St. Mary's (Dover) Limited

St Mary's

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced inspection of this service on 12 and 13 August 2016.

St. Mary's is a large detached property providing residential and dementia care for up to 36 older people. The service is located within the town of Dover. Residential accommodation is situated over four floors. There is a separate unit to support people living with dementia. The service also has its own chapel and a well maintained garden to the rear of the property.

This service did not have a registered manager in post. The previous registered manager left the service in April 2016. The deputy manager has been acting manager since that time and assisted with the inspection. A registered manager is a person who is 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 time of inspection there were 22 people living at the service.

At the previous unannounced, comprehensive inspection of this service on 10 and 11 February 2016, a warning notice was served together with three requirement notices. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. Although some improvements had been made the provider had not fully complied with the issues raised in the warning notice and one of the requirement notices. These shortfalls will be outlined in the report, together with the improvements made to the service.

There were areas of the premises that were still in need of repair. There was ongoing re-decoration and a plan in place, but progress was slow. Thermostatic valves or a system to regulate the water temperature had been installed, however; bathrooms had not been fitted with restrictors to make sure the risk of scalding was reduced.

The provider had carried out a legionella test which confirmed the water system was safe to use. The two electric pumps in the garden to manage waste water had been repaired and were working. Some windows had also been repaired, but others still remained closed and could not be opened as they needed new sashes to enable them to open safely. There were no timescales as to when this outstanding work would be carried out.

The uneven floor on the third floor had been repaired and new flooring was in the process of being fitted. The first floor shower room was still out of action. The first floor bathroom seat had been replaced and was in working order.

Checks on the fire system had been made on a regular basis and fire drills had been completed, but staff attending these drills had not been recorded to ensure that all staff were included and were fully aware of

fire procedures. The personal evacuation plans for each person had been reviewed but there was no information on people's behaviour or mobility to show how they could be supported to evacuate the premises in the event of a fire.

Equipment to support people with their mobility had been serviced to ensure that it was safe to use. However, during the previous inspection staff had identified that the service required an additional hoist. Staff asked the provider to purchase a new hoist in 2015 but this request had not been actioned at the time of the inspection The provider visited the service weekly and was aware of these issues, but progress to improve the environment and equipment was slow.

There were eight people who needed assistance to move with a hoist and several people who were using bed rails to reduce the risk of falls. The acting manager told us that they had not been assessed by health care professional to ensure the right equipment was in place and people were being moved as safely as possible.

The acting manager was in the process of reviewing all of the behavioural risk assessments as it had been identified that they had insufficient detail to ensure people were supported appropriately with their behaviour. These lacked guidance to show staff how to support people positively when their behaviour challenged themselves and others. There was no information on what may be the trigger for this behaviour and how to reduce the risk of this happening again.

One person was at risk of choking and this had been recorded in their health care notes but the care plan had not been updated to ensure that staff were fully aware of the issues.

Accidents and incidents were recorded, bur further investigation and action had not been taken, for example, when records identified that people were found asleep on the floor in or near their bedrooms. The accidents had not been analysed sufficiently to show that they had looked for patterns or trends, to prevent further occurrences.

There were not always enough staff on duty to ensure that people were safe and received the care and support they needed. Staff had been recruited safely although records for one new member of staff were not available at the time of the inspection.

The provider had carried out interviews for the registered manager's position several weeks prior to the inspection but no one had been appointed. There was an acting manager, a new deputy manager and a team leader which formed the management team. There were no lines of accountability in place as the members of the management team did not have job descriptions in place. There had been no specific training or supervision to support the managers in their new role. The provider visited the service on a weekly basis and all decisions about the service were made by them. There was no autonomy for the acting manager on the day to day running of the service.

Visiting health care professionals said they were not aware of the management structure. Staff said sometimes they got different guidance from members of the management team.

Staff told us that they did not feel valued by the provider. They said the acting manager was supportive and had worked really hard to improve the service, but the provider did not listen or act on what they said. They had concerns that there was a lack of funds to run the service as the budgets were being cut. They recognised that the premises still needed lots of repairs and they were also concerned that the additional hoist they requested in 2015 had not been provided, which resulted in people having to wait for their

personal care or going to the bathroom.

The system to ensure people received their medicines safely had been reviewed; however, there were still shortfalls in the medicines administration, storing and recording. The temperature to store medicines safely was too hot to ensure the medicines remained effective.

Some people's mental capacity had been assessed; however there was a lack of understanding of the legalisation as not all people who lacked capacity to make decisions or needed continuous supervisions had an application made to the local authority to assess if they required a Deprivation of Liberty in place.

The acting manager had a training programme in place and staff had received the required training, including mental capacity training. Apart from the management team, all care staff received individual supervision and an annual appraisal to address their training and development needs.

People's health care needs were monitored and they were supported to access health care professionals when required. However, the service had failed to recognise that a person had a medical condition until they had been admitted to hospital after a fall and the information was recorded on the discharge note. The person had been living at the service for six months.

Not all relevant information had been included in care plans to identify people's medical conditions and to ensure that staff received appropriate training to meet their needs. Regular reviews of the care plans had taken place but the main part of the care plans had not always been updated with people's changing needs. There was a risk that people were not receiving the care they needed.

The activities programme had not improved since the previous inspection. There were some activities in the dementia unit, on the day of the inspection, however there were no activities in the residential unit.

