Little Sisters of the Poor

St Anne's Home - London

Inspection report

Little Sisters of the Poor, St Anne's Home
77 Manor Road
London
N16 5BL

Tel: 02088262500
Website: www.littlesistersofthepoor.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 August 2018 and was unannounced. The last inspection for the service was 27 February 2017 and this was a focused inspection. This was in regard to a recommendation made from 25 July 2016 comprehensive inspection in relation to safe care and treatment. The service was rated overall as Good.

St Anne's Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St Anne's Home provides accommodation for 34 people who require nursing or personal care. At the time of our inspection there were 32 people living at the home. Accommodation was provided over three floors and offered comfortable and spacious facilities. There were a number of independent flats attached to the home including separate living quarters for the Sisters. The aim of the provider is to offer the highest quality of care and security for older people, taking into account the particular conditions associated with the ageing process.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always receive time specific medicines at the correct time, which may have affected their health and well-being. The arrangements for storing medicines for people were not always robust. Medicines records were not always completed fully and accurately. We were not assured that appropriate arrangements were in place for the recording, using and safe administration of some medicines.

Staff told us they felt supported and received supervision and training. However, the home did not record formal supervision for all staff that worked at the service. Staff received appraisals twice yearly. The home had recruitment procedures in place however the provider did not have a system in place to update criminal record checks for staff.

The home did not follow their complaints policy whilst addressing people's complaints. The home did not have an effective system in place to record and investigate complaints.

The home had monitoring and auditing systems in place to check the safety and quality of the service. However, they were not always effective in identifying gaps and errors. People, relatives staff, and health and social care professionals told us the senior management was approachable. People's, relatives' and health and social care professionals feedback was sought and considered to improve the service.

The service had appropriate systems in place for safeguarding people. Risk assessments were in place which provided guidance on how to support people safely. There were enough staff to meet people's needs.

People were able to make choices about most aspects of their daily lives. People were provided with a choice of food and drink and supported to eat healthily. People had access to health care professionals and were supported to lead healthy lifestyles.

People and their relatives told us they liked the staff. We saw staff interacting with people in a caring way and staff had a good understanding of how to promote people's dignity.

Care plans were in place and people were involved in planning the care and support they received. People had access to a wide variety of activities at the home.
We have made two recommendations about formal supervision for staff and continued suitability for staff to work with vulnerable people or people at risk.

We found the registered provider was not meeting legal requirements and was in breach of three Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to safe care and treatment, receiving and acting on complaints and good governance.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The service did not have effective systems in place for the management of medicines.

Individual risk assessments were in place for people to help protect them from harm.

The service had a safeguarding procedure in place and staff were aware of their responsibilities with regard to safeguarding adults. Staff were trained in infection control procedures and the home was immaculate.

Sufficient and suitable staff were recruited to meet people's needs safely.

Is the service effective?

Good

The service was effective. The service did not have a formal supervision system in place. Staff received appropriate induction and training to do their job effectively.

The home carried out assessments of people's mental capacity and best interest decisions were taken as required. The service was aware of its responsibility with regard to Deprivation of Liberty Safeguards (DoLS) and was applying for DoLS authorisations for people that were potentially at risk.

People received support with their nutritional needs and were offered choices of their preferred foods.

The service worked with health professionals to ensure people's physical and mental health needs were met.

Is the service caring?

Good

The service was caring. People told us they were treated with respect by kind and caring staff.

People were treated with respect. Staff understood how to provide care in a dignified manner and respected people's right to privacy.

The staff knew the care and support needs of people well and took an interest in people and their families to provide individual personal care.

Is the service responsive?

Requires Improvement

The service was not always responsive. The service did not have an effective system in place to make sure all complaints were investigated and recorded.

People's needs were assessed and care plans to meet their needs were developed and reviewed with their involvement. Staff demonstrated a good understanding of people's individual needs and preferences.

Staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had an end of life policy for people who used the service. The service explored end of life wishes during the initial needs assessment and care planning.

Is the service well-led?

Requires Improvement

The service was not always well-led. Quality assurance audits were not always effective in identifying problems with the service provision.

