Institute of Our Lady of Mercy

McAuley Mount Residential Care Home

Inspection report

Padiham Road
Burnley
Lancashire
BB12 6TG

Tel: 01282438071
Website: www.ourladyofmercy.org.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of McAuley Mount Residential Care Home on 12, 13 and 14 July 2017. The first day of the inspection was unannounced.

McAuley Mount Residential Care Home is located on the outskirts of Burnley, it is a two-storey purpose built care home set in its own grounds. The service is registered to provide accommodation and care for up to 26 people. The accommodation includes apartments, single en-suite bedrooms and single rooms without en-suite facilities. The communal rooms include a sun room, dining room, conservatory/lounge and a chapel. A passenger lift provides access to the first floor accommodation. The grounds are accessible to people using the service. There is car parking available next to the service. The philosophy of care at is underpinned by the Roman Catholic faith. The service specialises in providing personal care and accommodation for older people.

At the time of the inspection there were 26 people accommodated at the service.

The service was managed by 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.

At the last inspection on 22 and 23 October 2014 we found the service was meeting all the standards assessed and the service was rated Good. During this inspection we found there were no breaches of the regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. However we found there were some matters requiring improvement.

We found there were management and leadership arrangements in place to support the day to day running of the service. However comments from staff indicated there was discontentment about aspects of management

People made positive comments about the caring attitude of staff. During the inspection we observed staff interacting with people in a kind, pleasant and friendly manner and being respectful of people's choices and opinions.

There were some good processes in place to manage and store people's medicines safely. We found some improvements were needed and most of these were put right during the inspection.

People told us they felt safe at the service. Staff were aware of the signs and indicators of abuse and they knew what to do if they had any concerns about people's wellbeing and safety.

Arrangements were in place to ensure staff were properly checked before working at the service. There were

enough staff available to provide care and support. There were systems in place to ensure all staff received regular training and supervision.

Processes were in place to assess and plan for people's needs before they moved into the service. But we found the assessment process needed to improve to make sure people's needs were more effectively identified.

People had individual care plans and 'care passports' however we found progress was needed to ensure the design and content of the plans promoted a person centred approach.

People were supported with their healthcare needs and received appropriate medical attention. Changes in people's health and well-being were monitored and responded to.

People were happy with the variety and quality of the meals provided. We found various choices were available. Support was provided with specific diets. Drinks were readily accessible and regularly offered.

Arrangements were in place to promote the safety of the premises, this included maintenance, servicing and checking systems. We found the service to be very clean in the areas we looked at.

People were happy with the accommodation at the service. We found some areas had been upgraded and redecorated to provide for people's comfort and wellbeing.

The service was working within the principles of the Mental Capacity Act 2005. During the inspection we observed staff involving people in routine decisions and consulting with them on their individual needs and preferences.

There were opportunities for people to engage in a range of group and individual activities.
People were keeping in contact with families and friends. We found visiting arrangements were flexible.

People spoken with had an awareness of the service's complaints procedure and processes. They said they would be confident in raising concerns. However we found improvements were needed with the management of complaints.

Arrangements were in place to encourage people to express their views and be consulted about McAuley Mount Residential Care. People had opportunities to give feedback on their experience of the service. Processes were in place to check and monitor systems and practices. We found improvements were needed with processes for planning and developing the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff recruitment included the relevant character checks. There were enough staff available to provide safe care and support. Staff knew how to report any concerns regarding possible abuse and were aware of the safeguarding procedures.

We found there were some safe processes in place to support people with their medicines.

Risk assessments and risk management plans were in place to help protect people from harm. Processes were in place to maintain a safe environment for people who used the service.

Is the service effective?

Good

The service was effective.

People told us they enjoyed the food, their preferred meal choices and dietary needs were known and catered for. People's health and wellbeing was monitored and they were supported to access healthcare services when necessary.

People were supported to make their own decisions. The service was meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Processes were in place to develop and support staff in carrying out their roles and responsibilities.

Is the service caring?

Good

The service was caring.

We found the service had a friendly and welcoming atmosphere. People were supported to maintain contact with families and friends.