Although a quality survey had been completed, no further analysis had been carried out to show how any comments or shortfalls had been addressed. Therefore people's views had not been taken into account for continuous improvement. Records, such as the medicine records, positioning charts and night check forms were not accurate and completed consistently.

Staff listened to what people asked them and responded appropriately. People were not always treated with dignity and respect as, at times, they had to wait to go to the bathroom due to the lack of equipment and staff availability.

The provider had not ensured that the published rating from the previous inspection was on display.

People told us they enjoyed the food and had a choice of meals. Their nutritional needs were assessed to ensure they received a balanced diet.

Staff understood how to protect people from the risk of abuse. Safeguarding training was ongoing and in addition one to one supervision with their line manager so that they were aware how to report any concerns in order to keep people safe. However, there was an incident where the staff had not consulted the local safeguarding team. Staff were confident to whistle-blow to the acting manager if they had any concerns, and were confident that appropriate action would then be taken.

People were supported by their relatives to be involved in the planning of their care. Care plans included people's preferred routines, their wishes, preferences and what support they needed to remain as

independent as possible. People and relatives told us the staff were kind and caring. Staff knew people well and supported them with their daily routines.

Checks had been carried out on the premises, such as the gas safety certificate; portable electrical appliances, and lifts.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Parts of the service remained unsafe and were in need of repair. People did not have the equipment they needed.

Accidents and incidents had been recorded but not investigated or analysed to ensure action was being taken and to reduce the risks of further events.

There were not always enough staff deployed in the home to meet people's care and support needs.

People's medicines were not well managed, stored and recorded accurately.

Staff had been recruited safely but some records were not available at the time of the inspection.

Staff understood the process of how to report and action allegations of abuse to protect people from harm but on one occasion they had not consulted with the local safeguarding team.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received Mental Capacity Act and Deprivation of Liberty Safeguards training but there was a lack of understanding of how this was applied to people's care.

People had access to health care professionals when needed, however medical information had not always been recorded to ensure that people's specialist needs were met.

The service provided a variety of food and drinks to ensure people remained as healthy as possible. People's nutrition care plans had not always been updated when people had a risk of choking.

Staff had received training, supervision and appraisals to ensure

they had updates with current care practice to effectively support people.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was compromised due to a lack of equipment, environmental issues and a lack of staff.

People were offered choices and were encouraged to remain as independent as they could be.

People and relatives told us that the staff were kind and caring.

Staff knew the people well and treated them as individuals. They interacted with people positively,

People's personal information was stored securely but records were not always accurate and up to date.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and relatives told us there was a lack of activities and people were not being supported to maintain their hobbies and interests.

People and relatives were involved in planning their care. Care needs assessments did not always show that people's medical conditions had been assessed and recorded.

Although care plans had been reviewed regularly some plans did not show how people's needs had changed.

People and their relatives were able to discuss their views at regular meetings.

Formal complaints had been investigated and resolved, and then responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider had failed to comply with the warning notice requirements and previous breaches of the regulations.

Checks and audits had not identified shortfalls found during this inspection.

The acting manager and deputy manager had not received supervision to support them in their new roles.

Staff told us that the acting manager was very supportive and had improved the service but they did not feel valued and supported by the provider.

Quality assurance surveys had been sent to people, relatives, staff and health care professionals, but these had not been analysed to show what action was needed to improve the service.

The provider had not ensured that the published rating from the previous inspection was on display.

St Mary's

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.

We undertook an unannounced inspection of this service on 12 and 13 August 2016. The inspection was undertaken by two inspectors. We spent some time talking with people in the service and staff; we looked at records as well as operational processes. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority. On this occasion the provider had not received a Provider Information Return (PIR) to complete. 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 gathered and reviewed information about the service before the inspection, including previous inspection reports and notifications. A notification is information about important events, which the provider is required to tell us about by law.

We reviewed a range of records. This included eight care plans and associated risk information and environmental risk information. We looked at four staff files, the recruitment, training and supervision records, in addition to the training record for the whole staff team. We viewed records of accidents/incidents, complaints information and records of some equipment, servicing information and maintenance records.

We also viewed policies and procedures, medicine records and quality monitoring audits undertaken by the registered manager and provider. We spoke with eight people, five relatives, three health care professionals, eight staff, the acting manager, deputy manager, and team leader.

At the previous unannounced, comprehensive inspection of this service on 10 and 11 February 2016, a warning notice was served together with three requirement notices.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at the service. They said: "Yes I feel safe here" and "I do feel safe here, my family are pleased with the way I am treated". Relatives said: "I have no worries; I know my relative is safe here". However staff, relatives and people all commented that there was not enough staff. One person said, "I think we should have more staff which would help them with their jobs".

At our last inspection in February 2016, a warning notice was served to the provider as they had failed to take proper steps to ensure the premises and equipment was safe. The hot water temperatures had not been regulated to reduce the risk of scalding, the electrical wiring system had not been checked to ensure it was safe, the two pumps in the garden to remove waste water were not working, the water had not been checked to confirm the legionella test was clear, the shower room was out of action and there was a broken seat in one of the bathrooms. There were also areas in the service in need of refurbishing and redecoration. The provider sent us an action plan telling us how they were going to improve with a timescale to complete the works as 'ongoing'. At this inspection we found that some improvements had been made and some action had been taken to improve the safety of the environment, but there remained areas of the service that were still in need of repair and re-decoration.