The service had a registered manager in place. People and staff told us they found the registered manager to be approachable.

People who used the service and their relatives told us that the service was well run and they received good care.

St Anne's Home - London

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 the 9 August 2018 and was unannounced. The inspection team consisted of two inspectors, one pharmacist inspector, one nursing specialist and an expert by experience, who had experience with older people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before we visited the home we checked the information that we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placements at the home, the local borough safeguarding team, and the clinical commissioning group. We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we observed how the staff interacted with people who used the service and looked at people's bedrooms and bathrooms with their permission. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. During the inspection we spoke with six people who lived at the home. We also spoke with two people who lived at the independent living accommodation which was based at the same location of the home. We spoke with the registered manager, the deputy manager, the clinical lead person, two nurses, four care workers, the chef, the administrator, and the activities co-ordinator. We also spoke with a volunteer from a health and social care agency who visited the home. We looked at eight care files, staff duty rosters, a range of audits, minutes for various meetings, medicines records, accidents and incidents, training information, safeguarding information, a health and safety folder, and policies and procedures for the home. We also looked at six staff files which included recruitment and supervision 7 St

Anne's Home - London Inspection report 17 September 2018 information.

Requires Improvement

Is the service safe?

Our findings

Most people were assessed as not being able to order, store or administer their medicines, therefore the service was responsible for this. We checked the service's arrangements for the management of people's medicines by checking a sample of medicines records and medicines supplies. Although we found some practices of safe medicines management, such as regular medicine reviews, and observations showed medicines being given to people in a caring and respectful manner, we found that medicines management required improvements.

We found that staff were not always checking instructions for people who required time specific medicines. For example, one person had been prescribed medicine for Parkinson's disease three times a day. The prescription stated the person was to have their medicine at 7am, 12pm and 6pm. However, the pharmacy had completed a medicine administration record that had a different time of 1pm for the 12pm administration. We spoke to the nurse about this and they advised this discrepancy had not been identified. This meant the medicines were not administered on time to ensure effective management of people's health conditions.

Medicine records were not always robust. For example, we found gaps in the recording of medicine administration. For example, one person who was at risk of choking was taking thickening powder to help improve swallowing however we found gaps in the recording of this being administered. We also found the home did not manage stock control effectively. We found large numbers of overstocked medicines being stored which made it difficult to effectively manage medicines being stored.

People were not always receiving the right dosage of medicines. We checked how people were supported to manage their diabetes. One person's records showed their diabetes was insulin controlled and their care records stated that staff should check their blood sugar and this would guide the amount of insulin the person was to receive. Care records showed a sliding scale which gave information on the amount of insulin to be administered depending on the person's blood sugar level. Records showed this person had received a lower dosage of insulin as the sliding scale indicated. We highlighted this to the nurse who gave the person the correct amount of insulin. For one person on prescribed oxygen, there was no information about the prescribed dose or expected flow rate. For other people prescribed oxygen, we found full oxygen cylinders in people rooms and a treatment room but these had not been fixed to the wall or on trolleys, in accordance with best practice guidance. After the inspection the provider advised us they had purchased a trolley to store oxygen cylinders. This meant people were at risk of not receiving their medicines safely.

During the inspection we gave feedback to the registered manager and senior staff about the concerns we found regarding medicines. The registered manager sent us an action plan on 13 August 2018 addressing the concerns raised and what immediate action had been taken. For example, the action plan stated overstocked medicines have been removed and will be given to the pharmacist for destroying, meeting with the nursing staff to address concerns about people with diabetes, and time specific medicines have been updated on the medicine records.

The above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed people had available "pro re nata" (PRN) medicines. However, during the inspection PRN protocol for one person was not available. After the inspection the provider sent us copies of PRN medicine protocols for people who used the service. PRN medicines are those used as and when needed for specific situations.

People told us they felt safe living at the home. One person said, "Yes I am safe, the staff make sure I am ok." Another person told us, "Of course one hundred percent safe." A third person commented, "Security all around, security gates, lights in the garden, things like that [make me feel safe]."

