Private Medicare Limited

St Marys Nursing Home

Inspection report

344 Chanterlands Avenue
Hull
Humberside
HU5 4DT

Tel: 01482307590
Website: www.burlingtoncare.com

Date of inspection visit:
01 August 2017
02 August 2017

Date of publication:
15 September 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 1 and 2 August 2017 and was unannounced on the first day. At the time of the inspection, there were 42 people using the service.

St Marys Nursing Home is a single storey, purpose-built home, situated in its own extensive grounds in a residential area of west Hull. The service can support up to 48 people who may have a range of physical health needs. There are 40 bedrooms; some have en-suite facilities and some are for shared occupancy. There is a large communal room divided into distinct areas for dining, watching television, relaxing quietly and enjoying a chat and a coffee with friends and family. There are plenty of bathrooms, shower rooms and toilets within easy reach of bedrooms. There is a large enclosed, landscaped garden and patio, which provides a secure area for people to enjoy the outdoor space.

The service had a registered manager in post. 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.

During the inspection, we found some concerns regarding the management of medicines. People had not always received their medicines as prescribed due to stock control or administration practices.

There was an inconsistency in the implementation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This had led to some people potentially being deprived of their liberty unlawfully as staff had not recognised they met the criteria for a DoLS. Not everyone who lacked capacity had best interest meetings to record how decisions were made on their behalf. However, staff had a good understanding of the need to gain consent from people prior to carrying out care tasks.

People had assessments of their needs completed and care plans developed but these were not always thorough and information was missing from them. This had the potential for important care to be overlooked and also care to be delivered which wasn't in line with people's preferences.

Although we recognised there was a quality monitoring system that had just been started, which consisted of an audit timetable, surveys and meetings to gain people's views, this had not been embedded into practice yet. This had resulted in shortfalls being missed when audits and checks were completed and when some issues were identified, these had not been addressed in a timely way. We could see this was a result of changes implemented since the new provider had taken over the service and their priority had been focussed on upgrading the environment. The refurbishment plan was well underway and some areas were looking very nice.

You can see what action we have asked the provider to take in response to concerns about medicines management, consent, care planning and quality monitoring at the back of the report.

We found staff had received training in how to safeguard people from the risk of harm and abuse. They knew what to do if they had concerns and how to report them. Staff had completed risk assessments for people, which helped to identify areas of concern and how to help minimise them.

We found staff were recruited safely and there were sufficient staff on duty to meet people's needs. Some people told us response times to call bells could be improved. This was to be checked out by the registered manager.

People who used the service and their relatives were complimentary about staff approach. They said staff were kind and caring and respected people's privacy and dignity.

People's nutritional needs were met and menus provided a range of meals and alternatives over a four-week period. There were some mixed comments from people who used the service about the variety of meals; the registered manager told us they would complete a survey to check out people's views and address any issues.

We found people's health care needs were met. They had access to a range of community health care professionals for advice and treatment. The four health care professionals spoken with said staff referred to them in a timely way although one had a concern about how staff managed an on-going health care issue. This was discussed with the registered manager during the inspection and the person's records checked to ensure appropriate care and support had been provided to them.

Staff had access to training, supervision and support. Gaps in training had been identified, plans made and courses booked to address shortfalls. Staff told us they felt very supported by the registered manager and were able to raise concerns. There were staff meetings which enabled them to receive information and express their views.

The provider had a complaints procedure and people spoken with felt able to raise concerns and complaints. People who used the service named specific members of staff that they would talk to if they were worried about anything.

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 consistently safe.

People had not always received their medicines as prescribed.

Staff were recruited safely with full employment checks in place prior to them starting work in the service. There were enough staff on duty but there were mixed comments about response to call bells. The registered manager was to check this out.

Staff knew how to safeguard people from the risk of harm and abuse.

The service was clean and tidy.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There had been inconsistent application of mental capacity legislation and deprivation of liberty safeguards. This meant best practice guidelines had not always been followed when people lacked capacity to make their own decisions, and important document had not been completed.

People were able to see community health care professionals for treatment and advice when required. People's nutritional needs were met although there were mixed comments about the variety of meals on offer. The registered manager was to check this out with people who used the service.