At this inspection we found the hand basin in every bedroom had been fitted with a thermostatic restrictor to ensure the temperature remained below the required level to reduce the risk of scalding. Records showed that the temperature of the water in the bedrooms ranged from 35 to 38 degrees which was a safe temperature. However, the thermostatic restrictors had not been fitted in the bathrooms. The provider had instructed staff to lock the bathroom doors to deny people access as they considered this prevented the risk of scalding. Staff supported all of the people to bath and they were responsible for checking the temperature of the water before use. Water temperature in the bathrooms was consistently over the recommended level of 43 degrees.

The electrical wiring system had been checked and any necessary remedies had been carried out. The two pumps in the garden were working and the legionella test had been completed to confirm the water systems were safe. The broken seat in the bathroom had been replaced. The shower room was still out of action so people were still unable to have the choice of a shower. This had been identified on the environmental risk assessment dated 10 December 2015 to be repaired within 12 months and had not been carried out at the time of the inspection.

Although some redecoration had taken place, and the uneven surface in the corridor had been addressed and new carpet was to be fitted, there remained areas of the service that required further attention. The quality of furnishings, fittings and decoration in the many communal areas and bedrooms, was in need of attention. Doors and skirting boards were scuffed, and furnishings appeared old and worn making it difficult to keep them clean.

People and staff were unable to open some windows for ventilation in hot weather as not all of them had been repaired. The windows needed new sashes to enable them to open safely. There were no timescales

on the provider's action plan as to when this outstanding work would be carried out. The maintenance/development plan had not been updated since the previous manager left in April 2016.

The provider employed a full-time maintenance person who was repairing day to day issues in the service, as well as completing some painting in the corridors. There were plans in place to refurbish the kitchen areas and bathroom by the first floor lounge and the provider said that this was to be started the week after the inspection.

The provider had not ensured the premises were as safe as possible. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in February 2016, a warning notice was served as the provider had failed to mitigate risks in relation to proper and safe management of medicines. Tablets had not been dispensed but had been signed to say they had been administered. Records did not confirm people's identity in the dementia unit. People were not being given their medicines if they were sleeping, and people's medicine was recorded as not being available so they did not receive their medicine. The stock of medicines did not match the 'countdown' sheets, and the temperature for the storage of medicines remained above the recommended temperature of 25 degrees. The provider sent us an action plan telling us that systems had been put in place to ensure medicines were stored and administered correctly and confirmed this action had been completed.

At this inspection, although some improvements had been made, the breach of regulations outlined in the warning notice had not been complied with.

People who needed specialist medicines like Warfarin (an anticoagulant treatment that needs to be closely monitored) were not receiving their medicines safely. One person needed to have varied dosages of their warfarin on certain days; the records were not accurate to show the correct dosage was given to the person on the right day. There were three different dosages of tablets, 1 mg, 3mg and 5mg. The stock showed that there was one 5mg tablet missing, which could not be accounted for and records showed that on two occasions, the person received 4mg instead of 5mg.

The acting manager told us it was standard practice to date the warfarin packets when they were opened but some of the packets did not have any dates recorded. The person was having regular blood tests to ensure their blood was in a satisfactory order and they did not seem to have any adverse effects. When this error was found the acting manager arranged for a further test to take place as soon as possible to check the person's blood was as it should be. We could not be assured that the systems in place to manage the administration of warfarin were effective to make sure people were receiving their prescribed dosage correctly.

Medicines were not always stored safely and at the correct temperature. If medicines are stored at too high or too low a temperature the medicine may not work as intended. Room temperatures were not recorded consistently which meant there was a risk medicine had been stored at a temperature that was either too high or too low. Staff had not regularly recorded the temperature of the room where stock medicines were kept in both the residential and dementia units.

In the dementia unit, when temperatures had been recorded, they were 25c (the maximum temperature for storing medicines) or above which can affect the way medicines works. The form for recording temperatures had a column for recording, 'Action taken if near or above 25c' yet no action had been recorded. In the medicines room the temperature was consistently above 25c in August 2016 and the only actions recorded

were on two days when a 'fan was put on' and on another day when 'management were aware.'

People did not always receive their medicines when they needed them. Two people did not receive their Lansoprazole medicine as prescribed. Lansoprazole reduces the amount of acid produced by your stomach. Staff had written on the Medicine Administration Record (MAR) that it was 'not available' and it had not been administered. We spoke with the acting manager and senior staff about this and they showed us the stock checks for this medicine. The Lansoprazole had been checked and signed in and was in the stock cupboard, yet staff had still not administered it.

Staff did not always sign people's MARs when they had administered medicines. In the dementia unit there were gaps where staff had not signed for different people's medicines. Stock checks indicated that the medicine had been given, as the number of tablets had decreased, however we could not be sure that this was the case.

The provider had not ensured that medicines were managed safely. People were not receiving their medicines safely and in line with the prescriber's instructions. Medicines were not being monitored to ensure they were stored at the correct temperatures to ensure they were safe. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place for the ordering, receipt, and disposal of medicines. Staff ensured that the medicine trolleys were locked and secure. Most medicines with a required shelf life had been dated when opened to ensure people received them safely. Body maps were in place for people who required a transdermal patch application which documented when it was changed, and where on the body a new patch had been placed. It showed clearly that it was always applied to a different area of the body to reduce the risk of damage to the person's skin. There was a pain chart in people's care plans, and information on how people may act if they were in pain, such as 'staff to monitor body language and facial expressions', so that pain relief could be offered.