The service had up to date safeguarding and whistleblowing policies that gave guidance to staff on how to identify and report concerns they might have about people's safety. Staff and the registered manager were able to explain to us what constituted abuse and the action they would take to escalate concerns. Staff said they felt they were able to raise any concerns and would be provided with support from the senior management team and the registered manager. One staff member told us, "If I see something [abuse] I have to report to my manager or to [registered manager]. If it's more than that I can go to the council or the police." Another staff member said, "I have done my safeguarding training and I have no problems reporting anything wrong. I know what to do." A third staff member told us, "I would have no problem whistleblowing if I saw something wrong."

Risks to people's safety had been assessed and records of these assessments had been made. Records showed risks were reviewed monthly. Risks were individual to each person and covered areas such as bed rails, toileting, eating and drinking, falls, nutrition, skin integrity, mental capacity, end of life, personal hygiene, moving and handling, and medicines. Each assessment detailed the risk to people and the action needed to mitigate those risks. For example, assessments for people who needed support with hoisting detailed the level of support required and the equipment to be used to ensure risks were minimised. One risk assessment stated, "Place the slings on by letting [person] to lean forward. When using standing hoist carers need to make sure [person's] feet are correctly placed on the footboard and she is holding to the handles properly." Staff we spoke with demonstrated that they were aware of risks to people and that the guidance had been followed.

During the inspection we observed the home had a large stairwell for the three floors and a spiral staircase that went to the chapel. Both stairwells were not secured. Most people in the home had capacity however some people had been assessed lacking mental capacity. Records showed there was no individual risk assessments in place for people to access the stairwells. We discussed our concerns with senior management. They advised they would immediately carry out generic and individual risk assessments to ensure people were safe accessing the stairwells. After the inspection the provider sent us copies of the generic risk assessment. Also they advised us they had implemented a plan to make the stairwells safer for people who used the service.

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. We saw that incidents were responded to and outcomes, actions taken, and lessons were learnt. The home produced a monthly audit which looked at the cause of accidents, injuries and if needed, medical assistance. Records confirmed this. The registered manager told us due to an increase in falls the home had employed an additional moving and handling facilitator. The home had seen with the additional moving and handling facilitator that people were assessed more promptly and falls had decreased subsequently.

There were sufficient staff on duty to provide care and support to people to meet their needs. Most people and their relatives told us there was enough staff to meet people's needs. One person said, "On the whole plenty of staff." However, one person told us, "Sometimes you feel they could do with more." The registered manager told us staffing levels were based on people's needs and recently they had been increased due to people's dependency needs increasing. From our observations call bells were answered promptly and care staff were not hurried in their duties. One staff member said about staffing levels, "I think yes [enough staff]. It's not heavy work. Three people are independent. There's no rushing." However, another staff member told us, "We have enough staff, but today there is only one nurse."

Equipment checks and servicing were regularly carried out. The service had completed all relevant health and safety checks including fridge/freezer temperature checks, fire system and equipment tests, emergency lighting, gas safety, electrical checks, and water regulations. Fire alarm systems were regularly maintained. Staff knew how to protect people in the event of fire as they had undertaken fire training. The fire policy for the service stated that fire drills would be conducted every six months however we noted the last fire drill recorded was 27 October 2017. The registered manager told us and sent us an action plan after the inspection that a fire drill was to be held on 17 August 2018.

The service had plans to keep people safe in an emergency. We saw each person had a personal emergency evacuation plan (PEEP) this detailed action to be taken in the event of an emergency and was accessible to staff.

The home followed safe recruitment practices. Staff recruitment records showed relevant checks had been completed before staff had worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. However, some staff had been employed for a long period of time without subsequent DBS checks to ensure that staff were still safe to work with people. For example, one staff member had been employed since November 2008 however with no additional checks since the initial criminal check. This meant the service could not be assured that staff over a period of time were still suitable to work with people.

We recommend that the service seek advice and guidance from a reputable source, in relation to staff's continued suitability to work with vulnerable people or people at risk.