Staff had access to relevant training and gaps in training had been identified and planned.

Is the service caring?

Good

The service was caring.

People told us staff treated them well with kindness and patience.

Staff respected core values such as people's privacy, dignity and

right to choose. They encouraged people to be as independent as possible.

Staff protected confidential information by ensuring phone calls were held privately and storing records securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People who used the service had risk assessments and care plans but there were some areas of their needs that had not been identified in them. This meant staff may not have full guidance to support people and important care could be missed.

People had access to a range of activities. The registered manager was to check out if people had the right amount of activities to meet their needs.

The provider had a complaints policy and procedure and people felt able to raise concerns knowing they would be addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A quality monitoring system had just been implemented although this had not been embedded in practice yet. The audits, surveys and meetings had not always identified shortfalls or when they had been identified, these had not been resolved in a timely way.

The culture of the organisation was open and supportive to staff.

Staff felt able to raise concerns and said the registered manager had an open-door policy.

St Marys Nursing Home

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 1 and 2 August 2017 and was unannounced on the first day. The inspection team consisted of two adult social care 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.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with the local authority safeguarding, and contracts and commissioning team, about their views of the service. We also received information from health professionals who visited the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at mealtimes. We spoke with eight people who used the service and five people who were visiting their relatives. We spoke with the registered manager, the training and development manager, one health care assistant, three care workers, two domestic staff and the cook. We also spoke with three health professionals and one social care professional. We also spoke with a health professional a day after the inspection and received written information from another.

We looked at seven care files for people who used the service. We also looked at other important documentation relating to people who used the service. These included medication administration records (MARs) for 27 people and monitoring charts for food and fluid intake, weights, behaviour and pressure relief. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make

important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included recruitment files for three new staff, training records, the staff rota, menus, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Requires Improvement

Is the service safe?

Our findings

We had concerns with how medicines were managed within the service. There were some practice issues, for example, we observed staff leave the medicines trolley unattended with the keys in the door and a packet of tablets on the top. The member of staff spent time administering medicines to a person and did not observe the trolley properly. We also observed the member of staff signed the person's medication administration record (MAR) before they had given the person their medicines. We observed a member of staff used one person's prescribed thickener (used to thicken fluids when people had swallowing difficulties) for other people when they were supporting administration of medicines. Thickeners are for the sole use of the person they are prescribed for by the speech and language therapist as there are different types dependent on people's individual needs. The actual administration of medicines support by the member of staff was very patient and caring.

There were some concerns with how medicines were administered to people. For example, one person had not received eye drops as they were recorded as asleep at 6am. There was no reason why these were not administered later in the day. Four people were waiting for their medicines to arrive in the service; stock had not been managed appropriately. One person had a medicine that was prescribed to be given at night but was given at 4pm; this had the potential to make the person sleepy and should be given nearer their time for retiring to bed. One person was due to have a medicine between 10 and 11am each morning but we saw this had not been administered on the first day of inspection.

There were also some recording issues such as a lack of clear guidance for the use of 'when required' medicines, those with a variable dose or those where the prescriber had written 'as directed'; there was no indication of how staff made decisions about them. Staff had not always transcribed full instructions when they had hand written medicines and directions onto the MARs. There were some gaps in the MARs with no codes to explain the reason why. There was also an inconsistency regarding the use of codes when medicines were omitted and what they meant. We also found an error in recording which had not been noted by other staff.

Not having a safe system of medicines management was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Staff had received training in how to safeguard people from the risk of abuse or harm. In discussions, they were clear about the different types of abuse, the signs that would alert them and what action to take if they suspected abuse had occurred. People's personal allowance was managed appropriately when this was held for safekeeping; records were maintained and receipts obtained for monies in and out of their account. The system helped to ensure there was no abuse of people's finances.

Accident reports were fully completed and detailed the nature of the incident and the actions taken. We saw that people's care plans had been updated with relevant information following an accident. For example, one person had fallen and measures were put into place to make their room safer. People had risk

assessments completed for specific areas which included falls, moving and handling, nutrition, choking, skin integrity, smoking, and for use of specific equipment such as bedrails. There were documents highlighting a safe system of working for staff when mobilising or transferring people with equipment such as walking frames, wheelchairs, stand aids or hoists.