At our last inspection in February 2016, a requirement notice was served as the provider had failed to ensure that there was sufficient numbers of staff on duty to safely care for people. The provider sent us an action plan telling us that people's dependency levels had been re-assessed and the working rota had been adjusted to meet these requirements and confirmed this action had been completed. However, staffing levels remained insufficient to fully meet people's needs.

At this inspection the acting manager told us that the staffing levels were based on people's dependency and the number of people in the service. The staffing levels each day should be two senior staff, five care staff, in the morning, and four care staff in the afternoon. This was based on 22 people at the time of the inspection. The staffing rota indicated that staffing levels were not at this level and consistently fell below this figure on several occasions.

Relatives told us that there were staff shortages, especially at weekends. They said that this also had an effect on their relative's activities as there was not enough staff. One relative said, "Sometimes I worry when my relative wants to go to the bathroom or may have had an accident; they have to wait for staff as there is not enough of them". They emphasised that the staff provided good care to their relatives and they just needed additional staff to cover the regular shortages to make sure people received the care and support they needed.

Staff consistently told us they were rushed and there needed to be more staff on shift to support people effectively. Staff said, "There's not enough staff on duty in the mornings, you rush. It would be better to have

another person". "We always feel like we don't sit down. We could do with an extra pair of hands" and, "We struggle sometimes, we pull together and we'll cut our breaks short if we need to."

In the dementia unit we saw one member of staff supporting six different people in the lounge, while two members of staff assisted additional people with personal care in their rooms. One person was eating their breakfast and was struggling so the staff member offered to get them a different spoon. Another person then knocked their drink over and became distressed so the staff member went over and gave them reassurance. When they returned with a different spoon for the person eating their breakfast the person had gone to sleep, without finishing their meal.

On another occasion a person was making a high pitched noise and appeared visibly distressed. They were told to 'shut up' by another person. Staff were occupied with other tasks and were unable to intervene or offer the person reassurance. There were three members of staff in the room with nine people. Two members of staff were assisting people to eat their pudding and the third member of staff was administering people's medicines. The acting manager told us that they and the deputy manager supported the staff when shortages occurred, but this was not shown on the rota and was not observed.

Between the hours of 2pm to 4pm the staffing levels reduced. Some people needed more than one member of staff and the use of a hoist to support them. There were times, if two people wanted to use the bathroom at the same time, there would be no staff available for the other people living at the service. Staff told us that on occasions they had to ask people to wait as the stand aid hoist would be in use in the other unit or they had to wait for another staff member to be available.

The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Any accidents and incidents were regularly reviewed by the acting manager, but they had not been analysed and investigated to look at the root cause of why an incident may have occurred or to amend people's behavioural guidelines or risk assessments as a result. One person had grabbed a staff member's arm when they had been woken by staff. The analysis stated that the precipitating factor was 'having been woken by staff.' There was no consideration as to why the person had been woken up, if they needed to be woken and up and if staff should wake them up in the future.

Another incident form described an incident where a person pinched another person. The action taken was 'reported to a senior.' There had been no further analysis as to why the incident occurred and how to prevent it from happening again. There was no risk assessment in place or a clear behavioural care plan. All of the people who needed support with their behaviour did not have specific behavioural care plans in place. The acting manager told us that they were in the process of implementing the plans; however, due to people's complex needs they were seeking professional advice for guidance. There were no timescales when the plans would be completed.

Risks relating to people's care and support had not always been adequately assessed. One person had fallen several times when they had been on their own. Staff had recorded that the person did not use their call bell to alert staff to the fact they needed assistance when they had fallen. Staff had documented that they had 'asked the person to use their call bell to call for assistance' on one occasion and on another they had documented, 'The person did not press their call bell and lost their balance.' The person's call bell risk assessment said that they were at low risk of harm as they understood how to use their call bell and always used it, but this was not the case. No action had been taken to look into why the person was falling and to

reduce the risk of further falls.

Some people were at risk of falling from bed. Although bed rails had been fitted to reduce the risk of people falling, the acting manager had not sought consent from people or received professional advice to ensure that their use was as safe as possible and people had the right equipment.

Some people required assistance with moving and found it difficult to weight bare. Staff assisted people to move with the use of different types of hoists. Staff at the service had decided what kind of hoist people should use and what type of sling, and had not sought advice from a trained moving and handling assessor to ensure they were using the correct type safely. People were at risk if staff were using the wrong type of hoist. Owing to the number of people who need support to move with a hoist, the staff had requested that an additional hoist be purchased by the provider in 2015; however this had not been provided. Staff told us that the service had acquired a second hand hoist and this was waiting to be serviced and checked to ensure this would be fit for purpose. Staff told us that this would be carried out in September 2016

Staff undertook regular testing of fire systems, emergency lighting and equipment, and staff had training on fire and safety procedures. However, fire drill records did not show which staff were involved to ensure that every member of staff, including the night staff, completed the drill so that they were familiar with actions to take in the event of an emergency. The acting manager could only find a fire risk assessment which was dated 2013. This was accompanied by a review which was dated 2014 and stated it had been replaced with a 'horizontal evacuation policy.' When we asked if there was a more up to date risk assessment, taking into account changes in the building, the acting manager could not find one. The registered provider showed us a copy of a fire risk assessment dated 7 September 2016 after the inspection.