People made positive comments about the kind, caring attitude and friendliness of staff. We observed respectful and sensitive interactions between people using the service and staff.

People were supported to be as independent as possible. Their dignity, individuality and personal privacy was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Initial assessments and care plans needed some improvement, to promote a more personalised and responsive approach to care planning and care delivery.

People were offered a range of individual and group activities. Residents meetings were held to involve people in making group choices and decisions.

There were processes in place to manage and respond to complaints and concerns. However some improvements were needed to promote a more appropriate response to people's complaints and dissatisfaction.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People made positive comments about the management and leadership arrangements at the service. However we found staff morale and team work could be better.

There were processes in place to monitor the quality of people's experience at the service. We found that some of the checking, improving and planning systems could be better.

McAuley Mount Residential Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12, 13 and 14 July 2017. The inspection was carried out by one adult social care inspector.

Prior to the inspection the provider completed a Provider Information Return (PIR). This is an evaluation record that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make. We reviewed this this information and used it to make our judgments.

Before the inspection we reviewed the information we held about the service, including notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. We reviewed information from the local authority contract monitoring and safeguarding team. We used all this information to decide which areas to focus on during the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection we spoke with nine people who used the service and two relatives. We talked with a domestic assistant, two senior carers, three care assistants, the cook, deputy manager and the registered manager. We also spoke with the nominated individual and three visiting healthcare professionals.

We spent time with people, observing the care and support being delivered. We looked round the premises. We looked at a sample of records, including three care plans and other related documentation, two staff

recruitment records, complaints records, meeting record's, policies and procedures and quality assurance records.

Good

Is the service safe?

Our findings

The people we spoke with indicated they felt safe at the service. Their comments included, "I absolutely feel safe here," "It's secure. No-one can get in unless they are invited" and "I feel safe living here there are always people around. It has made me feel more confident."
They did express any concerns about how they were cared for and treated by the staff team. They said, "I have never felt frightened here," "I have never heard an angry word from staff" and "I feel safe. It's the way they look after you. They talk to you as if you are a friend." A relative said, "[My family member] is safe here."

We looked at how the service protected people from abuse and the risk of abuse. Staff spoken with expressed a good understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse. They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff confirmed they had received training and guidance on safeguarding and protecting adults. There were policies and procedures to support an appropriate approach to safeguarding and protecting people. Information on safeguarding adults at risk, including guidance from the local authority was on display in the service. Staff told us they were aware of the service's 'whistle blowing' (reporting poor practice) policy and expressed confidence in reporting any concerns. We discussed and reviewed some of the previous and ongoing safeguarding concerns and action taken with the registered manager.

We checked if the staff recruitment procedures protected people who used the service and ensured staff had the necessary skills and experience. We looked at the recruitment records of two members of staff. We found records had been kept of the applicant's response to interview questions. The required character checks had been completed before staff commenced work at the service and these were recorded. The checks included an identification check, clarification about any gaps in employment and obtaining written character references. An appropriate Disclosure and Barring Service (DBS) check had been completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Successful applicants were required to complete a health screening assessment. Arrangements were in place for new employees to undergo a probationary period to monitor their conduct and competence.

We reviewed how the service managed staffing levels and the deployment of staff. People spoken with felt that there were enough staff at the service. One person said, "I have never seen there not be enough staff, or staff not responding to people." During the inspection we found there were sufficient numbers of staff on duty to meet people's needs. We observed staff responding to people's requests and providing support, in a safe and timely way. One person told, "If I want anything I just need to ring my buzzer and they come." A visiting health professional commented, "I think there are enough staff. When I need assistance with [person using the service] they are there straight away. "

We looked at the staff rotas, which showed arrangements were in place to maintain consistent staffing levels. We noted agency staff were used quite frequently for holiday cover. The registered manager said that known agency workers were used where possible to help promote continuity of care. Care staff spoken

expressed differing views on the staffing arrangements. We received comments which indicated there were enough staff on duty. However issues were raised around the use of agency staff and the role of senior carers. The registered manager said staffing reviews were carried out in response to people's changing needs. We noted there was a dependency assessment process to monitor the level of support people needed and staffing levels had recently increased in the mornings. There was no structured staffing tool available to help determine appropriate safe staffing levels in response to people's needs, choices and the layout of the premises. However the registered manager told us a staffing tool was currently being researched.

