The Order of St. Augustine of The Mercy of Jesus

St Rita's Care Home

Inspection report

St. Georges Park
Ditchling Road
Burgess Hill
RH15 0GT

Tel: 01444873741
Website: www.anh.org.uk/st-ritas

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14 February 2023

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
St Rita's Care Home is a residential care home providing personal and nursing care to up to 60 people living with dementia and age-related frailties, 1 person being supported has a learning disability. At the time of the inspection, the service was supporting 55 people.

People's experience of using this service and what we found
Quality assurance processes did not always identify inconsistencies in relation to care records. Planned care and corresponding records of delivered care were not always documented. Audits did not highlight assessment tools were completed inconsistently. Formal feedback from relatives was not always addressed in a timely way.

People's health risks were assessed, some assessment tools showed some inconsistencies, however, this did not affect the planned care required. Care plans were written to guide staff on how to meet people's needs, this included providing safe support with swallowing difficulties and catheter care.

People were cared for by staff who knew them well and were trained to meet their needs. Staff understood their duty to respond to, and report safeguarding concerns. People received their medicines in a person centred and timely way, staff were trained and assessed as competent before administering people's medicines.

People were protected from infectious diseases by staff who followed the provider's policy. The service was clean and adapted to suit the needs of people. Dementia friendly signage helped people recognise communal spaces and their bedrooms.

People spoke highly of the support they received. People told us there were enough staff to support them, our observations confirmed this. One person told us, "The people are nice, and the food is good. The staff are very nice." People were encouraged to retain their autonomy and staff treated them with respect.

People were supported by staff who were trained and appropriately supervised. Staff completed training relevant to their role and were given opportunities to train further in areas of interest. One staff member said, "[Staff member] allocates training dependant on shifts and within work time so people can have a life and still complete the training." People told us staff were trained to meet their needs.

People were engaged and stimulated. Activity workers planned events around people's wishes. One person told us, "There is something every day, card making, bingo. It is well organised." People and their relatives told us they knew how to complain and felt comfortable to so do if necessary. Care was person-centred and people were involved in their care planning.

People and their relatives gave positive feedback about the running of the service and the registered

manager. They told us they were able to approach the registered manager with suggestions and felt listened to. One relative said, "It doesn't matter what the request, it is always dealt with and the home is spotlessly clean."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 4 January 2022 and this is the first inspection. The last rating for the service under the previous provider was good, published on 1 May 2018.

Why we inspected
This is the first inspection for this newly registered service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We have identified a breach in relation to governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

St Rita's Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 3 inspectors 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.

Service and service type
St Rita's Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Rita's Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. We visited the location's service on 9 February 2023 and 14 February

2023.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from Healthwatch, Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 14 people who use the service and 9 relatives of people who use the service about their experience of the care provided. We sought feedback from 5 health care professional who regularly visits the service and 11 members of staff including the registered manager, members of the management team, registered nurses, care workers, activity staff and the chef.

We reviewed a range of records. This included 9 people's care records and multiple medication records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of harm or abuse. People and their relatives told us they felt safe and could to speak to the registered manager or staff if they had any concerns. One person told us, "I feel safe living here, and listened to by the staff."
- Staff received training and demonstrated knowledge responding to and reporting potential abuse. Staff told us they would speak to the registered manager if they had any concerns and could contact external bodies if required. One staff member told us, "Any concerns I would go straight to [registered manager], they would listen, I would document everything. If [registered manager] did nothing, but I am sure they would, I would go to CQC and safeguarding."
- Safeguarding concerns had been investigated and responded to appropriately.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's health were assessed and lessons were learned when things went wrong. Following a choking incident, staff completed extensive training about modified diets and the prevention of choking. Works had been completed to ensure risks had been robustly assessed for people at risk of choking. Where people had swallowing difficulties, speech and language therapist (SaLT) advice had been sought and clearly updated in peoples' care records. Catering staff had updated information when people's needs changed and when people were newly admitted to the service.
- Some people had catheters in situ, care plans guided staff on how to minimise the risk of complications. People were encouraged to maintain a healthy fluid intake; staff recorded fluid intake and output to identify any concerns.
- People were involved in their risk assessments and were enabled to take risks. People were supported to go out with their friends, families and staff. People who wished to smoke cigarettes were able to do so safely following a risk assessment.
- Environmental risk assessments were in place and safety checks were completed. People had personal emergency evacuation plans (PEEPs) to highlight the support people required in the event of an emergency. Potential risks were assessed, the resident cat had a risk assessment to enable them to safely live in the service whilst minimising risks to people.

Staffing and recruitment

- Staff were recruited safely and there were enough staff to meet people's needs. We observed staff spending time with people and responding to their requests. Some staff had been trained to perform a dual role, for example, a care worker was trained to assist in the kitchen and provide activities. One staff member told us, "We all help out in various areas, it's good for experience."
- People and their relatives told us they felt there were enough staff on duty. One relative told us, "It's never

"felt understaffed." An agency staff member said, "There seems to be a lot of staff here, the residents seemed to get a lot of attention and I've noticed the call bells haven't been ringing constantly."
● Staff were recruited safely. Applications forms were completed and employment histories and gaps in employment were explored. References and Disclosure and Barring Service (DBS) checks were obtained prior to employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Registered nurses were employed at the service, their registration with the Nursing and Midwifery Council were up to date and verified.

Using medicines safely
● Medicines were stored and administered safely. We observed a registered nurse administering medicines to people in line with best practices. Medicines were administered by registered nurses and team leaders; all staff who administered medicines had been trained and assessed as competent.
● Some people were prescribed 'when required' (PRN) medicines and protocols were in place to guide staff on when the medicine would benefit the person. The service operated an electronic medication administration record (eMAR) system, staff had been trained to use the system. Each eMAR record contained a recent photograph of the person it related to.
● Where people required their medicines to be covertly administered (without their knowledge but within their best interests), mental capacity assessments had been carried out and records of best interest decisions were kept and regularly reviewed. Staff had liaised with family members and appropriate professionals to make sure this was completed in a lawful way.
● Staff monitored people's potential side effects following changes of medicines. Staff gave examples of when they contacted the prescriber for medicine reviews after noticing adverse effects.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● People were able to welcome their loved ones into the service when and where they wished, without restrictions.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before they moved into the service. The registered manager told us they were keen to ensure people's needs were met holistically. They told us, "Finding out about people, life history and past jobs are important. It helps and explains a lot, especially with dementia."
- The assessment process was robust and included people's wishes, goals and preferences. Care plans were written from the pre-admission process and were updated as staff got to know people. People were able to bring their pets to the service, upon risk assessment. The registered manager told us, "If the person has had a pet their whole life, why would I separate them?"
- A person who was newly admitted to the service had a comprehensive care plan completed in a timely way. The care plan included the person's preferences, so staff were able to support them appropriately. For example, it was important for the person to have a torch with them at night.

Staff support: induction, training, skills and experience

- Staff had the training, skills and experience to support people effectively. One staff member told us, "Our training is good, we have these roadshows put on for extra learning. It's handy because you can pop in, do a unit and go back for more learning."
- The provider practiced value based recruitment. A member of the management team told us, "When we recruit, we go out of our way of getting staff with the right ethos. You can teach people skills, but you can't teach them to care."
- The training manager ensured training and learning was relevant to staff roles. Staff had completed learning disability training and supported people appropriately. New staff completed the Care Certificate, the Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. New staff had shadow training with experienced staff members to get to know people and worked alone once assessed as competent.
- Records confirmed and staff told us, they received regular supervisions and with their line manager.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care

- People were supported to maintain a balanced diet and staff worked with professionals to ensure effective care was provided. One person lived with diabetes but experienced weight loss. Staff consulted with the diabetes nurses and dietician to create a diet to meet both needs. Catering staff were involved in developing an appropriate menu which further encompassed the person's preferences. The person's weight and blood sugars had stabilised.

● The kitchen staff had an up to date list of people's preferences and recommended diets. These were consistent with people's care plans which further identified people's intolerances. Menus were designed around people. A staff member told us, "I talk to as many people as possible find out what they would directly want. It's important to do this with them, and not assume. People with dementia may not always say what they want and potentially would eat what they are given. I want to make sure people's preferences are known from the beginning; we sometimes ask family."
● Staff used the malnutrition universal screening tool (MUST), to ascertain unexpected weight loss. Staff monitored people's weights weekly and addressed concerns. Where required, referrals were made to people's GPs and dieticians. For people who had been identified as needed support to gain weight, the kitchen staff introduced additional calories to people's diet by adding cream and butter to their meals.
● The dining experience was relaxed. Staff supported people to eat their meals in an unhurried way and communicated well with them. Where people had not eaten much, we observed staff offering alternative meals and gently encouraged people to eat more.

Adapting service, design, decoration to meet people's needs
● The service was adapted and designed to meet people's needs. The corridors were brightly decorated with talking points for people when moving to different areas of the service. Corridors had themed seating areas for people which were designed to emulate outside spaces. For example, a beach and a woodland, sounds were piped into the areas to create a sensory experience. A staff member told us, "The garden upstairs has the water flowing so there are sensory stimulations. [Person] likes the butterflies and feels them on the walls."
● People were able to bring items from their previous homes and had hung pictures on the walls and filled shelves with ornaments and frames. People's bedroom doors were personalised with photographs or pictures of interest to help them recognise their own space.
● The service was split into 4 house-holds, named after trees, each had a lounge or quiet space. Communal spaces were spacious, and wheelchair accessible, dementia friendly signage helped people orientate around the service.
● The service was located on rural grounds, farm animals were in the surrounding fields, people told us they enjoyed watching the animals. The garden was accessible from the dining room and had tables and seating ready for people to use.

Supporting people to live healthier lives, access healthcare services and support
● People had access to healthcare agencies and support. Staff engaged with healthcare professionals, such as, the community mental health team to provide good outcomes for people. The registered manager gave examples of when healthcare professional input benefited a person. This included a review of medicines and staff following methods of distraction to prevent the person from feeling anxious.
● Timely referrals were made to professionals. For example, a person had recently been admitted, staff were concerned about the person's ability to swallow and contacted the SaLT team the day of admission for advice. A visiting healthcare professional commented, "If I leave advice, staff follow the advice."
● People's oral care was routinely assessed; dental appointments were arranged where required. People had access to other healthcare services, such as, physiotherapy and chiropody.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● MCA assessments had been carried out in relation to people's care needs. Where people lacked mental capacity to make their own decisions best interest decisions were made with them, their legal representatives and professionals. MCA assessments were not always documented clearly. The registered manager had identified this as an area for improvement and had plans to address record keeping.
● DoLS applications were made when required; staff had assessed people's mental capacity and applications were made in their best interests. Conditions to some people's DoLS authorisations included regular reviews of certain medicines. Staff ensured the medicines were reviewed in line with the conditions. A relative told us "I have LPA (last power of attorney) and was involved in the DoLs decision. They do consult me when a decision needs to be made."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were supported by staff who were respectful of their needs. Staff had received equality and diversity training which was reflected in their practice. For example, staff sensitively supported a person to express their gender identity, providing help when it was needed. The registered manager said, "This day and age, everything goes. Everyone should live their lives regardless. People can be free these days and I wouldn't have it any other way."
- Staff knew people well and had good knowledge of people's background. One person led a very active life before moving to the service, staff told us about their previous employment and what they enjoyed. One staff member told us, "It's really important to know the people we care for. It gives us something to talk about and they feel better talking about things they love." Staff explained how they treat people differently dependent on their wishes.
- Staff looked at ways they could support people, respecting their abilities. A relative gave an example of this and told us, "My relative was a musician, they had never not had a piano in their house. My relative had an electric piano in their room. We tried to get them close to the piano, but it didn't work. The next day, staff wheeled my relative down and videoed them at the piano and sent it to me. I am a massive fan of this place."
- People had access to a range equipment depending on their abilities and preferences. This included equipment to move and position, and crockery and cutlery to support people to eat independently. A staff member told us of plans to replace dining tables with height adjustable tables. They said, "We also want to get some pedestal tables that go up and down, so they are more suitable for people with wheelchairs to eat comfortably."

Supporting people to express their views and be involved in making decisions about their care

- People were supported to make decisions with certain aspects of their lives. Where required, families were asked to contribute to decisions. We saw care plans were reviewed regularly, and people were asked if they wanted to make any changes. One relative told us, "[Person's] care is regularly reviewed. The staff are very approachable as is the registered manager. I suggest things for [person] and they are very accommodating."
- We observed people and staff communicating in different ways. People at the service had sight and hearing impairments and people were spoken to in the appropriate way varying their pitch and sound. One staff member told us, "We sometimes use flash cards to help with communication. How we talk to our residents is important to me. I want to know as best as possible they understand me."
- Staff made sure people were involved in day to day decisions. A staff member told us, "Some people have lots of nice clothes. I always get a few types of clothing out in the mornings and get them to choose. I wouldn't want someone to tell me what I was wearing each day!"

Respecting and promoting people's privacy, dignity and independence

● People's privacy and dignity was respected. Staff told us they had completed training in understanding dignity. A staff member told us what they felt dignity meant to them. They said, "Dignity means respecting everyone's wishes and how they wanted to be treated and to always feel respected. Although they are here and we look after them, they are still people."

● People were encouraged to maintain their independence. One person told us, "There is a balance in terms of my independence, the care I receive is about right." Staff told us how they encouraged independence. A staff member told us, "If I am helping someone with a wash or brushing their teeth for example, I try and encourage them to do as much as they can for themselves. I then help with the things they can't do."

● Staff showed good understanding of maintaining people's privacy. One staff member told us, "I always make sure I am aware of people's privacy. For example, if it's time for someone's medication and they are in the lounge, I will discreetly explain to them that they need their medication and take them to their room." We observed staff knocking on a person's door that needed support with personal care. They waited for a response before entering. Rooms had blinds covering side windows. Staff made sure these were closed on the before supporting people.

● The design and layout of the premises supported people's independence. The doors from the dining enabled everyone to access outside spaces. The spaces were flat, wheelchair accessible and a cushioned outside flooring minimised risk of injury.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were person-centred and included people's wishes, goals and aspirations. One person had a goal to increase their mobility, staff were working with them to achieve this. A staff member told us, "[Person] has physio. They [physiotherapist] ask us to come in and watch them do a transfer. They trying to get [person] strong enough to go home. [Physiotherapist] relies on us to feedback how [person] is getting on in between times."
- Staff knew people well and described what was important to them. Where people had preferred names or nicknames, this was respected by staff. The registered manager told us of ways they tried to meet people's needs in the absence of information. They said, "I take a (person's) date of birth and add 18 years on and look at the era of music to play."
- People were involved in planning their care and support. Where they were unable to give views, staff used the information they had about people's life histories and family input to plan person-centred care.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were assessed; care plans guided staff to people's preferred method of communication. This included communication aids for people, such as, glasses and hearing aids.
- A staff member told us about a person who had limited hearing and was unable to effectively communicate with a visiting social care professional. They said, "[Person] has a hearing impairment. They [professional] thought [person] wasn't understanding. We wrote things down and they seemed to understand, so we got [person] a whiteboard for staff to use to communicate. They then talk back."
- The registered manager described how the service met the Accessible Information Standards. Documents were available in larger print formats and staff were available to read documents aloud. The activity schedule and menu were pictorial to support people to make choices. The registered manager shared plans for further meeting the Accessible Information Standards to include documentation to be made available in audio format and Braille.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to take part in activities relevant to them and maintain relationships with their friends and family. Visitors were welcomed to the service and people could go out with them. There was a guest bedroom for visitors to use if they wished to stay overnight.
● A schedule of activities included arts and crafts, reminiscence and entertainment. We observed a show by 'Elvis' during our inspection which people appeared to enjoy. The activity schedule was displayed in each of the households with photographs of people participating in previous activities. The activity schedule was designed around people's histories and preferences. People had opportunities to attend smaller group activities, such as, baking, trips outs and gardening.
● People were engaged in areas that interested them. One person using the service enjoyed laying the tables. The person was given a staff name badge and referred to themselves as the 'dining room supervisor.' Where feedback mad specific requests, these were met. For example, 2 people wished to go out for coffee at the local garden centre.
● The service was a Christian faith-based service providing pastoral care. Catholic services and Church of England services were also held for people who wished to practice their faith. A chapel was situated in the grounds if people wished to attend. People were welcomed to the service regardless of their faith and culture. The registered manager told us how they supported people with other faiths and cultures; they described an Indian virtual experience was created for a person who was unable to visit their home country.

Improving care quality in response to complaints or concerns
● Information about how to make a complaint was displayed and leaflets were available for people to take away and read. Information included who to direct complaints to.
● People and their relatives were satisfied with the service. No formal complaints had been received. The registered manager told us, although there had been no formal complaints made, there had been a theme of comments made about the laundry service. A person, with the help of their relative had suggested the implementation of a laundry system to helped them identify their clothes when they returned from being washed. This was in the process of being completed.

End of life care and support
● People were supported when at the end of their lives. The registered manager described how they met the Gold Standard Framework, "It's how to create beautiful passing away, making sure everything in place. Simple things like having relatives there, a lantern on, soft music, hold the person's hand, soothing people. We have had the most peaceful passings I have ever seen." A relative told us how they had been well supported by staff when their loved one passed away.
● People were involved with advanced care planning and where appropriate their families contributed. Care plans included what was important to the person, music they may wish to listen to and their faith. A staff member told us, "They (people) can be treated palliatively. We make sure people are comfortable and not distressed, spiritual needs are met, we make sure that they can breathe properly. All symptoms are controlled with injections, as required."
● People at the end of life were kept comfortable. Staff worked with professionals to ensure the right medicines and equipment were in place for people to remain relaxed, pain free and able to pass away with dignity.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Managers and staff were not always clear about risk requirements and did not always involve people and relatives in the service. Systems and processes for quality monitoring did not always identify shortfalls in documents relating to supporting people's assessed needs.
- Quality assurance processes did not highlight inconsistencies in assessment tools. Assessment tools required some information to be repeated, for example a person's body mass index (BMI), was required for a range of assessments; these were not always completed with the correct information. Inconsistencies could lead to confusion to staff when delivering care.
- Quality monitoring processes had not highlighted people's care records were not always reflective of the care they received. Some people required assistance to move and position, staff did not always record when this had been done. No person had sustained any pressure damage to their skin; however, the registered manager had not identified these omissions to take appropriate action.
- Feedback from people and their relatives was not always sought and addressed. An annual survey was distributed to relatives in 2022. The results had been analysed; negative comments had not always been addressed. For example, 33% of relatives felt their loved ones were not stimulated. The senior management team had shared positive survey results with staff but did not share plans of addressing the negative results.

The provider's governance systems were not always effective and failed to consistently assess, monitor and drive improvement in service delivery. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager responded to our concerns about quality monitoring processes. On the second day of our inspection they had revised audit forms to document specific details and to include actions to follow up. The registered manager planned a relatives' meeting during our inspection to take place in the coming months.
- The registered manager completed daily walk arounds of the home, they told us this was to identify any improvements needed to the environment. During daily tours the registered manager told us they spoke with people to give them an opportunity to provide feedback.
- People were given limited opportunities to express their views in group settings, however, were asked their views on an informal basis. The registered manager gave an example of listening to people. One of the service's cats had passed away, people told the registered manager of the therapeutic benefits of having a

pet, they listened, and another cat was rescued. We saw people happily interacting with the cat throughout our inspection.

● Staff were clear in their roles. The registered manager appointed 'champions' from the staffing team based on skills and experience. For example, one of the registered nurses was a wound champion; they were responsible to ensure relevant medical dressings were in stock. The registered manager told us this had worked well.

● Health and safety checks had been completed and meetings were held to discuss the findings. Where shortfalls were identified, action plans set out timescales and responsibility to make improvements. Staff told us they had made suggestions to improve the environment, they had been listened to, we saw the dining room was being updated based on their suggestions.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●The service was positive and inclusive. Staff used a keyworker system to understand people in depth and review their needs considering preferences. Staff mostly worked in 'house-holds' and were keyworkers for people. A staff member told us, "We are all keyworkers for a group of residents. It works well so we all get to know each other and understand our residents."

● A high percentage of staff had worked for the provider for many years. Staff described close relationships with people, although understood professional boundaries. One staff member told us, "The best thing about St Rita's is the residents, they feel like family to me and I think they see me as family too. I have been here for so long, but residents have too, it gives us a chance to really get to know them, and their families."

● Regular staff meetings were held; staff were encouraged to speak up and give suggestions on the running of the service. One staff member told us, "I can go the manager for anything, they're accommodating. Always has time to listen, I've made suggestions. Some of the ladies' skin was a bit itchy, I suggested hypoallergenic incontinence pads and the laundry supplied to change to non-bio. [Registered manager] just said straight away to order them. It's made a difference."

● Staff updated people's relatives about medicine changes, professional visits and changes of needs. One relative told us, "The communication is very good, I am always pro-actively informed about any developments in respect of my relatives health or other matters."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager demonstrated a working knowledge of the duty of candour. They described the duty of candour as being open and transparent when things went wrong and to provide an apology to those concerned. The duty of candour was considered for incidents, accidents, complaints and safeguarding matters.

Continuous learning and improving care; Working in partnership with others

● Staff worked well in partnership with health and social care agencies and were keen to continually improve people's experience of care. People received external professional involvement including, GPs, SaLT, and chiropodists. Advice was documented and people received support in accordance to the advice. One visiting healthcare professional told us, "I get good feedback (from staff) on the residents when I ask a question, it is quite detailed and relevant to the person."

● Referrals to professionals had been made for people and staff knew where to access support. The falls prevention team had been contacted as a person using the service had experienced a series of falls. They suggested additional equipment to support the person's abilities and to minimise falls. Some staff had been trained as moving and handling assessors which equipped them to understand the possible reasons for falls and how to prevent them.

● The provider had arranged a trial of audible sensor equipment. This allowed staff to monitor people without the need to disturb them at night. The trial was successful and was rolled out to the rest of the service. People who did not wish to be monitored remotely had their wishes respected and the sensor equipment was not installed.
● The registered manager met with other managers of the provider's services. Where lessons had been learned in other services, the registered manager applied the lessons to the service to ensure good care. For example, the registered manager was in the process of adding learning disability to their registration with CQC.

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 17 HSCA RA Regulations 2014 Good governance The provider's governance systems were not always effective and failed to consistently assess, monitor and drive improvement in service delivery.