People had a personal emergency evacuation plan (PEEP). A PEEP sets out the specific physical and communication requirements that each person had to ensure that people could be safely evacuated from the service in the event of an emergency. Although the acting manager showed us PEEPs for people these were not detailed or person specific so did not give staff clear guidance on how to evacuate individual people safely. For example individual needs had not been considered including whether the person was mobile or not.

The provider had failed to ensure that care and treatment was provided in a safe way. There was a lack of risk assessments to guide staff how to mitigate risks when supporting people with their behaviour. The provider was not ensuring that equipment such as hoists were suitable for its purpose and available. The provider had not ensured that suitable arrangements were in place in the event of an emergency such as fire. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew how to recognise and report different types of abuse. They had received safeguarding training and information about abuse. The Kent and Medway safeguarding protocols were on display in the office for all staff to refer to if needed. Staff told us they would report any concerns to a senior, one of the deputy managers or the acting manager. One member of staff told us, "I'd tell a senior and then document it. Whoever you inform would take it further, but I know I go to social services or to you, the Care Quality Commission."

The acting manager told us about a potential safeguarding concern. They had asked staff for statements but had not yet reported this to the local authority. We advised the acting manager to contact the local authority safeguarding team immediately to discuss the issue and if any further action was needed.

At our last inspection in February 2016, a requirement notice was served as the provider had failed to ensure that all the information, as required in the regulations, was obtained before new members of staff started working with people. The provider sent us an action plan telling us that a thorough recruitment process was now in place and new staff were being recruited safely.

New staff had been recruited safely and there were systems in place to ensure staff were of good character and suitable for their role. Staff completed an application form, gave a full employment history, and had a formal interview as part of their recruitment and relevant checks had been completed before staff worked unsupervised at the service, which included records of police checks, proof of identity, and health declarations. However, there was a member of staff whose records were not available at the time of the inspection as they had transferred from the provider's other service. These were received by us after the inspection.

Requires Improvement

Is the service effective?

Our findings

People told us they were satisfied with the care they received. They told us that the staff knew them well and called the doctor if they were unwell. One person said, "The staff do not hesitate to get a doctor if you feel unwell".

Relatives told us that communication with the staff was good. They said they were informed regularly about their loved ones care, such as if they needed to see a doctor or had fallen. One relative said, "My relative has done so well here, they are well looked after and their health has improved".

On the day of the inspection a district nurse and a doctor both visited the service to see people. The district nurse told us, "The patients seem happy and well looked after." Other health care professionals said: "The staff are helpful and take me to see the person I am visiting, they take advice and the acting manager is very good. We don't always see the staff on duty, the staff are fine but I feel there could be more leadership within the service". "The staff make lots of referrals and always ring for advice".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can 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.

The acting manager and staff had knowledge of the Mental Capacity Act (MCA) 2005 and were aware of their responsibilities in relation to these. Staff had been trained about the principles of the Mental Capacity Act 2005 (MCA). Staff asked people for their consent before they offered support. People's capacity to consent to care and support had been assessed and assessments had been completed with people's involvement.

Staff and the acting manager did not have a clear understanding regarding DoLS. Some people had a DoLS authorisation in place; the acting manager told us these had been applied for because people had indicated they wanted to leave the service and were unable to. All people who lack the capacity to make decisions about their care and residence, or who need continuous supervision and lack the option to leave their care setting are deprived of their liberty. There were people living with dementia, who lacked capacity and were unable to leave St Mary's and no DoLS applications had been made.

There were some care plans which were signed by relatives even though the person concerned had the capacity to sign for themselves.

People were at risk of being restricted unlawfully. The provider had failed to apply for authorisations to deprive people of their liberty in line with the Mental Capacity Act. This was in breach of Regulation 13 of the Health and Social Care Act 2008.

At our last inspection in February 2016, a requirement notice was served as the provider had failed to ensure staff received basic training necessary to meet people's needs. The provider sent us an action plan telling us that a training programme was in place to ensure staff received the training they needed to meet people's needs.

The acting manager had reviewed the training and ensured that staff had completed basic training. This included first aid, moving and handling, safeguarding, medication, mental capacity and DoLS. The training programme used was on line computer based courses as well as face to face training and distance learning. Specialist training, such as diabetes, was ongoing and five members of staff had completed the course. Staff told us, "All our training is up to date. The acting manager is always on at us about that, to make sure it is done."

People told us that staff knew how to care for them well and often carried out training. Relatives felt staff were well trained and had the skills to help their relatives living with dementia. The acting manager showed us a training matrix and there was only one outstanding course, for one person, all other training had been completed and was in date. The acting manager told us, "Staff development is the most important thing. I have made sure everyone has done their training."

The acting manager had not received any management induction training to support them in their new role. An acting deputy manager had started at the service in May 2016. They had worked at another of the provider's services previously so had an awareness of the organisation's policies and procedures and had shadowed senior staff but they had not received an induction specific to the service.

The acting manager met with staff on a one to one basis for supervision to discuss their role and performance. The acting manager had carried out themed meetings on topics such as safeguarding and medication to improve staff understanding of their role. Annual appraisals were in the process of being completed, where staff discussed their personal development needs, and any areas where they could benefit from further training. The supervision policy stated that that supervision should be every four months. The acting manager said the usual practice was every two months. The acting manager and the deputy manager had not had supervision since the end March 2016. This was an area for improvement.

