Private Medicare Limited

St Marys Care Centre

Inspection report

Beverley Road
Anlaby
Hull
East Yorkshire
HU10 7BQ
Tel: 01482 307592
Website:

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 10 and 11 September 2015 and was unannounced. The last inspection took place on 18 November 2013 and no actions were required.

St Marys Care Centre is a purpose-built care home situated in a residential area in Anlaby. The service supports people with long-term nursing care needs and can accommodate a maximum of 60 people. Accommodation is in single occupancy rooms with en-suite facilities. There is a large car park onsite for the use of visitors and staff.

The service comprises of two units within one large building. Riplingham unit supports people with residential care needs and Newland unit supports people who need nursing care.

The registered provider is required to have a registered manager in post and there was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The recording and administration of medicines was not being managed appropriately in the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

You can see what action we told the provider to take at the back of the full version of this report.

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and that there were enough staff to meet people's needs. Staff had been employed following appropriate recruitment and selection processes.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community.

People spoken with said staff were caring and they were happy with the care they received. They had access to community facilities and most participated in the activities provided in the service.

Staff received a range of training opportunities and told us they were supported so they could deliver effective care; this included staff supervision, appraisals and staff meetings.

The registered manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We saw from recent audits that the service was meeting their internal quality standards.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Some aspects of the service were not safe.

The recording and administration of medicines was not being managed appropriately in the service.

There were processes in place to help make sure the people who used the service were protected from the risk of abuse and the staff demonstrated a good understanding of safeguarding vulnerable adults procedures.

Assessments were undertaken of risks to the people who used the service and the staff. Written plans were in place to manage these risks. There was sufficient staff on duty to meet people's needs

Is the service effective?

Good

The service was effective.

Staff received relevant training, supervision and appraisal to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

We saw people were provided with appropriate assistance and support with regard to nutrition and hydration and staff understood people's nutritional needs. People reported that care was effective and they received appropriate healthcare support.

Is the service caring?

Good

The service was caring.

People were supported by kind and attentive staff. We saw that care staff showed patience and gave encouragement when supporting people. People were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Is the service responsive?

Good

The service was responsive.

Care plans were in place outlining people's care and support needs. Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

Summary of findings

People were able to make choices and decisions about aspects of their lives. This helped them to retain some control and to be as independent as possible.

People were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Good

The service was well-led.

The registered manager made themselves available to people and staff. People who used the service said they could chat to the registered manager, relatives said the registered manager was understanding and knowledgeable and staff said they were approachable.

Staff were supported by their registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with their registered manager.

The registered manager regularly checked the quality of the service provided and made sure people were happy with the service they received.

St Marys Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 and 11 September 2015 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector from the Care Quality Commission (CQC) and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to physical disabilities.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authority who commissioned a service from the home. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the service.

As part of the inspection process we contacted the local authority safeguarding adults and local authority quality monitoring teams to enquire about any recent involvement they had with the service. Both teams had visited the service recently to follow up concerns raised by a relative. The complaint was substantiated but both teams said the registered manager had worked with them to ensure the lessons learnt were used positively to prevent any further issues of the same nature.

At this inspection we spoke with the registered provider and registered manager, the deputy manager, training and development manager and the administrator for the service. We also spoke with seven staff members and then spoke in private with three visitors and eight people who used the service. We observed the interaction between people, relatives and staff in the communal areas and during mealtimes.

We spent time in the office looking at records, which included the care records for three people who used the service, the recruitment, induction, training and supervision records for four members of staff and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

We asked people who lived at St Marys if they felt safe, if the staff assisting them had the right skills, and did they feel the premises were safe and secure. Everyone spoken with responded positively and comments included, "I can go for a walk outside around the grounds, I take my 'buzzer' so that if anything went wrong someone would come" and "I would recommend it to anyone – no fears, every attention, clean linen and clothes." One person told us, "Yes, I do feel safe. The best part about living here is it takes the worry away from being at home."

We saw that the medicines policy and procedure had been reviewed and updated in March 2015 to ensure it followed the National Institute of Health and Care Excellence (NICE) guidance on best practice with regard to administering medicines within a care service.