We looked at the way the service supported people with their medicines. During the inspection we observed people being sensitively and safely supported with their medicines. People spoken with indicated they received their medicines appropriately and on time. One person told us, "They bring me my medicines on time. I have an idea what they are for, I have been told."

The service had a process in place to risk assess and plan for people choosing and able to self-administer their own medicines. One person told us, "I manage my own medicines I had had a full needs assessment." We found people's involvement and preferences were not routinely assessed. This meant there was a lack of information to demonstrate how decisions that people could not self-administer their medicines had been made. However the service was working towards ensuring the care planning process included this assessment.

We checked the procedures and records for the storage, receipt, administration and disposal of medicines. The processes included staff having sight of repeat prescriptions for checking prior to them being sent to the pharmacist. This was to ensure all the required items were included on the prescriptions.

There was a monitored dosage system (MDS) for medicines. This is a storage device provided and packed by the pharmacy, which places medicines in separate compartments according to the time of day. We found medicines were being stored safely and securely. Room and fridge temperatures were monitored in order to maintain the appropriate storage conditions. Arrangements were in place for the safe management and storage of controlled drugs, which are medicines which may be at risk of misuse. We checked one person's controlled drugs and found they corresponded accurately with the register. We noted people had secure facilities in their bedrooms where medicines could be stored.

The medicines administration records (MAR) included a medicines profile. This included a photograph of the person to assist with identification. The profile listed the prescribed items, people's specific support needs and any known allergies. We noted peoples prescribed medicines were not routinely included in people's care plan records. This implied the use of medicines was not effectively included within the care planning process. The registered manager commenced action to rectify this matter during the inspection.

The MAR provided clear information on the name and strength of the medicines and dosage instructions. The records we looked at were mostly clear, up to dated and appropriately kept. We noted one example where the 'key code' had not been appropriately used to explain and clarify the administration process; the registered manager was to pursue this matter. We found there were specific protocols for the administration of medicines prescribed "as necessary" and "variable dose" medicines. The protocols are important to ensure staff were aware of the individual circumstances when this type of medicine needed to be administered or offered. Processes were in place for care staff to sign in confirmation of the application of people's external medicines, such as topical creams. There were recording charts with 'body map' diagrams for care staff to refer to and complete.

The service had a stock of 'homely remedies', this meant people would benefit from access to 'over the counter medicines' in a timely way.

Staff had access to a range of medicines policies and procedures which reflected nationally recognised guidance. Information leaflets were available for each of the prescribed items. Records and discussion showed staff responsible for medicines management had received various levels of training. We looked at records which demonstrated staff had been appropriately competency assessed in undertaking this task. There were weekly checks and monthly audits of medicine management practices; action plans were devised to appropriately rectify any discrepancies.

We looked at how risks to people's individual safety and well-being were assessed and managed. Individual risks were considered as part of the care planning process. The risk assessments included: dependency, skin integrity, malnutrition and risk of falls. Strategies had been drawn up in care records to guide staff on how to monitor and respond to identified risks. The assessments were kept under review monthly or earlier if there was a change in the level of risk. Referrals were made to relevant health and social care agencies as appropriate. Each person had a personal emergency evacuation plan in the event of emergency situations. There were separate risk assessments to support independence, including people accessing the community and the safe use of equipment such as kettles.

We reviewed the processes in place to maintain a safe environment for people who used the service, visitors and staff. One relative commented, "The upkeep of the home is really good. I am really happy with things." Health and safety checks were carried out on the premises on a regular basis. There were accident and fire safety procedures available. There were contingency arrangements to be followed in the event of emergencies and failures of utility services and equipment. Records showed arrangements were in place to check, maintain and service fittings and equipment, including electrical safety, water quality, water temperatures, fire extinguishers, hoists and the passenger lift. We found fire safety risk assessments were in place. Fire drills and fire equipment tests were being carried out.

Good

Is the service effective?