We found staff were recruited safely and full employment checks were carried out prior to new staff starting work in the service. These included an application form to assess gaps in employment history, obtaining references, a disclosure and barring service (DBS) check, which would highlight any criminal record, and an interview. In addition, for nurses, there was a check to see if there were any conditions on their registration. These all helped the provider to make safer recruitment decisions. Occasionally, agency nurses were used to fill short notice absences; we discussed the need for the provider to show they received important information about them and ensured an induction was recorded.

We found there were sufficient staff employed to meet the needs of people who used the service. There were two nurses on duty during the day as well as the registered manager who is also a nurse. There were between seven and eight care staff in a morning during the busy period of supporting people to get up and four to five for the late afternoon/evening shift. There were between four and five staff at night, which included one or two nurses. Ancillary staff consisted of an activity co-ordinator, catering, domestic, administration and maintenance personnel; these staff enabled nurses and care staff to focus attention on treatment and care tasks. However, some staff told us they could be stretched in the early evening when numbers dropped to one or two nurses and four care staff. Comments from staff included, "We have been short in the past but we are waiting for new staff to start."

People who used the service seemed relaxed and comfortable in the company of staff but there were mixed comments about whether there were sufficient staff on duty. Comments included, "I feel safe here, there's always people around", "The staff here make you feel safe", "There are lots of staff", "There's plenty of staff but they never have time to talk to you" and "They respond quite quickly." However, other people stated, "I think there should be more staff", "I was late getting up this morning so I missed the hairdresser so [care worker's name] set my hair for me [in curlers]" and "There's not enough staff and you have to wait sometimes." One person told us they sometimes had a long wait when they wanted to use the toilet. In light of the feedback from some people who used the service, the registered manager told us they would look at the deployment of staff at specific times.

Relatives said, "Excellent care and attention by all staff; I know my mum is safe at all times", "He says there is always staff around and no-one has ever hurt him" and "Yes, I feel she is safe here; it's brilliant here." One relative was concerned about security as they had walked in without any challenge. We spoke with the registered manager about this and they confirmed the front door does have a security code but occasionally some people who used the service sat outside to smoke and the door was left unlocked so they could re-enter at will. They told us they would speak to staff about checking the identity of people they didn't recognise when they entered the building.

We found bedrooms and communal areas were clean and tidy. Staff had personal, protective equipment to use such as gloves, aprons and hand sanitiser, and in each person's bedroom there were paper towel dispensers and soap for staff to use. There were some minor issues regarding cleanliness of equipment used in the service; these were addressed during the inspection.

Equipment used in the service was well-maintained and serviced appropriately. There was a business continuity plan which detailed the actions to take in emergency situations such as utility failure or a flood.

Requires Improvement

Is the service effective?

Our findings

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.

We found the application of MCA was inconsistent. Some people had restrictions in place such as bedrails, a recliner chair, sensor mats and lap straps; however, their capacity to make these decisions had not been fully completed and the decision to provide them had not been discussed and recorded as in their best interest and as the least restrictive option for people. One person had declined speech and language therapy advice regarding the texture of food that was assessed as safe for them to eat and there was a statement in a 'capacity and consent care plan' which stated the person had capacity. However, their capacity to make this decision had not been formally assessed and recorded; a previous assessment in April 2017 refers to them having fluctuating capacity. One person had been in receipt of nursing interventions but there was no capacity assessment and no best interest decision-making record about them. There was also a lack of evidence that capacity and consent decisions for wound care monitoring photographs had taken place. In discussions with staff, it was clear they had an understanding of the need for people to consent to care provided to them.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the provider was working within the principles of the MCA for some of the people who used the service but not for others. Applications for DoLS had been submitted to the local authority and were awaiting assessment. However, despite staff and management having a good understanding of the necessity and process of this, these had not yet been completed for some people who we saw met the criteria for DoLS. For example, one person lacked capacity to consent to care, required full support for all care tasks and regularly received nursing interventions but did not have a DoLS in place. This meant some people may be deprived of their liberty unlawfully.

