was a system of checks carried out at St Margarets to ensure that quality in all areas of the service were checked. Care plans and medicines were regularly audited. However, we found the premises checks had not effectively and consistently addressed concerns about fire doors and hot water temperatures.

A staff member who had been working for six months at St Margarets did not have all the appropriate recruitment checks carried out before they began working alone with vulnerable people. This had not been identified prior to this inspection.

Infection control concerns found at this inspection had not been identified by the maintenance checks. Bins without lids containing food waste, used gloves, aprons and used paper towels were seen in places and were overflowing. Staff routinely hung their coats and jumpers together with communally used moving and handling slings. People had to share slings due to the service not having sufficient slings to allow each person to have their own named sling. There were no large slings available. Staff told us this concern had been identified and reported. A member of staff had carried out an audit of slings available at the service and what additional slings were required to ensure people were always moved safely and comfortably. This had been passed to the management of St Margarets. We were told no action had been taken to address this concern at the time of this inspection.

The survey responses of September 2017 from people using the service were mostly positive however, some people had expressed dissatisfaction with activity provision at St Margarets.

Lessons had not been learned from requirements issued by CQC following the last two inspections. The service was not effectively assessing, monitoring and mitigating the risks relating to the health and safety and welfare of people using the service. It was not acting on feedback given by CQC, staff and people living at the service for the purposes of continually evaluating and improving the service it provides at St Margarets Nursing Home.

This is a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had two registered managers. There had been a recent departure of one registered manager and this was being covered by a deputy manager who ran St Margarets on a day to day basis. The second registered manager also had oversight of St Margarets, but was also the registered manager for the sister home in the group, where they spent the majority of their time. Neither managers were present at this inspection. We spent time with the administrator who provided us with all the information we required.

The deputy manager was based the service so was aware of day to day issues. The deputy manager had

made themselves available so staff could talk with them, and be accessible to them.

Staff, seniors and nurses met regularly with the deputy manager, both informally and formally to discuss any problems and issues. Staff told us they felt the transition between one registered manager leaving and the deputy manager taking over had been seamless and had not raised any issues for them. Staff felt very well supported through one to one meetings and staff meetings. There were handovers between shifts so information about people's care could be shared, and consistency of care practice could be maintained. Staff enjoyed their work, they responded by saying, "I am very happy here, I love my work" and "We have amazing staff"

People told us they were happy with the service they received from St Margarets. They told us, "We have staff that work very hard," "I get on well with all the staff and the cook is a good laugh," "The laundry service is very good" and "We all get on together." Relatives told us the deputy manager was approachable and friendly. They told us, "We are always kept well informed about Dads health and welfare" and "The home is kept so clean and tidy."

There were systems in place to support all staff. Staff meetings took place regularly. These were an opportunity to keep staff informed of any operational changes. They also gave an opportunity for staff to voice their opinions or concerns regarding any changes.

Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service was notifying CQC of any incidents as required, for example expected and unexpected deaths. The previous rating issued by CQC was displayed. The deputy manager had raised issues relating to CQC inspections with staff. Staff had a clear understanding of their roles and responsibilities.

There was a clear management structure. The deputy manager was supported by the registered manager. However, the lines of accountability and responsibility both within the service and at provider level were not robust. This has been evidenced in the repeated concerns found at the past three inspections.

People and their relatives had recently been given a survey to ask for their views on the service provided at St Margarets. People responded by saying they felt the staff were skilled, communicated well, and responded to their wishes. Relatives felt able to visit at any time and were generally happy with the service provided.

People's care records were kept securely and confidentially, and in accordance with the legislative requirements. Staff and visiting healthcare professionals had access to these records as required.

Equipment such as moving and handling aids and lifts were regularly serviced to ensure they were safe to use. The environment was clean. People's rooms and bathrooms were kept clean.