People were very satisfied with the way in which their medicines were managed by the service. Comments included: "I can get pain relief when I need it and I can self administer my own co-codamol" and "My medication is always spot on time." One person told us, "I self-medicate for some things and others the staff do."

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them and disposed of appropriately. Medicines that required storage at a low temperature were kept in a medicine fridge and the temperature of the fridge and the medicine room were checked daily and recorded to monitor that medicine was stored at the correct temperature.

The nurses and senior care staff informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training plan and staff training files. However, we found unsafe practices around the administration and recording of medicines.

We looked at a selection of medicine records on both the nursing and residential units. We saw evidence that staff were signing for medicines they had administered, but on four out of ten MAR charts we looked at the records for administration did not match the amount of medicine we found in stock. The medicines we checked and found incorrect balances for included tablets taken on a daily basis and others that were taken as and when needed (PRN). This indicated that either people were not getting their medicines or that staff were not recording these correctly. This was not safe practice and could potentially result in people being put at risk of harm.

Discussion with the registered manager, the deputy manager and the registered provider indicated that they carried out monthly audits of the medicine records and we were given copies of the latest audit from July 2015. The audit included spot checks of the medicine stock held and no errors had been noted at that time. The deputy manager told us that they thought the problem was that staff were not always carrying forward stock held in the service onto the new MAR sheets so this did not give a clear audit trail when counting the medicines in the service. We were told by the registered manager and registered provider that this would be dealt with immediately.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable people from abuse (SOVA). The registered manager described the local authority safeguarding procedures. This consisted of a risk matrix tool, phone calls to the local safeguarding team for advice and alert forms to use when making referrals to the safeguarding team for a decision about investigation. There had been instances when the safeguarding risk matrix tool had been used, when alert forms had been completed and when the CQC had been notified. These were completed appropriately and in a timely way. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We spoke with five staff about their understanding of SOVA. Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse. Staff said they were confident their registered manager would take any allegations seriously and would investigate. The staff told us that they had completed SOVA training in the last year and this was confirmed by their training records. The training records we saw showed that all staff were up-to-date with safeguarding training.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included

Requires improvement

Is the service safe?

falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond to and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives. One visitor told us, "I have great trust in the staff, I can see when they support people they have been well trained. My relative isn't hoisted, just helped, but I always see two members of staff when they need to be moved and it is done well from both sides."

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and acted upon as needed. We were given access to the records for accidents and incidents which showed what action had been taken and any investigations completed by the registered manager. For example in May 2015 it was recorded that the wheelchair ramp in the greenhouse was too steep for people with mobility problems to use safely. The records further show that in June 2015 a handrail was fitted to aid people's descent when using the ramp.

Discussion with the registered manager and checks of the records held in the service showed that a dependency level tool was used by the registered manager to calculate the required staffing levels to meet the needs of people who used the service. We saw that the dependency levels had been reviewed every three months in the past, but over the last six months the registered manager had reviewed these on a monthly basis due to people's needs changing frequently. Each person who used the service had their own dependency profile; these were last reviewed in August 2015.

People and relatives who spoke with us said the staffing levels were good and they had no problems with the staff. We observed that the home was busy, but organised. Staff worked in and around the communal areas throughout the day and we found that response times to the call bells were consistently efficient. We saw that at there was a system in place to monitor response times to call bells and we noted that this never went beyond 90 seconds on the occasions that we checked it. One person told us, "There are staff on duty over the 24 hours, press the button and they are there. Someone is almost always on the station (at centre of each corridor)."

We spoke with the maintenance person and looked at documents relating to the servicing of equipment used in the service. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment serviced included the fire alarm and the nurse call bell, moving and handling equipment including hoists, portable electrical items, water systems and gas systems. We saw that the registered provider also had regular checks of the electrical wiring carried out and we were shown a copy of the five year electrical wiring certificate for the service.

Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person for wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights, window opening restrictors and bed rails. These environmental checks helped to ensure the safety of people who used the service. We saw that there was a 'repairs' folder where staff could write down any issues that required action from the maintenance team. These were dated and signed off by the maintenance person when completed. For example, the most recent issue was reported on 8 September 2015 and the records showed action had been taken the same day. This showed that maintenance of the environment was important to the registered provider and resources were available to ensure its upkeep was dealt with as a priority.