Not working within the principles of MCA and DoLS is a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

We saw people's health care needs were met. Records showed they had access to health care professionals in a timely way. Staff were knowledgeable about specific issues such as the management of catheters, prevention of pressure ulcers and how to spot the signs of a urinary tract infection and the action to take. Comments from people who used the service included, "I've not needed to see the doctor yet but I'm sure I could." One person told us staff always ensured they kept their medical appointments. Relatives said, "We are informed when the GP is visiting and we are asked if we would like the chiropodist to attend", "He sees the GP if he needs to" and "She has put on weight since she has been here, which is good."

Visiting health professionals told us they were often asked to visit people to provide treatment. They all said they had no concerns regarding the care and support given to people. Comments from health and social professionals were, "I have only ever heard good things about St Marys", "They are aware to refer to us if indicated", "The staff appear to know the patients well and are aware of individual issues" and "The quality of care appears good. Various comments and feedback via family and friends are positive." We received some negative comments from a health professional about specific issues that had occurred recently; these were addressed with the registered manager during the inspection.

People had an assessment of their nutritional needs and a care plan which indicated the support they required. There was also a nutritional risk tool used to calculate whether professional input from a dietician was required. Some people required their nutrition through a tube directly into their stomach; records were maintained which showed these people received their nutrition as prescribed. We observed one person was not positioned correctly in bed as an agency member of staff was about to support them to eat their meal. This was addressed straight away and the registered manager spoke to senior staff, overseeing people who were supported to eat their meals in their bedrooms, about this.

There were mixed comments from people about the variety and preparation of food. Comments included, "The food is okay", "The food depends on which cook is on duty", "The food is well-cooked but there's not much variety", "The food is great although I'm on a soft diet", "I'm not too keen on the food; tomato soup is my favourite", "The food is not so good" and "The food is satisfactory; I just take what comes." We asked one person what they had chosen for lunch and they told us meatballs. When we asked if they liked meatballs, they told us, "Not really, but I dislike meatballs less than I dislike sausage and mash." A relative said, "Mum is on a soft diet and on several occasions they have cooked something different, if what is available does not appeal to her." There were four weekly menus which provided two choices at lunch and the evening meal. The cook told us special diets were catered for and people could choose what they wanted to eat. Staff showed us the list they had created by asking people what they would like for their next meal. Several people had requested alternatives to what was on the menu and their wishes were catered for.

We observed the lunchtime experience for people and noted that some improvements were required. We observed staff were slow to serve meals which meant some people were eating their dessert whilst others hadn't received their first course. The rice pudding was lumpy and we saw staff cutting this with a spoon. There was congealed gravy on a pureed meal making it look unappetising. People were not offered second helpings. Some crockery needed replacement. Medicines were administered during lunch. Staff took what was meant to be hot desserts round to people who preferred to eat their meal in their bedroom; these were uncovered and cold. Staff told us they were waiting for a part for one of the hot trollies. However, we found the dining room was light, spacious and airy and staff were attentive when supporting people to eat their meals.

We mentioned the range of comments about meals and observations about the lunchtime experience to the registered manager and recommend a survey is completed to seek people's views and action taken to address shortfalls. The registered manager told us they would do this straight away.

We saw staff had access to a range of appropriate training and induction. There were some gaps in training but these had been identified and planned for by the training and development manager. Each member of staff had a personal development plan; a supervision and appraisal system had just started. Staff confirmed they received sufficient training and support for them to feel confident when supporting people who used the service. Comments from health and social care professionals included, "Care and nursing staff demonstrate experienced and competent practice" and "The nursing staff appear to have significant knowledge and skills."

Good

Is the service caring?

Our findings

People who used the service told us staff were kind and caring, and supported them to make their own decisions. They also said staff were approachable, listened to their needs and respected their privacy and dignity. Comments included, "I rely on staff for everything; they do a good job and are pleasant to be with", "I give this place full marks" and "We can't grumble, they all do their best." Other comments were, "They always shut the door for me to use the toilet", "They are all very nice and ask if I'm alright; I'm quite happy here", "They ask me what I want to do" and "I go to bed whenever I want."