Our findings

The people we spoke with were very satisfied with the care and support they experienced at McAuley Mount Residential Care Home. They told us, "It's alright. It's a nice place," "It's going very well" and "I'm glad to be here." One health care professional told us, "I think on the whole things are okay. They are good with the service users," another said, "People here are well looked after."

During the inspection we observed staff regularly consulting with people on their individual needs and preferences. There were instances where staff involved people in routine decisions and sought their consent to provide care and support. One person told us, "They talk me through things with me." Some people spoken with were aware of their care plans and indicted they were asked about matters affecting them, including their care needs and choices. They said, "We went through it and I signed it everything is okay" and "I have signed my care plan, we talked about it."
We noted examples in the records we reviewed, of people signing in agreement with care plans which confirmed their consent to care.

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

We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met. The registered manager explained the service's approach to assume people had capacity. However action was ongoing to clarify and strengthen this response, by routinely assessing and highlighting each person's capacity to make specific decisions. There was information to demonstrate appropriate action had been taken to apply for DoLS authorisations by local authorities in accordance with the MCA code of practice. The registered manager told us of further applications which were in the process of being submitted. Records had been kept to monitor and review the progress of pending applications.

Staff spoken with indicated an awareness of the MCA and DoLS, including their role to uphold people's rights and monitor their capacity to make their own decisions. The service had policies and procedures which aimed to underpin an appropriate response to the MCA 2005 and DoLS. Records and discussions showed that staff had received training on this topic.

We looked at how the service supported people with their nutritional needs. People made positive comments about the meals provided at the service. They told us, "The food is lovely there something for everybody," "The food is lovely not bad at all," "The food is absolutely excellent, it's all cooked on the premises" and "The food is good and plentiful and the variety is good."

We spoke with the chef who told us the menus were changed every two to three months. People were encouraged to make suggestions for meals during residents meetings and 'taster days'.
Consideration was given to providing a nutritionally balanced diet. The menus we looked at showed variety of meals were offered. The main three course meal was served at lunchtime; there were two options in each course. There was scope for the days' menu to be displayed in the dining room; this would help remind people of the choices on offer.

Specific diets could be catered for. Pureed meals were blended in separate portions to palatable and appealing. Information had been shared with kitchen staff on people's individual dietary needs, likes and dislikes. The chef said people could have whatever they wanted and that every effort was made to provide for people's specific requests. One person explained, "They come and ask what we want. There are usually two things. If you don't want it they offer something else. They will do anything." We discussed with the chef further ways of involving people with menu planning and promoting mealtime choices.

We observed the meals service at lunch time. The dining tables were set with table cloths, flower arrangements, drinks and serviettes and condiments. People enjoyed the mealtime experience as a social occasion; the atmosphere was relaxed and friendly. Various individual choices were offered and catered for. We noted people could easily change their minds about their selection and staff readily provided alternatives. We observed examples of people being sensitively supported and encouraged by staff with their meals. People's satisfaction with their meal was sought and further portions offered. The meals looked plentiful very well presented and appetising. Consideration had been given to promoting people's independence, choice and control. For example, some vegetables were served in tureens and there were individual teapots and milk jugs to promote self-help. Mealtimes were flexible and people could eat in their rooms if they preferred. Drinks were available and offered throughout the day.

Care records we reviewed included information about people's individual dietary requirements. Records showed people's weight was checked at regular intervals. This helped staff to monitor risks of malnutrition and support people with their diet and food intake. Health care professionals, including GP's, speech and language therapists and dieticians were liaised with as necessary.

We looked at how people were supported with their healthcare needs. People spoken with told us of the attention they had received from healthcare professionals, including district nurses and GPs. There were 'care passports' which provided information on people's medical histories and current medical conditions. People's healthcare needs were monitored daily and considered as part of ongoing reviews. Records were kept of healthcare visits and appointments. This included GPs, community nurses, speech and language therapist and chiropodists. The service was signed up to a system whereby they could access remote clinical consultations; this meant staff could access prompt professional advice at any time. The service had good links with other health care professionals and specialists to help make sure people received prompt, co-ordinated and effective care. The health professionals we spoke with made the following comments, "If there are any health issues we a made aware. We get an accurate and informative description" and "They are enthusiastic. They want to know the treatment plan and take a note of our instructions."