The registered manager spoke to us about the registered provider's business continuity plan for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. The care plans identified how people would be evacuated in the case of a fire. There was a 'grab pack' in the administration office for staff to use during any fire emergency. This included equipment and directions for the designated fire marshal.

We looked at the recruitment files of four members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). These measures ensured that people who used the service were not exposed to staff who were barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions and terms

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Is the service safe?

and conditions. This ensured they were aware of what was expected of them. The registered manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

Good

Is the service effective?

Our findings

People who used the service and visitors told us that the service was very effective and that staff were sufficiently skilled and experienced to care and support them to have a good quality of life. One visitor told us, "Staff know about my relative's needs. They are competent and know what they are doing." People who used the service told us, "I'm supported with my independence, I get 'in trouble' for not using the buzzer" and "The staff are very, very nice. You can't expect perfection but people know me and it works."

People who spoke with us said their health needs were being met, both in terms of regular medication but also access to GP services and support for hospital visits. One person said, "There's a physiotherapist who comes and I have treatment in my room. I have exercises to do" and another person told us, "There is a chiropodist every six weeks. And it is six, not five weeks or nine. They are on the ball and come to my bedroom."

We saw evidence that individuals had input from their GP's, district nurses, chiropodists, opticians and dentists. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). We asked people who used the service what happened if they did not feel well and they told us, "If you want a GP they are quick, it seems as though there are plenty" although one person said, "The GP was supposed to be coming but in the end I went there, one of the girls came with me in the taxi."

We asked people who used the service if they felt the staff were sufficiently skilled and experienced to care and support them to have a good quality of life. Everyone who spoke with us said "Yes." Comments included: "The staff? I don't think you can go anywhere and meet as good staff, they are brilliant" and "They do their best for you. It depends on you as a person, it's a difficult job to do." "The place is really good. Incredible. And I can argue with anyone." There was broad consensus that peoples' needs were being met and the staff knew people who used the service as individuals. This was borne out in our observations. Staff used first names for people who used the service and were on friendly terms. On the day of the inspection we observed that staff interactions with people were supportive, meaningful and natural.

Staff confirmed they completed an initial day induction which orientated them to the service and covered corporate information such as employment issues, policies and procedures and layout of the building. Each new member of staff then went on to complete an induction based on the Care Certificate from Skills for Care. Skills for Care is a nationally recognised training resource. We saw that new staff were allocated a mentor and the documentation we looked at indicated new staff shadowed more senior staff for the first few weeks of employment. As they gained new skills or were deemed competent in certain aspects of care, these were signed off on their induction paperwork.

We looked at records of staff training to check that staff had the appropriate skills and knowledge to care for people effectively. We saw that staff had access to a range of training that the registered provider deemed both essential and service specific. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling during their induction and then as refresher courses. Records showed staff participated in additional training to guide them when supporting the physical and mental health care needs of people who used the service. This training included topics such as palliative care, pressure ulcer prevention, dementia care, diabetes awareness, Deprivation of Liberty Safeguards, Mental Capacity Act 2005 and equality and diversity. Staff told us, "Some courses are computerised, some distance learning and some face to face." Discussion with the qualified nurses indicated that they attended sufficient clinical training to ensure they met the criteria for renewing their registration with the Nursing and Midwifery Council (NMC) each year.

The staff told us they had supervision meetings twice a year and annual appraisals with the registered manager. This was confirmed by the records we looked at. The training and development manager told us, "I work alongside the staff on a daily basis and I spend some time with the night staff. I carry out observations of their working practice." Staff told us that they found the supervision sessions beneficial as they could talk about their concerns and were given feedback on their working practice. However, we found that there was little documented evidence of the observational supervisions and the training and development manager confirmed to us that these were not always recorded. We were informed that this would be done in the future.

Good

Is the service effective?

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. Records showed that two people who used the service had a DoLS authorisation in place around restricting their freedom of movement. Both people required an escort when leaving the service to keep them safe whilst out and about in the community. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS.

During discussions with the registered manager and staff they demonstrated to us a good understanding of people's rights with regard to capacity and deprivation of liberty. The training and development officer was a qualified nurse who split their time between formal training and working within the service as the nurse in charge. They told us that they had seen some significant changes in working practice over the last year especially around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff told us they had received training on MCA, DoLS and equality and diversity which had given them more confidence in the way they approached people who used the service.

Staff followed the basic principle that people had capacity unless they had been assessed as not having it. In discussions staff were clear about how they gained consent prior to delivering care and treatment. One staff member told us, "For people who cannot communicate verbally with us we use our knowledge of them, talk with their family about their preferences and observe them individually to see what they like and dislike. We always offer them choices and talk with people to ask for their consent before we offer any support." We asked people if they had the opportunity to make decisions and choices and their responses were very positive about the service and staff. People told us, "Yes, I am treated as an individual, there's no restrictions" and "I can rise and retire when I wish. I'm up at 05:50 and watching the news by 06:00" and "We're all treated equally, honest, there never seems to be any difference."

We saw that where people had a person acting as their Power of Attorney (POA) this was clearly recorded in their care file. A POA is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare and / or finances) on behalf of the person who chose them to act for them at a time in the future when they no longer wished to make these decisions or lacked the mental capacity to make those decisions.

When people displayed particular behaviours that needed to be managed by staff in a specific way to ensure the person's safety or well-being, this information was recorded in their care plan. The staff told us that restraint was not used within the service. The staff were able to describe what they would do if an individual demonstrated distressed or anxious behaviours. Staff said, "You have to know how to approach people. We would talk to them, give them a cup of tea and distract them from whatever was upsetting them. On occasion it is best to walk away and come back a little later and try again." We saw that the registered provider had a policy and procedure in place, which confirmed that restraint would not be used within the service.

Entries in the care files we looked at indicated that people who were deemed to be at nutritional risk had been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. We saw that the service was working with the dietetics team in the community who had introduced the 'Nutrition Mission' to encourage people not to have supplements in their diet, but look at 'fortified' diets to increase their calorific intake. In response the service had introduced milkshakes, smoothies, fresh fruit, full fat yoghurts, cheese and crackers as between meal snacks and drinks. We were shown the records kept by the staff with regard to the Nutrition Mission and there was evidence that the registered manager monitored its success through regular weighing of people and checks of diet and fluid intake. The training and development manager and the head chef had completed the training for the Nutrition Mission and four staff had also completed the training and become the dietary 'Champions' in the service.

Everyone we spoke with said the food was very good. They told us the choice of meals, flexibility to 'go off menu' and availability outside of normal meal times were strong points for their overall satisfaction with the menus. One person told us, "Food is two good main meals, soup, a choice and so on. If I want different e.g. a salad they will do it for me. It's flexible and not forced and there are different

Good

Is the service effective?

things every day." Another person said, Here's my list of recent food – chicken pie, beans on toast, pork steak, pasty, haddock mornay……...very good but plastic cheese. I'll have a mushroom omelette for supper they are happy to cook something special." Visitors to the service were also able to participate in the meals if wished. One visitor said, "I can come to visit any time, including lunchtime. Lunch costs £5.00 and the food is good. Today was a typical menu choice - the beef in red wine was very tender."

Lunch was observed in a bright, airy, clean dining room with plenty of space for people who used mobility equipment to move around. Staff interaction with people was good and there was regular checking for adequacy, satisfaction and requirement for fluids. We noted that during our observations none of the people who used the service required help with eating or drinking. Progress with eating was at various speeds as might be expected and the service was unhurried. We saw that several people opted for extra food and alternative meals as offered by the staff. One person told us, "I could have my meals in bed if I wanted, it's up to me. There is a full English breakfast seven days a week and after meals you can have fruit, ice cream, anything."

People who used the service lived in a spacious and homely environment that had been designed to accommodate the use of moving and handling equipment in the bedrooms and communal spaces. The environment and fabric of the facility was clean and housekeeping staff were well in evidence. Furnishings and decorating were to a high standard and individual bedrooms were personalised to people's taste. There was a wide range of communal spaces for people to use including a library with recent magazines, a cinema room, a hair dressing salon and a physiotherapy room.

Good

Is the service caring?

Our findings

We observed that there were good interactions between the staff and people who lived at the service, with friendly and supportive care practices being used to assist people in their daily lives. Small acts of kindness were noticed several times. We saw that staff were invariably pleasant with people who used the service, the staff clearly knew them and their personality traits and peoples' often repeated comment to us was that, "Nothing is too much trouble for the staff." The phrases, "Home" and "Family" were also heard more than once. Random, cheery smiles were much in evidence and people told us that their care was individual and not generic.

The staff we spoke with were all long serving and knew the people in their care well. There was evidence of care staff knowing people's personal tastes but we saw they also checked with people for confirmation. Care plans included information about a person's previous lifestyle, including their hobbies and interests, the people who were important to them and their previous employment. This showed that people and their relatives had been involved in assessments and plans of care. Some people had signed their care plans to show they agreed to the contents. For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the registered manager.

The registered provider had a policy and procedures for promoting equality and diversity within the service. Discussion with the staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in the care files. One visitor told us how staff respected their relative's wishes regarding their religion and diet. We were told, "Staff ensure they are not served food they would not wish to eat (even though they cannot make this decision for themself anymore), there is always a choice of food and they will do an omelette at night if wished."

We saw that visitors came to the home throughout the day and that they were made welcome by staff. It was apparent that these were regular visitors who had a good relationship with the staff and the registered manager. They chatted to other people who lived at the home as well as their relative or friend. One visitor told us, "There's a very good atmosphere, everyone is very friendly and everyone is happy to help you."

We found that people who used the service were immaculately dressed in clean, smart, co-ordinating clothes. Their hair was brushed and many had been to the hairdressers, including the gentlemen. Finger nails and hands were clean and well cared for and gentlemen were clean shaven (if that was their choice). People told us, "I can't complain from lack of attention, there is always someone about even at night time. For example, I just ask for a shower and I get one." Everyone we spoke with was happy that their privacy and dignity was maintained. People said, "I've got no problem with dignity or privacy, the staff are very good" and "Everything is okay, dignity-wise, all done privately.

In discussions, staff had a good understanding of how to promote privacy, dignity, choice and independence. They said, "We close doors and curtains and gain consent for tasks. We always knock before going into a person's room or bathroom as a number of people like some privacy at times. Everyone has different preferences and routines, so it is important we listen to what they want from us and ensure they have the opportunity to make their own choices." We observed how staff promoted people's privacy and dignity during the day by knocking on bedroom doors prior to entering, ensuring toilet and bathroom doors were closed when in use and holding discussions with people in private when required.

When we asked people if the staff encouraged them to be as independent as possible, they replied, "The staff don't pressure you to do anything, but they're encouraging. I think they try to keep people active and mobile." One person told us, "As I've got worse (mobility) they've adapted, things like now I need help to move about, for example, from my bed into a chair." Visitors told us, "My relative needs full help, they cannot walk. The girls are always laughing and jolly them along" and "My relative thinks highly of the staff, their face lights up when the staff come into their room."

People were able to move freely around the service; some required assistance and others were able to mobilise independently. We saw that people who needed equipment to help them move from place to place were

Good

Is the service caring?

spoken with by the staff before, during and after the procedure to make sure they understood what was happening at all times. One person told us, “The staff are very experienced and I have full confidence in them.”

Staff were able to communicate effectively with people who could not verbally express their wishes. We saw them respond quickly and appropriately to meet people’s needs. We were shown examples of the communication sheets used with individuals; these included word charts and pictorial charts that had basic needs written on them, for example, drink, food, hot, cold, pain, glasses, bored and happy. Each person had a communication care plan in their care file which informed staff how best to communicate with them and any difficulties they might experience and how to overcome these.

Staff spoke confidently with us about end of life care. They were able to talk about palliative care and people’s needs and what this meant in practice. Staff told us they had completed training in end of life care in 2015 and they had found the session to be informative and useful. We saw that death and dying wishes were recorded in each of the care files we looked at.

One person whose care file we looked at had an advanced directive in place and their care plan reflected their wishes and choices about their end of life care. Their care file used a ‘traffic light’ system with care sections highlighted in green, orange or red dependent on a prognosis of life expectancy. Staff reviewed this file weekly to ensure they were aware of the person’s needs and kept their risk assessments up to date. As the person neared their end of life, the reviews of the file could become more frequent as needed to ensure appropriate care and support was given to the individual at all times.

Good

Is the service responsive?

Our findings

People who used the service and relatives were very positive about the service itself and the staff. It was compared to a five star hotel on more than one occasion when we spoke with people and no-one said they were unhappy or wished to be elsewhere. People's safety was considered to be good, as was enrichment – the list of things to do that people could tell us about was extensive and there was a good level of engagement for a post lunch activity that was briefly observed. The enrichment extended to gardening and a very impressive new greenhouse, which supplied some of the fresh produce for the kitchen.

We spoke with one of the activity co-ordinators for the service who worked on a flexible basis during the week (Monday to Saturday) to provide people with social events and activities to take part in each afternoon. The activity programme we saw indicated that quizzes, bingo, reminiscence sessions, outings, shopping, gardening, meals out and bowling classes were all part of the regular events taking place in the home. There were volunteers coming into the home three times a week to take people out for a walk and the activity person told us, "There is no difficulty meeting people's religious needs as we have a church service and everyone loves it."

We saw there was a directory of possible things to do in people's bedrooms and we asked people if activities were available and if they suited their needs; we received very positive responses. Comments included, "We have so many activities, look at this list (in room). I've been out to take part in a contest for indoor bowling, I only started after I came here." "I get to go out, sometimes it's a bus to visit places but I let the wheelchair people go, I'm not too bothered" and "We went to Eden Camp at Malton, six people, six carers, mini-bus, lunch, all free" and "I take advantage of the activities I can do." Some people preferred more simple pastimes such as reading a book in the library or watching a film on television. One person told us, "I'm the paper lad. They get delivered to the door then I sort them out and get them to people" and another said, "There's things to do but I'm not a person for quizzes and I have a hearing aid."

The service was seen to be very responsive, particularly in response to people's immediate needs or requests. Where people required help with anything the staff gave quick assistance. One person told us, "My watch stopped yesterday. I mentioned it and within three hours the handyman had got a new battery in it for little cost."

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide personalised care to each individual.

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. Each person living at the service had their own care file, which contained a number of care plans. We looked in detail at three of these files. The information recorded was detailed and person centred. Records evidenced that the information had been gathered from the person themselves, their family and from the registered person. One person told us, "I've been here three years, my son looked at lots of places before we decided on this one. There are a lot of places that smell and are not very nice, but this place is like gold, not coal."

Not everyone who used the service was sure if they had seen their care plans or had input to them. However, we saw that people and families were invited to yearly reviews of their care plans and those who spoke with us were unanimous in the view that things were okay in the service and staff did change their care practices to match circumstances such as deteriorating health or mobility. For example, one person told us, "I'm not aware of a care plan but I'm not backward in coming forward and I'd see it if I wanted to" and another person said, "Care plan – I should imagine there is one, I've not seen it but I can talk to the staff if I have any concerns and they listen to me."

Staff took the time to include people in daily life within the service. One person who used the service told us, "I'm the friendship champion, the staff knew I was feeling lonely. Now my picture is up there with the staff and I feel honoured." The staff told us that this individual helped new residents settle into the service and aided them in making friends with others and taking part in activities and resident meetings.

There was a complaints policy and procedure on display in the entrance hall of the service. This described what people could do if they were unhappy with any aspect of their care. We saw that the service's complaints process was also

Good

Is the service responsive?

included in information given to people when they started receiving care. Our checks showed that a review of the registered provider's complaints log indicated that there had been 15 formal and informal complaints made about the service in the last 12 months. We saw evidence that the registered manager had responded to these complaints and where necessary had sent the complainant a written response.

People told us they felt comfortable speaking with staff and would not hesitate to raise issues if they had any. One person said, "Staff listen to you when you mention any concerns. I have never had to make a formal complaint, but I am confident about how to do this if needed." Visitors also confirmed to us that they were aware of the complaints procedure.

Good

Is the service well-led?

Our findings

We found the service had a welcoming and friendly atmosphere and this was confirmed by the people, relatives, visitors and staff who spoke with us. Everyone said the culture of the service was open, transparent and the service actively sought ideas and suggestions on how care and practice could be improved. People who used the service and staff told us they enjoyed being at the service and references to being part of a family were made. Staff told us they had confidence in their colleagues and there was visual evidence of good day-to-day teamwork.

There was a registered manager in post who was supported by a deputy manager and an office administrator. The registered manager monitored the quality of the service by regularly speaking with people to ensure they were happy with the service they received. People who spoke with us all knew and claimed to get on well with the registered manager. One person told us, "I have a good relationship with [manager]. They always have a smile for you and are usually in the building from around 07:00 – 07:30 so they are available if you want a chat." Another person said, "I get on okay with [manager], they pass by my door and they always 'pop in'. I think the management do a good job, they are to be admired."

Staff described the registered manager as, "Approachable." They said that they could talk to them about any issues and they were listened to and that information discussed with the registered manager was kept confidential whenever possible. Staff had regular supervision meetings and annual appraisals with the registered manager and these meetings were used to discuss staff's performance and training needs; they had also been used to give positive feedback to staff. Staff also commented that they saw the registered provider at least twice a month and they made themselves available if staff needed to talk to them about any concerns.

Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires, meetings and one to one sessions. This information was usually analysed by the registered provider and where necessary action was taken to make changes or improvements to the service. The last questionnaire was sent out to people and relatives in July 2015. The analysis of the responses received showed that 30 surveys were sent out and 29 were received back (97%).

People said the best things about being at St Marys were, "Feeling safe, secure, lovely facilities, no worries and being looked after." The worst things were, "Leaving own homes and missing family."

We saw that the registered manager held regular 'resident' meetings and we were given the minutes of the last one held in July 2015 which 15 people who used the service, the registered manager and the activity coordinator attended. The items on the agenda that were discussed included gardening, the bowls contest, staff leaving and the results of the recent satisfaction questionnaire. Although some people who spoke with us could not remember if they attended a meeting there was an overwhelming response expressed with us that the match between their care requirements and the provision of the service was excellent.

People were encouraged to maintain their links within the community through their social activities such as meetings with the local church and schools, visitors / family and friends taking them out and about and trips with the staff into the local area to garden centres, pubs and shops. People had daily newspapers delivered to the service and some had on-line access to social media sites and the internet so could keep up to date with news and views relating to their social and political outlooks.

Quality audits were undertaken to check that the systems in place at the service were being followed by staff. The registered manager carried out monthly audits of the systems and practice to assess the quality of the service, which were then used to make improvements. The last recorded audits were completed in July / August 2015 and covered areas such as finances, reportable incidents, recruitment, complaints, staffing, safeguarding and health and safety. We saw that the audits highlighted any shortfalls in the service, which were then followed up at the next audit. We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed by the registered manager monthly, and again annually. We also saw that internal audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified.

We saw that the registered provider had a number of health and safety risk assessments in place for the service. These were reviewed and updated by the registered manager on a regular basis. For example, we saw the Control of substances hazardous to health (COSHH) risk assessments

Good

Is the service well-led?

were reviewed in February 2015 and the policy and procedure for risk management was updated at the same time. We also noted that the fire risk assessment had been reviewed in May 2015 and an action plan had been written and included the dates when action had been taken to resolve the issues noted. This monitoring of risk meant that the risk of harm to people using the service and those working in the service was managed well and reduced risk as much as possible.

A recent complaint about end of life care had caused the registered manager to review how the service delivered end of life care. An important part of monitoring of the service was to reflect on past events, what went well and why, and what did not go well and why and use this as an effective way of learning for the service and staff. We were shown the changes in practice that had been made as a result of this learning from events, for example, better communication with the GP practice and more robust checks of the end of life medicines held in the service. The staff were able to participate in the 'lessons learnt' process through discussion at supervisions and in team meetings. We saw evidence of the meeting minutes from January to August 2015.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered provider failed to protect people against the risks associated with the unsafe use and management of medicines by the inappropriate arrangements for recording and handling of medicines used for the purposes of the regulated activity. Regulation 12 (1) (2) (g)