Relative's comments included, "The care is very good", "The carers are lovely", "The staff always seem to say the right thing at the right time. [Name of staff] supported me when I had to tell mum she was not able to return home", "The staff seem kind enough; dad usually does his own thing", "I think the staff are wonderful. They keep her covered and absolutely promote privacy and dignity" and "I come here whenever I like and it's never been a problem. This is the best service."

Health and social care professionals made positive comments about the staff approach. These included, "Nursing and care staff are approachable, friendly and caring", "During visits and reviews, staff are caring and respectful. Their encouragement has facilitated change and enabled people to meet personal goals" and "The visit I have performed today demonstrated the patient's dignity and choice were promoted." One professional stated they had observed staff offer choices to people, sought consent and enabled them to make their own decisions. Another stated that staff were always pleasant and helpful when they visited, and that people were involved in choices regarding their care.

We observed care interactions were completed in a kind and sensitive way. Staff gave explanations to people before carrying out tasks, spoke to them in a patient and friendly way and every member of staff knew people by their first name and knew their relatives. We observed nursing staff giving people their medicines; they took time to point out that some tablets were very small and put them on a spoon to ensure the person swallowed them; they provided juice as well as water for the person. We did notice that only cold drinks were offered at the mid-morning 'tea round' and mentioned this to the registered manager to investigate the reason why.

We saw people were smartly dressed and well-groomed. One relative said, "She is always clean and tidy; that's one thing I am really pleased about." We saw staff promoted people's privacy and dignity and knocked on bedroom doors prior to entering. In discussions, staff gave us examples of how they respected core values such as privacy, dignity, choice and independence. Comments included, "We keep doors and curtains closed during personal care and keep people covered."

Shared rooms had privacy screens, toilet and bathroom doors had locks and people had access to a lockable facility if they wanted to store personal items securely. We observed mail was delivered to people in their bedrooms for them to open; staff discussed letters about health appointments to make sure these were recorded in the diary and not forgotten.

Relatives told us they were welcomed at any time although they had been informed to avoid early mornings if possible as that was the most busiest time. A café style area with tables and chairs and a coffee making machine had been installed at one end of the main communal room. The coffee was free and visitors were asked to make a small donation for biscuits which were supplied by a member of the relatives committee.

Information was provided to people who used the service. This was included on notice boards throughout the service. The notice board in the entrance provided information about the quality monitoring system, the last inspection report, the rating for the service, a copy of the last 'residents meeting', the business continuity plan and the latest environmental health score. There were small brochures about the service and leaflets about advocacy at the reception. There were menu boards and a service user guide on display.

We saw staff maintained confidentiality. They completed telephone calls and discussions about people's health care needs in private in the nurse's office or the registered manager's office. There were quiet areas to hold reviews of people's care needs or these could be held in their bedrooms. People's health and care files and medication administration records were held securely. Records were also held in computerised form and the registered manager confirmed the computers were password protected. The provider was also registered with the information commissioner's office, a requirement when computerised records were held. Staff records were also held securely.

Requires Improvement

Is the service responsive?

Our findings

We found staff had not always been as responsive to people's changing needs as they should have been. For example, we checked a three day period of daily recording for one person and saw there was very limited information about their nutritional intake during this timeframe. On one day staff had recorded 'no diet this afternoon'. Staff had not responded to this and informed the nurse or registered manager nor had they started a nutritional monitoring chart to make a thorough assessment of the person's food and fluid intake. The person had also not been weighed since they were in hospital, prior to admission to the service several weeks before. We asked the registered manager to weigh the person and found they had lost weight since the record made in hospital; the registered manager started a monitoring chart straight away.

We saw there was an inconsistency with assessment information. For example, some assessments were detailed and provided sufficient information to write a care plan. However, others had basic information. We looked at an assessment for a person in a step down bed. These beds were used for people who were medically fit for discharge from hospital but were waiting for care arrangements in the community. The assessment had not been completed fully; the sections on medication, sleep, pain, social support and end of life were blank and the section on capacity stated 'capacity'. Some parts were written in code, for example, the section on eating and drinking stated 'N D&F feeds self'. There was no further information about the type of foods the person liked or disliked, portion size, utensils used, any special equipment required such as a plate guard, how they took their tea or coffee, or whether they preferred cold drinks.

We saw the registered manager was in the process of transferring information from old style care plan to the new provider's documentation. The content and quality of care plans was variable. One of the care plans we looked at was very comprehensive and explained in detail how to support the person with all aspects of daily living. Another person's care plan for the management of behaviour which could be challenging to others was also very detailed. However, we found some of the other care plans we looked at were brief and did not provide full person-centred information for staff in how to support people in the way they preferred.

For example, the care plans for nutrition didn't consistently include people's likes and dislikes. Care plans to support people with continence needs didn't identify the type of aid to be used and referred to them being changed 'regularly' but didn't state how often 'regularly' was. Some care plans didn't detail the airflow mattress setting so staff would be unable to check if this was correct. One person's care plan was confusing as it stated that bed rails were to be used but the risk assessment stated they were not to be used as there was a risk the person would climb over them. There was also no reference to monitoring seizure activity or management of leg ulcers in this person's health care plan. The care plan for a person who had insulin-dependent diabetes did not provide information about their optimal blood sugar level range and the rescue action to take should daily blood tests prove levels were outside the range. There was no mention of what signs and symptoms staff were to look out for if the person was having a diabetic episode, despite staff recording the person could not reliably indicate or express potential symptoms of ill-health.

We also found wound care documentation could be improved to record clearly the on-going assessment, the dressing regime including frequency and evaluation of the wound. Information about wound care was

documented in a number of places instead of a comprehensive wound care plan.

Not ensuring people's needs were properly assessed and failing to ensure care was thoroughly planned to ensure those needs were met and changing needs were recognised was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Despite the shortfalls in documenting assessments and planning of care, we found staff knew people's needs well and were able to connect certain behaviour with specific needs, for example, when someone needed to use the toilet or wanted a drink and were unable to ask.

Visiting health and social care professionals stated that staff were responsive. Comments included, "Staff always ring to report any deterioration and refer patients they have concerns about" and "Clear action plans are in place to identify probable risk and to effectively manage immediate concerns." When asked if staff were responsive to people's changing needs, one health professional said, "This is variable with examples of excellent practice on some occasions but some cases when this could have been better." This comment and information was discussed with the registered manager to address.

On the first day of the inspection, the activity co-ordinator was unavailable so there were no planned activities. Usually the activity co-ordinator worked five days a week for five hours each day. We saw there was a four-weekly activity plan which included visits to people's bedroom to sit and chat to the occupant, bingo, games, ten pin bowling, baking, reminiscence, pampering sessions, and arts and crafts. There were also visits from entertainers some weekends and 'pat the dog' therapy.

On the second day of the inspection, we spoke with the activity co-ordinator and they described how they tried to ensure everyone who wanted to join in activities had the opportunity to do so. We saw there were ample facilities and materials available. A visit to another service for a bowls competition had taken place recently. People told us how they had enjoyed this and how the provider had agreed to purchase bowls equipment for their use at St Marys Nursing Home. Some people told us they would like to have more activities whilst others were content with what was provided. Comments included, "We had a singer from Scarborough and our families were invited to attend; it was a right good night and he's already booked for a return visit", "We like bingo and they play bowls and skittles; we also have a singer that comes in" and "A man came to entertain; I went to that but there are not things on every week. There used to be a good supply of books in the lounge for people to borrow." We did not see any books, magazines or newspapers on display in communal areas but there were some on shelves in people's bedrooms. In light of some of the comments about activities we have asked the registered manager to survey people's views and take any remedial action.

We found the service had been designed to respond to the needs of people with mobility problems. Corridors were well-lit, straight and wide enough to accommodate people who used wheelchairs. There were raised seats and grab rails in toilets, en-suites and bathrooms. The bedrooms we saw were bright and adequately furnished although some could be made more homely. Communal areas were clean, bright and well-furnished. There was plenty of seating for visitors.

The provider had a complaints policy and procedure, of copy of which was displayed in the service. This detailed who to refer complaints to and timescales for acknowledgement and completion. One person who used the service told us they had once made a complaint via their family and it was resolved. Other people said they would speak to one of the care workers should they have a problem. Two visitors told us that instructions on how to make a complaint were included in the Family Handbook. