Lilian Faithfull Care

St Faith's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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 Faith's Nursing Home is a residential care home which can provide personal and nursing care to 69 people aged 65 and over. At the time of the inspection 59 people lived in the home.

People are accommodated in one adapted building. Each person is provided with their own private bedroom with toilet and washing facilities. Additional toilets and bathrooms are available and are adapted to accommodate people's needs. A choice of communal areas provides additional places to sit, eat and take part in social activities. There is easy access to a garden with adaptions to the home's entrances to accommodate wheelchairs. Car parking is on site.

People's experience of using this service and what we found
The process for monitoring the administration of people's medicines had not been effective enough to identify that two people, had not been receiving some of their medicines as prescribed. A delay in senior managers being aware of this meant action was not taken in a timely way to review this and ensure, these people, were protected against the potential risks associated with not receiving medicines as prescribed. A process for identifying gaps in staff signatures, on people's medicine administration records (MARs), was in place. However, this was not leading to effective action being taken, in a timely manner, to follow these recording errors up and to ascertain if people had received their medicines or not. No harm had come to people, but these processes were not robust enough to protect people from, potential risks, associated with not receiving their medicines as prescribed.

During the inspection and after, immediate action was taken to ensure these two people's medicines management was reviewed. Action was also taken to improve the monitoring of people's medicines administration and the action taken when recording errors were identified. It was too early for us to make a judgement about whether the action taken would be effective in reducing risks to people.

The provider's quality monitoring processes, for monitoring other areas of the service and making improvements where needed was working well. In all other ways the service was being well managed. People told us they would recommend the service to others. A senior management structure was in place providing consistent leadership for staff who were being supported to work in such a way which resulted in good outcomes for people. There were effective communication processes in place to ensure people, their relatives and staff felt well informed of any changes to the service.

An open and transparent culture had been developed where staff were confident to challenge poor practice and people and their relatives felt able to report any concerns they may have. Staff felt well supported and valued by both the registered manager and provider. They told us they felt proud to work at St Faith's Nursing Home. People considered the home to be well-led and they confirmed senior managers were visible and approachable. Managers engaged with people and their relatives to seek their views on the services provided to them. They were keen to learn from areas of dissatisfaction or when things did not go to plan.

Other medicines had been administered to people as prescribed. Medicines were received into the home in time for administration and they were stored according to pharmaceutical guidelines. Risks to people's health and potential environmental risks were identified, assessed and managed to reduce or mitigate risks altogether. People lived in a clean home where arrangements were in place to prevent and control infection. There were processes in place to learn from errors and near misses, so staff practice, and the service people received could continually improve.

People told us they were well looked after, and they had confidence in the staff to meet their needs. Staff received training and support to be able to meet people's needs safely and lawfully. People told us they received plenty of food and drink and had a choice in what they ate and drank. People's nutritional health was supported, and any associated risks to this assessed and managed.

People confirmed they had access to healthcare professionals who helped them maintain their health. Staff worked with commissioners of adult social care and acute health care to ensure people could access support when they needed it. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive was possible and in their best interests. The policies and systems in the service supported this practice.

People told us staff were kind, caring and supportive. Care was delivered in a way which maintained people's dignity and privacy. People told us staff explained things to them in a way they could understand. Staff supported people to maintain their independence and, where possible, to retain skills they already had. Those who mattered to people, family, representatives and friends were made welcome and could speak on behalf of people where needed. There were no restrictions on visiting.

People's care was planned and designed around their needs and personal preferences. People or their representatives were included in this planning and in the review of their care. Care was reviewed and altered to accommodate changes in health, abilities and risks. People told us they were treated as individuals and their care was personalised.

People had access to social activities and supported to take part in activities which suited their abilities and preferences. There were arrangements in place for people, their representatives and others to raise a complaint and for this to be investigated and addressed. People's end of life wishes were explored with them, or their representatives, and they were supported to have a dignified and comfortable death.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was Good (published 17 December 2016).

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the 'Is the service well-led?' section of this full report. Effective action was taken during the inspection to reduce and mitigate potential risks to people.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Faith's Nursing Home on our website at www.cqc.org.uk.

Follow up

We will discuss with the provider their progress on the improvements they made during and after the inspection, about the monitoring of people's medicines administration, to ensure this action leads to the service improving their rating in well-led to at least Good. We will continue to monitor information we receive about the service. We will return to visit the service as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 Faith's Nursing 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 Care Act 2014.

Inspection team
The inspection was carried out by two 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. In this case caring for older people.

Service and service type
St Faith's Nursing 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service since the last inspection. This included information of significance reported to us by the provider, such as, a death, allegation of abuse, an incident involving the police, serious injury to people and any other event which prevented the service from delivering services to people. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We sought feedback from commissioners of services.

We used all this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and two relatives about their experience of the care provided. We spoke with eleven staff which included the nominated individual, the registered manager, two deputy managers, two nurses, two care assistants, an agency care assistant, one member of staff who supports people with eating and drinking, the activities co-ordinator and the maintenance person.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care files which included care plans and risk assessments and six people's medicine administration records (from different units across the home). We reviewed four staff recruitment records. We also reviewed records relating to the management of the home. This included a selection of audits, complaints records and the maintenance records.

After the inspection
We continued to seek information from the provider in line with evidence reviewed and gathered during the inspection. The provider forwarded information to us about what they had put into place to address the shortfalls identified in monitoring medicines. This included a copy of the provider's amended medicines policy and procedures.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
•□People told us they felt safe. People's comments included "Yes, I feel comfortable with the staff" and "Safe, extremely so."
•□The provider's safeguarding policy and procedures were available to all staff. Staff had received training on these and training on how to recognise potential abuse and how to report it.
•□Information about safeguarding vulnerable people and how to contact relevant agencies was around the home for staff, people, relatives and other visitors to reference.
•□Senior staff shared information with, and worked with, relevant agencies and professionals to safeguard people. This included the local authority, police and the Care Quality Commission (CQC). In the case of one person, action was taken to safeguard them others around them.
•□Staff were aware of the whistle blowing policy and procedures. Staff told us they felt able to report concerns they may have in relation to another staff member's practice or attitude, to their managers. They were confident managers would act appropriately. The provider had zero tolerance towards any form of abuse or discrimination.
•□An open and transparent culture was in place where staff were supported to report things that had gone wrong or near misses, so lessons could be learnt from these.

Assessing risk, safety monitoring and management
•□Risk assessments were recorded and gave staff information about people's risks and what actions to take to reduce or mitigate risks.
•□Risks associated with people's health and which were assessed, included for example, those related to falls, how people were supported to move, skin damage due to pressure, weight loss, choking and bleeding.
•□These risks were reviewed monthly or when a change in health or equipment indicated a further review was required.
•□All accidents and incidents were recorded and monitored by senior staff for any trends and patterns to ensure the measures in place to reduce risk remained effective.
•□Environmental risks related to the building, equipment, main safety systems and the home's grounds were assessed, and action taken to reduce or mitigate risks. This process included regular health and safety monitoring, maintenance and servicing arrangements.

Staffing and recruitment
•□People's dependency levels, their changes in health and the needs of the home were kept reviewed to

ensure appropriate numbers of staff were on duty to meet people's needs.
•□People told us they did not have to wait long for support when they rang their call bells. We observed staff to be available to provided support when people needed it. One person said, "I press the bell when I need help and yes, it is answered quickly" and another person said "I press the bell. Not really a long wait."
•□Managers used agency staff if needed, to cover last minute staff sickness or gaps in staffing. They aimed to use the same agency staff to provide continuity if longer-term cover was needed. We spoke with one agency member of staff who confirmed they were receiving a detailed introduction into the home's way of working and its safety systems.
•□The staff recruitment records showed that appropriate checks were completed on staff before they started work to protect people from those who may not be suitable. This included the right to work in the UK, a police and criminal record check, employment references, employment history and reasons for leaving previous jobs.

Using medicines safely
•□There were arrangements in place for people's medicines to be prescribed, delivered and stored safely.
•□People received support to take their medicines.
•□Staff who administered medicines received training on how to do this and had their relevant competencies reviewed.
•□People were consistent in their comments about the support they received to take their medicines. Comments included "Yes, the staff give them [medicines]. You can get a tablet quickly if you've got pain" and "Yes, the staff give me my tablets. I take Paracetamol. No long waits. They [the medicines] are in the cupboard in my room. Nurse has the key."

Preventing and controlling infection
•□The home was clean, and people's comments confirmed this was usually the case. One person said, "Everything is clean" and another person said, "I would say, over clean."
•□Staff followed the provider's procedures for controlling the spread of potential infection. Staff wore protective aprons and gloves when attending to people's personal hygiene and when serving food. There were arrangements in place for the safe management of laundry. The kitchen had been awarded a rating of '5' by the Food Standards Agency for food hygiene and safety. This meant systems and processes for this were "very good".
•□Nursing staff and care staff were trained to identify symptoms which may indicate someone had an infection, for example, sepsis or a urinary tract infection. Where needed action was taken swiftly to refer people to their GP.
•□People and staff were supported to have a flu vaccine at the appropriate time of the year.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

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; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People's needs were assessed before they moved into the home to ensure these could be met by the staff according to current guidance and legislation. For example, in line with the Equality Act 2010, the Mental Capacity Act 2005 and nationally and locally agreed pathways of care; dementia and end of life care.
- Staff liaised effectively with commissioners of care and providers of acute healthcare to help people access the home in a timely way.
- People had equal access to health and adult social care support once they moved in to the home. They spoke positively about the support they received to maintain their health.
- Arrangements were in place for a GP to visit the home on a regular and planned basis to attend to people's medical needs. One person said, "I tell the nurse if I want to see the doctor. Then she pops in to see me. Never too much bother. Wonderful" and another person said, "Yes, I can see the doctor quickly."
- People were supported to attend healthcare appointments. One person told us they had a hospital appointment and two staff took them to this and remained with them.
- Staff liaised with NHS professionals to ensure people were referred to other professionals as needed. One person told us their blood had been taken for analysis and another person had been assessed by an occupational therapist. One person had received healthcare treatment in the home to avoid attending the hospital which would have caused them distress.
- The provider retained the services of a physiotherapist to assess and support people's mobility and posture needs and to help people rehabilitate following surgery.

Staff support: induction, training, skills and experience

- The home's training record showed staff received and completed training which the provider considered necessary to carry out their tasks safely.
- All staff completed a classroom-based induction training and were later supported by experienced staff when they started work in the home until they were assessed as competent.
- Staff new to care completed modules of training from the care certificate (a course which provides new care staff with the knowledge and skills to be able to deliver care to a recognised and agreed standard). A new induction course, specific to the needs of nurses, had just been designed by the home's clinical lead (one of the deputy managers), for nurses new to the company. One new member of staff said, "There is so much support, the training is very good."

•□All staff were provided with regular one to one supervision meetings where they had an opportunity to discuss their progress and learning and development needs with their manager.
•□Some staff held lead roles in areas of practice, such as wound care, infection control and dementia care to promote and support best practice. Staff liaised with and worked alongside visiting NHS healthcare practitioners which helped them to keep updated with current best practice.
•□Further training had recently been organised by the provider, for all relevant staff, on textured and modified foods and fluids to reflect the International Dysphagia Diet Standardisation Initiative (IDDSI) guidelines. These standardised best practice guidelines had been introduced and implemented in the NHS. Staff in the care home needed to understand what the changes were and how this affected their practice when supporting people with swallowing difficulties and those at risk of choking.
•□There were arrangements in place to support nurses to maintain their registration requirements with the Nursing and Midwifery Council (NMC).

Supporting people to eat and drink enough to maintain a balanced diet
•□People told us they had a choice of food and drinks throughout the day. They also had access to food and drink at night-time. One person said, "Food, it's lovely… absolutely marvellous. Cracking meals. Sometimes two soups a day. Never tasted soup like it… I've told the ladies to tell the cook it's good. There's always extra if you want it… Porridge in the mornings. Plenty to drink. Tea time is at any time. I've put on [weight given] since I've been here." Other comments were equally as positive and included "Well I like it, plenty to eat and drink", "Yes, I like the food. There is a choice and enough to eat" and "The food is alright."
•□The provider employed staff who specifically supported people at mealtimes and with drinks and snacks in-between meals. One of these staff told us how proud they were of their role. They provided support to people who needed additional time and support to maintain their nutritional well-being. These staff also supported people to make their food choices.
•□People at risk of choking were identified and action take to reduce this risk. This included referrals to speech and language therapists and changes in the texture of their food and drinks. For example, one person's care plan gave clear guidance to staff about what texture the person's food should be and how to support the person to be in the correct position for eating and drinking.

Adapting service, design, decoration to meet people's needs
•□The home's environment had been adapted to support people's needs. Bathroom and toilet facilities enabled people who were not independently mobile to access these with support.
•□Corridors and communal rooms were spacious allowing the use of wheelchairs and other care equipment to be used such as hoists to move people.
•□Call bell points were in all bedrooms and communal areas and arrangements were in place for pendent call bells to be used for people who moved away from these points.
•□The homes decoration was neutral and avoiding strong patterns and altered floor coverings so as not to confuse and disorientate those with visual perception difficulties.
•□Signage was in place to help people orientate themselves.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff had received training on the MCA and DoLS. They understood what restrictive practices would look like and supported people in the least restrictive way possible.
- People were supported to make decisions about their care, where they were able to do this.
- Where people had been assessed as lacking the capacity to make independent decisions, decisions made on their behalf, were made in their best interests. People's legal representatives and other professionals, including independent mental capacity advocates (IMCAs) were involved in this process.
- Staff had appropriately applied for DoLS where required and were waiting for people to be assessed by the supervisory body (the local authority). Where DoLS had been authorised and conditions applied, these had been met.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now remained the same.

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; Respecting and promoting people's privacy, dignity and independence

- Everyone we spoke with told us they were treated as an individual and their diverse needs and preferences considered and met when planning and delivering their care.
- Staff received training on equality and diversity and the provider's policies and procedures were in line with the Equality Act 2010.
- People told us staff were caring and that they knew them well. Comments from people included "Yes, very kind", "They know me well" and "No staff I'm unhappy with."
- People confirmed they had a choice in how they were supported and most confirmed their independence was supported. One person said, "Yes, I choose when I get up and go to bed and shower" and another said, "I'm encouraged to do things for myself".
- People confirmed their dignity and privacy was maintained and we observed this to be the case during the inspection. Personal care was delivered in private, staff knocked on people's bedroom doors before entering and staff preserved people's dignity when supporting them to move, for example, in a hoist. One person said, "Yes, they keep personal care as private as they can".
- Staff spoke to people respectfully and we observed good interactions between staff and people. This included staff showing compassion and having appropriate banter with people. One person said, "We have a bit of banter between us."
- Dignity in care was upheld; people were referred to by their preferred name, they were supported to make choices, about what they wore for the day, ate and wanted to do. One person said, Yes, they keep my dignity and do indeed close the door".

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

- Staff supported people to make daily decisions and we observed this throughout the inspection. Comments from people about this included, "They do talk things through with me, they explain", "I tell them what I need" and "They talk through as they go."
- People were able to make decisions about things that were important to them and which gave them some control of their life. For example, one person said, "Yes, I choose when I get up and go to bed and shower". Another person said, "I go to bed quite late [time given], I sleep better then. I have my breakfast in bed".
- People were given a choice of which gender of staff they preferred to receive support from for their

personal care. One person said, "I'm happy with male and female staff."

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

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

- The care people required and wanted was recorded in care plans. These were detailed and kept up to date so staff and visiting professionals had up to date information about people's needs, abilities and support.
- Care plans were formulated in partnership with those receiving care or, where this was not possible, with people's representatives. One person said, "Yes, my daughters were here to set up the care plan. They had a say and I did."
- Care plans included information about peoples, life history, likes, dislikes, preferences, wishes and information about what was important to that person. Care planning was person-centred and tailored around people's individual needs and protected characteristics.
- People told us they felt included in planning their care and they confirmed they had opportunities to talk about this and express their views if they wished to. Comments from people included "Oh yes if I wanted to [talk about care]. The lady who runs it [the registered manager] comes in at intervals too", "Yes, I can talk through things that are important to me" and "Yes, they sit and have a chat [about the care] when I want to".

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information about how to communicate with people and how people needed information to be given to them was explained in their care plans.
- Where people required glasses, hearing aids or a specific approach from staff, to support good communication, this detail was included in people's care plans.
- We spoke with people who had difficulty in verbally communicating and who indicated they had no say in their care planning. People's communication care plans (and other care plans) were detailed and centred around that person's needs and abilities. For example, one person's care plan explained they predominantly communicated through facial expression. A review of this person's care plan recorded the fact the person continued to smile when staff conversed with them and through care delivery. This showed that staff were observing for signs which would indicate the person was unhappy or distressed so they could alter their approach if needed.
- These care plans also gave staff information about whether a person who had difficulty in verbal

communication, could give consent and make choices, and how they could achieve this with support.
•□Where needed information could be provided in different formats to suit people's needs; large print, audio, easy read and braille. Information could also be sent by text and by text relay (using an appropriate service written text messages are translated into the spoken word).
•□Some staff assisted communication with one person by communicating with them in the person's own language.

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 which they enjoyed. The home had a designated activities coordinator who was supported by the provider's peripatetic (a team who travelled between the provider's services) activities staff. This arrangement enabled group-based activities and social events to be arranged, but also provided help to support those who required activities to be provided on a one to one basis or to reach those who were at risk of socially isolating themselves.
•□People told us they enjoyed the activities they attended. They also told us when they chose not to take part, which was their individual choice. Comments included "I did take part in activities downstairs", "No", do not take part in activities" and "Yes, I do take part in activities. The good ones here are very good."
•□The home had become involved in a community cycling scheme. Adapted bikes provided different levels of support for people, to be able to, either cycle again or enjoy it as a new experience. For example, bikes had different seating arrangements and some meant people could cycle with a member of staff seated alongside them on the same bike, supporting them. This activity was to be available soon after the inspection.
•□The provider also ran a free 'bus service' for people who lived in their services. People could use this, with a friend or relative if they wished, to get to local community destinations such as the town's shops, cinemas, theatre, art galleries, local pubs, and restaurants. This meant people could access the community, enjoy their outing, and return to the home safely. People also had opportunities to go on longer day trips out.
•□Volunteers were involved in helping to prevent social isolation and loneliness. One volunteer, for example, read the newspaper or poetry to people who enjoyed this.
•□Further work was being done to support people's opportunities to engage in activities and to socially integrate. It was planned for some staff to become activity champions whose role it would be, in their day to day work when supporting people, to have a focus on how staff could better support social integration, provide cognitive stimulation and reduce loneliness in care.

Improving care quality in response to complaints or concerns
•□People spoken with told us they had no complaints but if they did, they felt confident action would be taken to address their complaint.
•□Arrangements were in place for people, their relatives and other visitors to the home to be able to raise a complaint, or, express dissatisfaction and have this looked at and addressed.
•□Information about the provider's complaints policy and procedures was on display. This information could be provided in different languages or formats to suit people's needs.
•□We reviewed the home's complaints log. This showed that all complaints and areas of reported dissatisfaction were recorded. The record showed when these had been received, acknowledged, investigated and responded to.
•□The action taken, to address the issue raised, was also recorded. In each case an apology had been given and lessons learnt from the situation.
•□The registered manager was keen for anyone to be able to talk with them about anything which concerned them or if they were not happy about something. An open-door policy was in place and managers could be contacted by telephone and email.

End of life care and support

- People were supported to express and explore their individual end of life wishes and preferences so that, at the appropriate time, staff could meet these. We saw examples of people's wishes recorded in their advanced care planning.
- People's representatives and those who knew people well, and who mattered to them, were supported to be involved in this process.
- Staff liaised with and worked alongside other professionals such as GPs, community nurses, end of life practitioners and pharmacists to ensure people had a dignified and comfortable death.
- Staff received support to care for people at the end of their life and to do this in line with best practice.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement.

This meant the service management and leadership was inconsistent. Although leaders and the culture they created in the main supported the delivery of high-quality, person-centred care, the monitoring of people's medicine administration required improvement.

As actions were either implemented during or straight after the inspection to address this shortfall we were unable to judge the effectiveness of these new arrangements during this inspection, which is reflected in the rating of this key question.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The monitoring processes in place to ensure people received their medicines as prescribed had not been effective in ensuring, issues related to two people's medicines administration, were identified and addressed in a timely way. These people had not received several doses of their prescribed medicines because they had been asleep at the time their medicines were due to be administered.
- Although no harm had come to these people the monitoring processes had failed to trigger an appropriate review into the reasons for this and whether these medicines could be administered at times which better suited each person.
- We had also found staff signature gaps on some people's medicine administration records (MARs). Over the last year this type of recording error had been significantly reduced as improved monitoring of people's MARs had taken place and staff practice had improved because of this.
- At the time of the inspection however, the time frame in which these recording errors were being followed up did not result in quick enough action being taken to reduce risks to people associated with potentially having not received their medicines. These recording errors were not being effectively reported to senior managers, so they could take timely action to address these.
- Action was taken immediately to organise a review of one person's medicines and to ensure the other person's medicines were administered at a time which better suited their daily routine.
- The arrangements for monitoring people's MARs and following up recording errors were reviewed during the inspection. This was to ensure monitoring processes were effective and they led to actions being taken, in a timely way, to reduce potential risks to people associated with their medicines.
- Amendments were also made to the provider's medicine policy and procedures. This was to ensure the provider's expectations about what action should be taken, and when, was clear and available for staff guidance.
- Although the registered manager and deputy managers already communicated with each other daily, and more often when needed, daily 'flash' meetings were also to be implemented. This would formalise the

meetings and provide a set agenda to be covered. Any risks concern or issues were to be identified and addressed immediately, as was current practice, but it would include those associated with medicines, so they could be addressed that day.

•□We reviewed a selection of other audits, related to care plans, infection control, health and safety and individual households (units) kitchenettes which showed that any required improvements in these areas had been identified and acted on.

•□Arrangements were in place for the different households to also report on key areas of care and risk, such as people's weights, falls, skin condition and accidents and incidents. These were all centrally audited by the registered manager and deputy managers and included in a weekly report to the provider.

•□Trends and patterns in this information were looked for to ensure actions being taken and ways of working remained effective in reducing risks to people.

•□The provider's quality monitoring system also included visits to the home by representatives of the provider who had quality monitoring roles and responsibilities. They carried out audits and checks on behalf of the provider to monitor the service's compliance with regulations and progress against the provider's expected performance outcomes.

•□A continuous improvement plan (CIP) recorded any on-going improvement actions which were identified through the auditing process. Regular reviews of the CIP were carried out with the registered manager, to ensure progress was being made in completing these actions. These were signed off as completed after being checked by the provider's quality manager.

•□Staff were clear about their responsibility to report any concerns they may have and to challenge poor practice if witnessed. One member of staff said, "It does not matter what you think, if something does not feel or look right, you report it immediately."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

•□Comments about how the home was managed, how people felt personally engaged with and cared for included "The manager is approachable", "Yes, I see the bosses" and "The bosses are out and about." People also said, "I would recommend the home" and "It's a good place to be."

•□Since being in post as interim manager and then as the registered manager of the service from August 2018, the registered manager had been involved in building a new senior management team which was effective in supporting good outcomes for people by promoting a person-centred approach to care.

•□A positive and inclusive style of management had been adopted and staff told us they felt included in decisions made about the home. They told us they felt personally valued and committed to providing a good service for people. One member of staff said, "They always say thank you (referring to the management staff) and you feel appreciated." When discussing how staff supported people's equality and diversity this member of staff said, "We (the staff group) are multi – cultured but we all work together to make sure all our residents are looked after, are safe and feel loved."

•□Feedback and the views of people, relatives, staff and visiting professionals were sought and acted on to improve the services provided to people.

•□An annual programme of regular meetings with the above groups of people, enabled managers to communicate important information to them and listen to their feedback. A newsletter was also printed and delivered to people and sent to their family members, so people had monthly up to date news about the home and any forthcoming events or plans.

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 and provider understood their responsibilities under duty of candour. There had

been no incidents which fell under the category of a person having been 'moderately harmed' or where a person had experienced significant or permanent harm.

•□We followed up one incident where managers had been open and transparent about what had gone wrong. The person had received an apology and both they and their representatives had been told of the actions taken to ensure this did not happen again.

•□This person's representatives told us they had felt reassured by these actions.

Working in partnership with others

•□The home had made links with various community-based groups to benefit and improve the lives of those who lived at St Faith's. Links were in place to support Christian worship and to meet where needed, other religious and cultural preferences.

•□Links with local schools supported intergenerational work which people who lived in the home enjoyed and which supported children's on-going education.

•□Links were also being made with local LGBT groups, so the home could learn and better understand the diverse needs of people from this community for when they required care and support.

•□Managers worked in partnership with groups supporting better mental health and dementia awareness to benefit both people and staff.