The home environment was immaculate and the home was free of malodour. The home managed the control and prevention of infection well. Records showed staff had completed training on infection control and prevention. Records showed infection control had been regularly discussed in staff meetings. Records showed cleaning audits were being completed. Observations during the inspection showed staff wearing PPE for tasks such as preparing food, personal care, serving food and cleaning. A visitor to the home said, "It is a very good nice home, very friendly, very caring, very clean and very well designed." One staff member told us, "I use the gloves, the aprons, dispose pads in the yellow bags, wash my hands before and after care. [I] don't wear the gloves when walking down the corridor. Here they provide everything."

Good

Is the service effective?

Our findings

Staff told us they felt supported and received supervision. One staff member said, "Yes, we do [receive supervision] with the unit manager. You can sort out any problems." Another staff member told us, "Yes regularly [receive supervision]." However, the service was not robust in recording formal supervision. During the inspection we were unable to see any individual supervision records as they were not available. During the feedback to senior management, they told us only care staff received supervision and not other staff working at the home. The provider's supervision policy stated, "Meetings with line managers will take place four times per year, or more frequently if the parties involved feel that this would be of benefit. At least two meetings will be allocated as supervision sessions. These may be on a one to one basis or as a group." This meant the provider's supervision policy was not being followed. Also, we saw a blank clinical supervision template for nurses which if used would cover issues discussed, areas of learning/support/professional issues identified, and an action plan. This meant that we saw no evidence that supervision was being carried out at the frequency as dictated by the provider's own policy on supervision to enable staff to deliver effective care

We recommend that the service finds out more about formal supervision for staff, based on current best practice.

People and their relatives told us the staff were very good and supported them well. One person said, "They [staff] are efficient in the work they do and in a caring way." A relative said, "Some of the carers [staff] are outstanding. [Relative] has made a lot of progress since she has been here. [Staff] have been wonderful here. [Staff] have done so much for her [including] doctors [and] physiotherapists. [Relative] really has improved immensely."

Records showed staff received two appraisals a year. This included a mid-year and end of year appraisal. Appraisals covered topics such as relationships, communication, training needs, goals for the following year and overall performance of the person's role.

Staff we spoke with told us they received regular training to support them to do their job. Records confirmed this. One staff member told us, "We have training, lots, all the time." Another staff member said, "We have lots of training. Every month there is [a] different training. [Senior management] reminds us of mandatory training." Records showed the training included fluids and nutrition, person-centred care, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), positive behaviour support and non-restrictive practice, medicines, dementia, dignity, equality and diversity, communication, record keeping and confidentiality, fire safety, first aid, food hygiene, health and safety, infection prevention and control, moving and handling and safeguarding adults.

The staff files showed that all of the staff had completed the two week induction programme, which showed they had received training and support before starting work in the home. Induction records showed that staff shadowed more experienced staff for at least three days.

Before admission to the service a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. An assessment of needs was undertaken at a pace to suit the person. The assessment looked at the person's medical history, medical diagnosis, social /domestic arrangements, person's feelings about possible admission, support networks, religion, mobilising, skin integrity, eating and drinking, physical assessment, breathing, sleeping, pain, bowel and bladder function, and psychological needs. Records confirmed this.

Records showed people were assessed in order to identify their support needs regarding nutrition. Details of people's dietary needs, food preferences, likes and dislikes were recorded in their care plan. Daily food and fluid intake was monitored for people who were at risk of malnutrition. Records showed people's weight was monitored regularly. If there were significant changes they would advise the GP and referrals were made to the appropriate health professional. Records confirmed this.

Most people told us they enjoyed the food. One person told us, "Good food, tasty." Another person said, "I really enjoy the food." One person we spoke with did not like the food however we saw the chef had made a separate meal to the menu for that person each day when requested. Staff also would get takeaway food for that person if they wanted.

The chef was aware of the people who were on specialised diets and explained the meal preferences for these people. This was reflected in the care plans and available in the kitchen. The chef told us that people could ask for alternatives to the food choices and records confirmed this. There was a rolling four week food menu in place which included at least two hot meal options. The food for people who were at risk of choking was presented well and blended separately allowing people to experience and taste the different flavours. We saw for blended food it was placed in a food mould so it looked like the food they were eating. This made the food more presentable and reflected what people were eating. For example, we saw blended food that was shaped like a sausage and separate vegetables.

We saw that people with complex needs of eating and drinking were protected from risks. For example, we saw one person who was had difficulty swallowing food being appropriately supported. The home had arranged for the speech and language therapy team (SALT) to assess the person. We saw all action had been applied quickly following this visit including the kitchen being updated of the person's requirements for a soft diet and an urgent referral to a dietician.

During the lunch time period we saw people being offered a range of drinks. Meals were attractively presented and there was a relaxed and calm atmosphere with music playing in the background. We observed people talking with each other in lively discussions. We overheard a person say to the people they were sitting with, "I never had lasagne before but I thought I would give a chance." We observed that person enjoying their meal. Another person told us, "I had such a big breakfast. Keeps me going for the day."

People in the home were supported to see health professionals when required. A GP carried out a visit on a regular basis and staff identified people who needed to be reviewed. Records were kept in people's care files to show when healthcare professionals had visited the person. This included GPs, podiatrists, dentists, chiropodists, opticians, speech and language therapists and dieticians. A health professional told us, "A review of my patient's documentation showed that his care plans were up to date and appropriate referrals were done."

The premises, décor and furnishings were maintained to a high standard. They provided people with a clean, tidy and comfortable home. Repairs were carried out in a timely way and a programme of regular maintenance was in place. There was secure access to a large garden for people to use. The home was

spacious and free from clutter. People's bedrooms were personalised.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager knew how to make an application for consideration to deprive a person of their liberty. We saw applications were documented which included detailing risks, needs of the person, and ways care had been offered and least restrictive options explored. Where people had been assessed as not having mental capacity to make decisions, the registered manager was able to explain the process they would follow in ensuring best interest meetings were held involving relatives and other health and social care professionals. Records confirmed this. The service informed the Care Quality Commission (CQC) of the outcome of the applications. We saw evidence of these principles being applied during our inspection.

Staff were seen supporting people to make decisions and asking for their consent throughout the inspection. Consent was recorded in people's care files. One staff member told us, "[Consent] for everything like when I go to their room. I knock the door and I say can I come. [People] choose everything." Another staff member said, "I ask every day for everything. I ask if it's okay to open [people's] curtains. I ask if it's okay to give them personal care." This meant the service was meeting the requirements relating to consent, MCA and DoLS.

Good

Is the service caring?

Our findings

People and their relatives told us that they were well treated and the staff were caring. One person told us, "Staff are so kind here. They treat me good." Another person said, "The [nuns] and staff do such a good job. They really are God sent." A third person told us about living at the home, "For me it is the most wonderful thing to happen to me after my [partner] died twenty years ago. It is a life saver and my children will confirm that." A relative said, "Some of the carers are outstanding. A year ago you could not of had this conversation with [relative]. She was so confused, but so much better now for being here. At first she always wanted to come back home, but now she calls this her home."

A health and social care professional told us, "Staff [have] a sound knowledge of the [people's] care needs which shows they knew the [people] very well." A person who lived at the independent living accommodation which was based at the same location of the home told us, "Oh my goodness me, amazing, absolutely caring, when we go [into the home] staff with residents are very good."

Staff knew the people they were caring for and supporting. Staff we spoke with were able to tell us about people's life histories, their interests and their preferences. One staff member told us about how they got to know people, "Reading the care plans, talking to the family, their friends and the resident as well. It's like family here. You have a more open [picture] of the resident." Another staff member said, "I treat these residents like my family. I know them all. I have been working here a long time." Staff communication with all residents was warm and friendly, and staff showed compassion when talking about people who lived at the home.

People were involved in decisions about the care they received and were offered choices based on their specific preferences. For example, the home had a medical suite and people were given the choice to be visited by the GP in the medical suite or their own rooms. Additionally, people were given the choice to remain registered with their GP or be seen by the visiting GP. Care records showed people were involved in completing a social assessment of their interests and hobbies. Care records documented people's preferences regarding their daily routines. People were supported to maintain relationships with their family and friends. Details of important people in each individual's life were kept in people's care records. Relatives and friends were welcomed to the service. This meant people's wishes and preferences were recognised, valued and respected.

People's privacy and dignity was respected. One person told us when asked about privacy and dignity in the home, "Yes, definitely." Another person said, "If I do not want to do something no one pesters me." Staff told us they knocked on people's doors before entering their rooms and we saw this during the inspection. Staff we spoke with gave examples of how they respected people's privacy. One staff member told us, "We have to respect everything. We have to cover them for personal care. We have to close the door. Even when we chat with them sometimes we joke but we have to have our boundary. We don't talk about them in front of [other] people."

People's independence was encouraged. Staff gave examples how they involved people with doing certain

aspects of their personal care to help become more independent. This was reflected in the care plans for people. For example, one care plan stated, "When [person] has bread or toast place them in her hand and encourage her to make an attempt to feed herself." One staff member told us, "I encourage them. I explain to them. If they can, I encourage and support them." Another staff member told us, "[Person] likes sugar in her coffee and I give her the sachet to put in herself. It makes her happy and makes me happy."

Requires Improvement

Is the service responsive?

Our findings

There was a complaint process available. The complaint process was available in the communal area so people using the service were aware of it. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. The complaints policy had a clear procedure to follow should a concern be raised. One person told us, "[Staff] ask me how things are going and if I am worried about something a carer might say speak to [senior management]."

The registered manager told us there had been no complaints since the last inspection. However, we spoke to one person who told us they made complaints recently. The person said, "Oh yes. [Complaint resolved] not to my satisfaction." The same person had also complained about a specific staff member but felt it had not been addressed. They told us, "I have reported [staff member], but [senior staff member] does not believe me." However, when we spoke to the registered manager they told us they were not aware of this specific complaint raised to us during this inspection. After the inspection the registered manager sent us a written formal investigation of the complaint made to us during the inspection.

The registered manager advised us verbal complaints were resolved, if possible immediately however these were not recorded. The registered manager told us all complaints will now be recorded. This meant the service did not have an effective system in place to make sure all complaints were investigated, analysed and recorded.

The above issues were a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed living at the home and the care they received was responsive to their needs. One person said, "You can rely on them [staff]." A health and social care professional told us, "My observation of the staff showed they were sensitive and responsive to [people's] care needs."

Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. Care plans were detailed, personalised and reviewed regularly. Care plans included guidance on personal hygiene, mobility, toileting, diabetes, nutrition, social and spiritual needs, skin integrity, eating and drinking, medicines, memory, and behaviour. Records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one care plan stated, "[Person] will some days walk to the dining room for her meals but she needs to be asked to see how she is feeling, as sometimes she may feel that she is breathless. When [person] is walking ensure that she has good walking shoes and they are fitted correctly." Detailed care plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

People had access to planned activities. The home employed a full-time activities co-ordinator. Activities on offer included ball therapy, board games, bingo, reminiscing, singing, flower arranging, films and knitting. The home employed a sessional physiotherapist to come in and support people with physiotherapy classes

using specialised equipment. A hall was equipped with a TV and video projector with a large screen for people to enjoy movies. A hairdresser and an aromatherapist were available to help people maintain their personal appearance and improve people's wellbeing. Peoples' views were mostly positive about the activities. One person said, "I go singing group and music group. If you want [activities] it is there and if you don't want [staff] do not hassle you." Another person told us, "Oh yes, [activities are] good in some respects, but I do not go to all activities as some are not very exciting or stimulating. I did not go to the sing along. I do not have a very good voice, they always sing the same songs as that is what people like." A third person commented, "There are plenty of activities, if you want them. There is an activities co-ordinator."

During our inspection we saw group activities with people. We observed in the morning a group activity with ball exercises. In the afternoon we observed a group singing session. Both sessions were tailored to people who used the service and were carried out with care and attention.

Staff supported people to meet their religious, cultural and spiritual needs and people could attend a place of worship of their chosen faith. Located in the home was a chapel for people to pray, attend [religious ceremonies], and evening prayers throughout the day. Overlooking the chapel was a large open gallery that people could use to watch and attend [spiritual ceremonies].

The registered manager told us members of other denominations or faiths were welcomed to the chapel if they wished to visit. People from different faiths and people of no faith had chosen to live at the service. For people who were unable to attend the chapel due to their mobility needs the home had installed a television link to enable those who wished to participate enjoy the service from the comfort of their own rooms. One person said, "[I] like to live here because of the spiritual and religious benefit I receive." Another person told us, "Without my religion I could not survive. [The] religious facilities [the home] offers means everything to me."

Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "We try and respect everybody." A staff member told us, "I know plenty of people who are [LGBT]. I like to see different people, [and] you can learn from everyone. The most important is people have a heart." Training records showed staff had completed equality and diversity training.

Advanced care wishes were written in people's care plans about how people wished to be supported with their end of life needs and evidence of discussions was recorded. Staff told us people were supported to receive end of life care at the home if they wished. People were supported by palliative care specialists such as a local hospice, nurses and the GP surgery for the home. End of life care plans were regularly reviewed to make certain people's wishes were met. Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were in place for individuals where appropriate and we saw evidence of discussions with multi-disciplinary teams and people's relatives to ensure that people were consulted about important decisions about their healthcare needs.

Requires Improvement

Is the service well-led?

Our findings

During this inspection, records showed the home had systems in place to regularly assess and monitor the quality of care people received. The purpose of having such systems in place is to identify areas of the service which require improvement and drive forward the quality and safety of the services provided. The systems the home had in place included quality assurance visits from the provider, medicine administration records audits and obtaining feedback from people who used the service, relatives and friends and visiting health and social care professionals.

However, we were concerned that the provider's approach to ensuring service quality, monitoring the service was not working effectively and bringing about improvement was not effective. This was because it did not pick up or address the issues that we have raised concerns about in this report. This includes concerns about people not receiving the medicines safely, lack of formal supervision for all staff, no effective system in place for recording and investigating complaints, and potential risks for people accessing stairwells in the home not being identified. This meant that systems were not effectively operated to monitor and improve the quality and safety of the services provided to people.

The above issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

People who used the service and their relatives told us they knew who the registered manager was and they thought the service was well managed. One person said, "[Registered manager] is brilliant. She listens to you. If there are any problems she will act on it and put it right."

There was a registered manager in post. They were aware of their responsibilities as registered manager and of the need to notify CQC about reportable incidents. They had current policies and procedures in place to run the service.

Staff spoke positively about the registered manager. One staff member told us, "The home manager is fantastic. She's very good. They are more than kind." A second staff member said, "[Registered manager] is very good. She understands everyone really well. She is professional. I am really happy with everything." A third staff member told us, "She is a good manager. What I like about [registered manager] is anything I ask for she gets."

The home held regular staff meetings where staff could receive up to date information and share feedback and ideas. Topics included were infection control, medicines, fluid charts, hydration for people, health and safety, training, risk assessments, quality assurance and accidents and incidents. One staff member told us about staff meetings, "Oh yeah it is useful. Especially if we have something important to discuss."

The service held a regular meeting where people could share and receive information. Records confirmed this. Topics discussed included activities, staff explaining their roles, fire safety, upcoming events and celebrations and home maintenance. One person said, "We have residents meeting once a month and you

voice your criticisms, opinions and suggestions."

The quality of the service was monitored through the use of annual surveys for people, relatives and friends and visiting health and social care professionals. All surveys had been completed for 2018. Overall the results were positive for all the surveys. Also comments from relatives and friends were positive. These included, "They really know and spend time with residents", "Always informed of changes", and "We are very pleased with the standard of care that [relative] receives and the wonderful atmosphere." Comments from health and social care professionals included, "All staff members at St Anne's are very welcoming, supportive, and respectful towards us", "Wish all care homes were as good", and "The place is well run and residents appear well cared for."

The home worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the registered manager told us they worked with health professionals, the local hospice, mental health teams, district nurses and volunteers. Records and feedback from health and social care professionals confirmed this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording and safe administration of medicines. Regulation 12 (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered persons failed to ensure people's complaints in relation to the regulated activity were appropriately received, handled, recorded, investigated and responded. Regulation 16 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance

The registered persons failed to effectively operate systems to: assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others in the carrying on of the regulated activity; accurately and completely maintain records in respect of each service user. Regulation 17(1) (2) (b) (c)