People had the support they needed to remain healthy and well. We observed senior staff arranging for medicines to be delivered and making appointments with health care professionals. People regularly saw the chiropodist, dentist, optician and attended out patient's appointments when required. One person had lost weight and staff had referred them to a dietician to ensure they were eating enough.

People were being supported to keep their skin healthy. Equipment, such as special cushions or mattresses were in place to reduce the risk of people developing pressure areas. Some people had specific medical conditions such as diabetes. There was detailed information in people's care plans about what a healthy range of blood sugars was for that person and what staff should do if they were too high or too low. Staff confirmed that they knew what to do if this occurred.

People told us that they enjoyed the food and that it tasted good. One person said, "The food is very nice, that is the chef for you." A relative told us, "My relative thinks the food is fantastic."

People were supported to choose what they wanted to eat from the menu each day. In the dementia unit some people were shown pictures of the different food available to help them decide what they wanted. Staff were patient and sat with people, explaining what was on offer so they could make an informed decision. Some people needed a specific diet because of their healthcare needs and this was provided. One person told us, "I'm a bit careful, I'm diabetic and they always accommodate me."

Staff encouraged people to eat in the dining room but some choose to eat in the lounge or in their rooms. Most of the people in the dining room could manage on their own, but when people needed assistance staff supported them to eat their meal. They encouraged them to remain as independent as possible and gently assisted them when they needed more help.

Relatives said, "The food is second to none here. My relative has a three course meal at lunch time and a cooked breakfast is offered every Sunday". "The food is good here, all home cooked". "The food is really good, my relative is really happy with the food".

People chatted at lunchtime, commenting that the soup was nice. Staff asked people if they enjoyed their meals and if they had had enough to eat. Each person had a nutritional care plan and a food and fluid record, to monitor that they were receiving a healthy diet. There were also nutritional risk assessments. There had been an occasion when a person had choked and this information had not been updated on to their eating and drinking risk assessment. This information had been recorded in the multi-disciplinary team visit notes and staff were aware, but this was not recorded in the person's care plan. The risk was reduced as this person was continually supported to eat and drink, but their records had not been updated.

Some people had their meals pureed in line with their medical conditions and others had thickening agents added to their food to help them swallow. The meals served looked appetising with ample portions. One person refused the pudding, the chef asked if they would like something else and encouraged them to eat one of their preferred puddings. The chef was aware of people's likes and dislikes, which were recorded in the kitchen. They explained how they boosted people's meals if they needed extra calories to gain weight and remain healthy.

Requires Improvement

Is the service caring?

Our findings

People choices were at times being compromised as they were unable to choose to have a shower as the shower room was out of use. People's dignity was not always maintained as there were occasions when they had to wait for equipment to be made available such as the hoist to support them with their mobility to go to the bathroom.

People and their relatives spoke positively about the kind and caring nature of staff. One person said, "I like it here, I liked it as soon as I came to visit" and "They're caring here, they do the best they can." A relative told us, "The staff are wonderful, they're friendly and are very good to my relative" and another relative commented, "Very caring staff. Show compassion and friendship to my relative."

Relatives said, "My relative is treated with dignity and respect". "My relative loves the staff; she looks upon some of them as her daughter". "All of the staff talk to everyone here from the cook to the handyperson they all speak with the residents". "The care staff are brilliant, absolutely fantastic". "The staff are fantastic here; they treat my relative with dignity and respect". "You have to see beyond the décor here, the care is really good".

Relatives told us how staff managed situations when people became anxious or displayed negative behaviour. They said the staff were gentle, kind and respectful. They spoke with people quietly until they became less anxious and calm.

Staff were able to interpret people's non verbal communication even when they were confused or unable to articulate themselves clearly. One person pointed at the window and one member of staff said, "Do you want to go outside? We can go out to the garden later if you like." The person smiled and appeared visibly pleased that staff had understood what they wanted. Later we asked staff if the person had been able to visit the garden and they confirmed that they had.

Staff told us that they worked hard to ensure people received good care. Staff treated people with compassion and kindness. One member of staff told us, "They're like our families, the ladies and gentlemen. We treat them how we'd want our families to be treated." One person was in bed and staff ensured that their windows were open to ensure that fresh air was circulating.

At lunch time the chef took time and spoke with people about their meals. They made sure people were encouraged to eat and discussed the lunch time choices. One person did not seem too keen to eat but once the chef had spoken with them they were happy to choose a variation of the meal.

People were treated with dignity and respect. One person was sitting in the dementia lounge and staff asked them if they needed to go to the bathroom. They gently touched their arm to gain the person's attention and knelt down and looked them in the eye. They spoke to the person in a quiet voice and asked if they needed some assistance. The person smiled and said yes, and left the lounge with the support of staff. They were given the assistance they needed in a discreet manner.

Staff respected people's privacy by knocking on their bedroom doors and waiting till they responded to enter. People told us that sometimes they preferred to be in their rooms and their decisions were respected. One person was able to lock their door to ensure their privacy was upheld.

People told us they chose what food they wanted, when they got up and went to bed. They said staff asked them what they would like to wear or where they wanted to sit. Some people preferred to stay in their rooms and staffed checked them regularly to ask if they needed anything.