We looked at how the service trained and supported their staff. Arrangements were in place for new staff to complete an initial 'in-house' induction training programme. This included an introduction to the service, familiarisation with policies and procedures and health and safety matters. Staff were allocated a mentor and 'shadowed' experienced staff on various shifts.

The induction training also included the completion of The Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers are expected to adhere to in their

daily working life. The registered manager explained that existing staff had also completed The Care Certificate induction to update their knowledge and skills. There was also shorter orientation induction programme for agency staff.

Staff spoken with told us about the training they had received. They confirmed that there was an ongoing programme of staff development at the service. This included: first aid, moving and handling people, infection control, food safety, malnutrition awareness, fire safety, dementia, diabetes awareness, challenging behaviour and palliative care. We looked at records which showed processes were in place to identify and plan for the delivery of suitable training. The service supported staff as appropriate, to attain recognised qualifications in health and social care. All carers had a Level 2 or level 3, National Vocational Qualification (NVQ) or were signed up for/working towards a Diploma in Health and Social Care. Senior carers had attained level NVQ 3, 4 or 5, or an equivalent qualification.

Staff spoken with indicated they had previously received one to one supervisions with a member of the management team. We saw records confirming supervision meetings had been held. The meetings had provided the opportunity for staff to discuss their role and responsibilities. We noted some supervision appointments were overdue. The registered manager acknowledged this delay and we noted plans were in place to schedule future supervision meetings. Processes were in place for staff to receive an annual appraisal of their work performance; this included a self-evaluation of their skills, abilities and development needs.

We looked around the premise and noted some developments had been made to the service, including new furnishings, carpets and decoration. Work was ongoing to refurbish a bathing facility. The registered manager explained how people had been involved and consulted on selecting the new dining furniture which had recently been ordered. We found people had been encouraged and supported to personalise their apartments and rooms with their own belongings. This had helped to create a sense of 'home' and ownership. We were also shown the ongoing improvements to the garden, decking had been provided and pathways were to be improved to help with access.

Good

Is the service caring?

Our findings

We found McAuley Mount Residential Care Home had a friendly and welcoming atmosphere. We observed staff engaging and interacting with people in a warm and friendly manner. People spoken with said, "This whole place is so caring. It's not just a case of them doing a good job. It's everything. They want people to be happy," "Staff are nice. They have good characters. I can trust them with anything" and "Staff are so friendly. We can have a laugh with them and a bit of banter."

We observed examples of staff showing kindness and compassion when they supported people with their individual care and daily living needs. For example, we saw people who needed personal support received this in a dignified and respectful way. People spoken with said, "They are very kind in their attitude. The way they speak is excellent" and "The staff have been unreservedly nice, engaging and helpful." One healthcare professional commented, "The staff are respectful to people and to us. They always introduce us to the residents."

Staff spoken with expressed an awareness of people's individual needs, preferences, routines, backgrounds and personalities. People's 'care passports' provided person centred information about their background history, interests, likes, dislikes and relationships. There were details of how the person preferred term of address name and instructions for staff to follow on sensitively providing support, such as 'remind me to… ' and 'encourage me with…' There was a team 'keyworker' system in place. This linked people using the service and their family to named staff members to help provide a more personalised service.

People's privacy was respected. Some people preferred to spend time alone in their apartments and rooms and this choice was respected by the staff. People's doors were fitted with suitable locks to help promote privacy of personal space. We noted the care planning process included people's needs and preferences on night time checks and having a key for their door. We observed staff knocking and waiting for a reply before entering rooms. One person told us, "They always knock on the door. This room is treated as my home. " Staff described how they upheld people's privacy, by sensitively supporting people with their personal care needs. People we spoke with did not express any concerns about how their care was delivered. One commented, "I get help with personal care. Initially it was a shock, but they are very discreet and courteous."

We saw people being as independent as possible, in accordance with their individual needs, abilities and preferences. We asked people their views on independence and autonomy. They said, "They encourage me to do things for myself," "They let me do things," "I feel control I can do more or less what I want within reason," and "I have never had any rules thrown at me." Staff explained how they promoted independence, by enabling people to do things for themselves.

There were no restrictions placed on visiting, relatives and friends were made welcome at the service. We observed relatives visiting throughout the days of our inspection and noted they were treated in a friendly and respectful way. The service had policies and procedures to underpin a caring ethos, including around the promotion of privacy, dignity, choice and equality and diversity. We looked at records of compliments received at the service and noted there were numerous positive comments about the care and attention

people had experienced at McAuley Mount Residential Care Home.

There were notice boards and displays at the service which provided information about forthcoming events, activities, meetings, the complaints policy and other useful information. Details of local advocacy services were available. Advocates are independent from the service and provide people with support to enable them to make informed decisions. We noted the service's CQC rating was on display in the reception. A copy of the previous inspection report was also on display at the service. This was to inform people of the outcome of the last inspection.

Requires Improvement

Is the service responsive?

Our findings

People spoken with indicated the service was responsive to their needs and preferences and they appreciated the support provided by staff. Some of their comments were, "I am very happy here they will do anything for us," "I only need to press the call bell if I need someone. I call for them in the morning and they come if needed in the night," "Staff are very helpful. They are very positive with people" and "They can't do enough for me." One health care professional commented, "Staff are cooperative and helpful. If I ask for anything they do it straight away."

We reviewed how the service provided personalised care. The registered manager explained that the care plan process was being further developed to support a more person centred approach. We looked at the way the service assessed and planned for people's needs, choices and abilities. We discussed with two people their assessment prior to using the service. They confirmed that they had their needs and choices assessed prior to moving in. The registered manager described the processes in place to assess people's needs and abilities before they used the service. The assessment involved gathering information from the person and other sources, such as families, social workers and health care professionals. Where possible people were encouraged to visit, to view the facilities available and meet with other people and staff. This would help people to become familiar with the service before making a decision to move in. Some people had experienced the service by visiting others and staying on a short term basis. People spoken with said, "So far it's very nice. I came to look around and I have been before" and "They made me feel welcome straight away."

However, during our visit we found there were circumstances which indicated the initial assessment process had not been successful in ensuring specific needs, abilities and preferences had been fully identified. Information had not been obtained from relevant healthcare professionals and family members had not been consulted with effectively. Furthermore, we noted that when the person moved into the service a care plan had not been fully developed and implemented.

Some people spoken with were aware of their care plans and had signed in agreement with them. A relative also told us, "I have seen the care plan [my family member] was involved with reviews." At the time of our visit we found care plans were in the process of being updated. We reviewed three care files which included care plans. The care plans were divided into sections in response to identified needs and preferences. They included instructions for staff on delivering care in response to people's needs. The care plans covered: sleeping and resting, personal hygiene, elimination and continence, religious and cultural needs, activities and interests and eating and drinking. But we noted there was a lack of care plans to provide guidance to staff on responding to physical and healthcare needs and safely supporting people with their medicines. We were also made aware of examples of relevant information which were no longer kept in the person's care files.

However there were 'care passports' which provided detailed person centred information on responding to people's, behaviours, personal care and other relevant needs. These were kept in people's rooms for easy reference. But, copies of the 'care passports' were not kept in care files. This meant the design of the care

planning process did not effectively support the completeness of a person centred response. We discussed these matters with the registered manager and deputy manager, who expressed a clear commitment to ensuring improvements were made to the care planning process and commenced action to rectify the shortfalls during the inspection.

Care staff spoken with expressed an awareness of people's needs and preferences. A healthcare professional told us, "They know the residents really well. All the staff are equally aware. They are on the ball with things. They seem to have good communication set up." There were ongoing discussions about people's needs and well-being. This included ongoing communication systems, such as regular staff 'handover' meetings. We were told care staff had ongoing access to people's care plans throughout the day. However care staff spoken with said they were not familiar with the content of care plans, but relied upon directives from senior staff.

We saw the care plans had been reviewed and updated on a monthly basis or more frequently, in response to people's changing needs. There was a 'resident of the day' system in place, to enable a person centred approach to the review process. Records were kept of people's daily progress, their general well-being and the care and support provided to them. There were also additional monitoring records as appropriate, for example relating to specific health care needs.

During our visit we observed people were routinely encouraged to make choices and that staff responded to their requests. Residents meetings were held; this provided the opportunity for people to be up-to-date, be consulted and make shared decisions. Some people told us they had attended the meetings. Their comments included, "We had a residents meeting. They say what's happening" and "They tell us what's going on. They ask our opinion in things." Records kept of meetings showed various matters, such as menus, activities and the programme of refurbishment had been raised and discussed with people. We did note there was no action plan following the meetings, this would show how people's choices and decisions were to be responded to.

People indicated they were mostly satisfied with the range of activities provided at the service. They said, "At first it was a bit boring, but we have a new activities organiser who gets things going," "Occasionally there are singers and entertainers," "They put things on like dominoes and darts," "I have seen the activities person" "They have an activity every day" and "Personally I think there is enough going on." A relative commented, "There's a new activities person it's a lot better now." Arrangements were in place to offer an activity each afternoon; we saw group activities taking place during our visit. We also observed staff spending time chatting with people.

There were proposed daily activities on display for the months of June and July, they included, dominoes, board games, baking, carpet bowls, arm chair exercise and pamper sessions. Some people also explained that they organised their own activities also that they occasionally went out with families and friends. There were also occasional visiting entertainers and themed events, such as the recent 'forces weekend'. People could access the chapel, which offered a quiet space for praying and contemplation. A short church service was held each morning; people not attending could choose to hear this in their rooms. One person explained, "I listen to the daily service through the intercom." There was an activity diary record, which provided information of the activities held or offered and people's participation. It is expected that the further development of individual person centred care plans will result in a more effective response to meaningful activities, stimulation and engagement.

We looked at how the service received and managed complaints. People we spoken with expressed an awareness of the service's complaints processes. They indicated they would feel confident if they had

concerns or wished to make a complaint. Their comments included: "If I had any complaints or concerns I would speak to the registered manager," "They would listen to me or [my relative] they would certainly try to sort it out," "If I had a proper complaint I would go to the office," "I have never made a complaint everything is satisfactory. But I would speak to one of the managers if needed" and "Nothing is too much trouble here." There was a 'suggestion box' in the reception hallway where they people could leave comments, anonymously if they preferred. We also noted people were given the opportunity to express any dissatisfaction or concerns in the residents meetings and in surveys.

The service's complaints procedure was made reference to in the guide to the service and the complaints policy was also on display in the service. The policy provided guidelines on responding to and managing formal complaints and concerns. This information provided directions on making a complaint and how the process would be managed, including timescales for responses. The contact details of the provider and other agencies that may provide support with raising concerns were included. However, the complaints procedure was not presented in a user friendly format to effectively meet the needs of the people who used the service.

There had not been any recent informal or formal complaints at the service. We reviewed the complaints records, including the last formal complaint. The response to the complainant clearly indicated that the matters raised had been taken seriously and showed action had been taken to rectify the concerns. However the complaints records were lacking in describing the investigation process, the outcomes and the action taken in response. We discussed with the registered manager the significance of ensuring appropriate complaints records are maintained, to show how concerns are investigated managed and responded to. We noted there were no structured arrangements in place to manage and respond to 'soft information' such as minor concerns. This would help ensure all matters raised were taken seriously and effectively resolved.

Requires Improvement

Is the service well-led?

Our findings

People spoken with had an awareness of the overall management arrangements at the service. They expressed an appreciation of how the McAuley Mount Residential Care Home was run. Their comments included, "It's really good I can't fault it, "I have got a good place now so I am keeping it" and "I like it, I am content here it's very well run." Throughout the inspection we observed people who used the service, visitors and staff frequently approached the managers who responded to them in a professional and courteous manner. Healthcare professionals made the following comments, "The managers are friendly, concerned and compassionate," "The registered manager is lovely and really helpful" and "The deputy manager has helped improve things." All the staff spoken with described the registered manager as approachable. One told us, "The home is run fabulously. I find the manager and deputy are both approachable."

There was a management team in place which included the registered manager, deputy manager and senior carers. There was an administrator providing additional management support. The staff rota had been devised to ensure there was always a senior member of staff on duty to provide leadership and direction. There had been recent changes in the senior carers at the service and new senior staff were adjusting to their roles. However, we found there was some discontentment amongst the staff team. We received mixed views from care staff around the management of the service. We were told there was a degree of inconsistency around some aspects day to day leadership, in particular the role, responsibilities, guidance and support provided by senior carers. Care staff said they were not aware of the content of individual care plans, which meant there was a reliance on verbal communication and direction from managers on the delivery of people's agreed care and support. Care staff also described the difficulties they occasionally experienced when working with agency staff. They told us they had expressed their views and concerns to managers, but felt improvements had not been made. We reviewed with the registered manager, the systems and processes in place to manage and progress these matters.

Various staff meetings had been held; they included one to one discussions, senior care, care staff, night staff and full staff meetings. Staff confirmed discussion meetings were held. We looked at the minutes of the last staff meetings and noted various work practice topics had been raised and discussed. Staff had been provided with job descriptions, contracts of employment and a staff handbook which outlined their roles and responsibilities. They had access to the service's policies and procedures. There were 'vision and values' statements displayed around the premises for staff to refer to. These focused upon McAuley Mount's recognition, commitment and approach to providing a service within the domains of safe, caring, responsive, effective and well-lead. All the staff spoken with indicated people who used the service experienced good care and support.

The manager had been registered with the Commission since July 2016 and confirmed her professional development was ongoing. Both the registered manager and deputy expressed commitment to the ongoing improvement of the service. Information included within the PIR showed us the manager had identified some matters for development within the next 12 months. The registered manager attended senior management team meetings with colleagues in the organisation and had established links with a local

'registered manager's network' and the Lancashire Care Home Providers network.

There was a guide to the service. This provided people with information about the services and facilities available, including: the mission statement, philosophy of care, staffing arrangements, visiting arrangements and the complaints procedures. We noticed some of the information in the guide was incorrect and out of date. The provider also had an internet website providing some additional information about the service. We noted the service's CQC rating was displayed on the website which is a regulatory requirement. The registered manager told us both the guide and website were due to be revised and updated.

There were systems in place to monitor the quality of the service. This included a system of daily, weekly and monthly audits and checks. The audits included: infection prevention and control, food service, housekeeping, health and safety, medicine management, accidents and dependency levels. We noted examples where shortfalls had been identified, addressed and kept under review as part of an action plan. However, we found some improvements were needed with assessing, planning and delivering person centred care, complaints processes and team building. Some of these matters were proactively responded to during the inspection process. But we would expect such matters to be identified and more effectively addressed without our involvement.

The service encouraged ongoing feedback from people. There were resident's meetings and the 'suggestion box 'for comments and ideas for improvement. The registered manager had an 'open door' policy that aimed to support ongoing communication and openness. We also noted there were numerous cards of appreciation and thanks, for the care and attention people had experienced at the service. The last consultation survey with people who used the service had been carried out in June 2016. The registered manager told us the results had been very positive and described how the only matter arising had been appropriately progressed with the person concerned. We noted the results had not had been collated, and reviewed to determine and show the outcomes. However, at the time of the inspection an electronic internet survey was underway for people who used the service and other stakeholders. The registered manager explained how this was to be more effectively utilised for the development of the service. Arrangements had also been made for a survey to be introduced to gather the views and opinions of staff.

The registered manager explained that and representatives of the provider continued to visit the service and completed reports on their findings. The reports following the visits were available at the service. Action plans had been developed to address any shortfalls; progress on these matters was reviewed and monitored. The nominated individual also visited the service to monitor and discuss ongoing developments. However at this inspection we found improvements were needed with person centred care planning, staff morale and complaints processes. Furthermore there was no overall analysis and evaluation of the service in response to the findings of audit systems, consultation processes and potential changes in the care industry. There were no strategic action/business plans to provide vision and direction on the ongoing development of the service.

Procedures were in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as, commissioners of service and the local authority safeguarding and deprivation of liberty teams. Our records showed that the registered manager had appropriately submitted notifications to CQC about incidents that affected people who used services.