People's religious beliefs were supported. Church services were held in the chapel which was always open if people needed some quite time to gather their thoughts. People were seen using the chapel when they wanted. Relatives told us they were always made welcome in the service. They said they were always offered refreshments when they arrived and could have a meal with their loved ones if they choose to.

People who needed support to make decisions about their care could be supported by the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

People's care plans and associated risk assessments were stored securely. This made sure that information was kept confidentially. When we asked questions about people staff answered in a quiet voice so not everyone was able to hear.

Requires Improvement

Is the service responsive?

Our findings

People told us they sometimes had to wait for the care they needed as staff did not respond to their calls promptly. One person said, "We have to wait. It's not five minutes, it's 10 or 15 and that's not good if you need to go to the bathroom."

A relative told us that sometimes they visited and their loved one needed to have their clothes changed as they had not managed to get to the bathroom in time. They thought more staff were needed to prevent this from happening.

Staff did not always have the time to provide person-centred care, and were, at times focused on completing specific tasks rather than focusing on people's individual needs. They told us that sometimes people had to wait for the care and support they needed. One staff member said, "We have to work together and we'll say, "Oh we'll do this person and then we'll do that person." We were mid-way through helping one person and then another person started buzzing as they wanted a wash and we had to tell them that they would have to wait." Staff told us that the use of another hoist and more staff would give them time to respond to people more promptly when they needed to go to the bathroom or receive personal care.

Systems were in place for pre-admission assessments to be completed to ensure that the service was able to meet people's individual needs and wishes. This information was used to develop the care plans but was not always thorough or complete. A relative told us that before their loved one came to live at the service they had discussed the care to be provided and had been provided with information about what to expect from the service.

One person had a discharge letter from the doctor that stated that they had epilepsy and had been seizure free for a year. Their pre-admission assessment, completed by the acting manager, had not stated that they had epilepsy. The acting manager said they had only realised the person had epilepsy when they were reviewing their file in July 2016 and this had been a surprise to them. Staff had not spoken with the person's GP regarding the epilepsy diagnosis or how this could impact on the person. There was no guidance in place for staff or risk assessments in the care plan regarding the management of this potentially unstable health care condition.

Although there was evidence in people's health care notes that their needs had changed the main care plan had not always been updated. For example, in June, one person had an incident where they had difficulty swallowing and an ambulance was called to assist them. The service had responded by requesting professional help from the Speech and Language Team who had carried out an assessment of the person's needs in July, but this information had not been included in the updated main care plan. The care plan had been reviewed twice since the incident and this information had not been changed to reflect their current needs. Staff told us that they were aware of the changes in this person's care through the daily handovers but without an up to date accurate care plan to follow there was a risk the person would receive inconsistent care.

People were not being supported to take part in activities of their choice. The acting manager told us that they were advertising for an activity co-ordinator for the service but had not had any response. Staff told us they did their best to provide some activities but did not always have the time to do this. One relative talked about the activities when staff made cakes with people in the dementia unit and how much people enjoyed this but this was not very often and in general there was a lack of other activities for people to join in with.

Relatives had commented on the annual quality survey that there was a lack of activities available for people. One relative said, "More stimulation of residents is needed." One person's social diary showed that during August they only participated in visits from a friend and relative, one bingo session and music therapy. There was no information about their personal likes and dislikes and what their previous hobbies were.

There were no activities observed for people sitting in the first floor lounge. Staff in the dementia unit's lounge spent time talking with people when they were free. One person sat looking at a colouring book and another person held a doll in their hand. One person asked to go outside and was taken into the garden in the afternoon. Staff told us that they did, "The best we can" and sometimes organised a pamper day, which people enjoyed. Staff assisted people to paint their nails and have a hand massage on these occasions.

The provider has failed to carry out a thorough and detailed assessment to ensure people's range of care needs were identified and fully met. People were not being supported to follow their interests and take part in social activities of their choice. This was a breach of Regulation 9 of the Health and Social Care Act 2008.

The care plans had detailed information about people's individual daily routines such as their preferred wishes to bath or shower, what they could do for themselves and how to support them with their personal care.

People were sitting the garden enjoying the weather and having tea and coffee with their relatives. Several people said they enjoyed going into the garden in the summer. The garden was enclosed with tables and chairs for people to sit and chat. There was an empty chicken coop as the chickens had been sent to a new home as there was no one to after them.

Relatives told us that there was good communication with the acting manager. Relatives told us they were confident to take any issues to the acting manager who would act on their information and resolve any issues.

People and relatives told us they did not have any complaints but would not hesitate to speak with the staff if they had any issues. One person said, "I would speak with a carer if I was unhappy".

There were systems in place to ensure that any complaints were responded to appropriately. Records showed that any concerns or complaints had been recorded and responded to in a timely manner.

All of the relatives spoken with told us that they would raise any issues with the staff. They were confident they would resolve any concerns they had. They said the staff and the acting manager listened and took their views into account. "No I don't have any complaints, I talk to staff if I am not happy, I would speak to the acting manager who would resolve any issues that I may have."

People and their relatives had some opportunity to provide feedback about the service provided; there were resident and relatives meetings. These were held regularly with minutes taken to action any ideas or suggestions.

Inadequate

Is the service well-led?

Our findings

Relatives said, "I am very happy with the care my relative has, I would definitely recommend the service". "I think the acting manager is doing a good job at managing the service".

Staff said, "The acting manager is amazing, they work so hard without any real support from the provider. They have improved the service so much". "The acting manager has certainly improved morale since they have been in post". "The acting manager was really good and had improved the morale of staff".

Staff told us that they liked working with the people at the service. Other members of staff raised concerns about the provider and leadership of the organisation. They felt the provider did not support them, as at times, there was a lack of supplies, such as gloves and aprons.

Staff did not feel that the provider listened to them as there had been recent changes to their conditions of employment which had not been handled smoothly. They had concerns about the future of the service, because progress to improve the premises was very slow and there was a lack of response from the provider to purchase another hoist. In addition they were worried about the recent reviews of the budget to cut costs which had resulted in staff leaving the service.

At the previous inspection in February 2016 we noted that there were concerns about the support from the provider to run the service efficiently. Since then the registered manager had left the service and there was an acting manager in place. In the last six months the provider had failed to appoint a registered manager, or make sure the management staff had a clear understanding of their roles and lines of accountability. Not having a registered manager in place is a failure to comply with the regulations and a breach of registration. The acting manager had not been given autonomy to run the business on a daily basis.

Staff told us the different managers had changed the ways of working in the service. They were aware of their roles and responsibilities and who to report to. However, visiting health care professionals were not aware of the roles and responsibilities of the managers. One professional said, "I know the seniors are in navy and the carers are in a lighter blue, but I'm not so sure about the management. I don't know who the different people are."

At our last inspection in February 2016, a requirement notice was given as the provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services and records were not completed fully or accurately. The provider had failed to seek the views of people, their relatives/carers or visiting professionals, to voice their opinions on the service provided. The provider sent us an action plan which did not include what improvements had been made to mitigate risks and no information was received about the improvements to records. At the time of this inspection not all risks had been mitigated and there were still shortfalls in record keeping. The opinions of people involved in the service had been requested but these had not been analysed or acted on to show what improvements had been made.

Records were not being completed properly or accurately. Risk assessments had not always been updated

to reflect the changes in people's nutritional needs. Re-positioning charts and night checks forms had not been consistently completed or recorded accurately. Another person had a chart in their room which staff should have signed every half an hour to confirm had checked the person. On the 12 August 2016 there were gaps between 2:40pm and 5pm and 5pm and 6:45pm, on the 13 August 2016 there were gaps between 8:45am and 2:25pm where staff had not signed and on the 6 August 2016 no staff had signed after 1pm. We could not be assured that the identified checks had taken place to ensure people were safe and receiving the care they needed.

Accidents and incidents had not always been recorded or completed accurately. One person had an episode of choking and received health care from paramedics. This incident was recorded in the multi – disciplinary notes but an incident form had not been completed. Another accident form had been completed when a person fell out of bed and injured their head. The form stated the accident took place on 23/06/2016 however the accident occurred on 21/06/2016 as the daily notes and doctor visits recorded what action the service had taken.

The acting manager had sent out surveys to staff, people, their relatives and other stakeholders involved in the service in April. These had been returned but no action had been taken to analyse the results or rectify any of the issues which were raised. People's relatives had commented on the lack of activities, the lack of staff and the need for further refurbishment but no action had been taken to address these. The provider had not analysed and responded to the information gathered, including taking action to address issues that were raised and to make improvements to the service.

The acting manager had undertaken weekly medicines audits and monthly care plan audits but these had not picked up on the issues identified at this inspection. Other audits had not occurred since March 2016. A monthly audit tool was in place covering areas such as how staff interacted with people, whether people's health needs were monitored and acted on, whether relevant health and safety checks were carried out and what the environment was like. The acting manager told us this had not been completed since the registered manager had left the service in April 2016.

People, staff, visiting professionals and relatives all mentioned that the service was in need of repair and could be improved. The provider visited the service each week and was aware of slow progress to repair and refurbish the premises and to ensure the additional second hand hoist had been serviced and ready for use. The maintenance/development plan had not been updated since the previous manager left in April 2016 therefore there were no clear timescales of when the décor and outstanding maintenance issues would be improved. One relative commented, "When I mentioned the state of the premises the provider just said 'It's in hand' with no further comment." Although the provider visited the service weekly, they had not recorded any quality audits since 25 November 2015.

The registered provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services. There was no analysis of the surveys to identify and address issues where they were raised and to make improvements to the service. Records were not completed or accurate. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008.

You had failed to display the CQC rating from the last inspection in July 2015. A provider has a maximum of 21 calendar days to display your rating from the date of the inspection report is published on the website. The previous report rating from the inspection on 10 and 11 February 2016, published on 15 March 2016 was not on display at the time of the inspection on 12 and 13 August 2016.

The provider had failed to display their rating. This was a breach of Regulation 20A (1)(3)(5)(a)(b) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us their vision and values of providing care to people at St Mary's. They told us they really cared for the people, were loyal to the people and came to work to make sure they were looked after properly. They said they did their best to ensure people had personalised care, were treated with dignity and respect and had the care they needed. One member of staff said, "I don't think the provider has any values, but for us, we treat people with respect." Staff told us they did not feel valued and supported by the provider. They said they did not feel listened to.

All services that provide health and social care to people are required to inform CQC of events that happen in the service so CQC can check appropriate action was taken to prevent people from harm. The acting manager notified CQC in line with guidance.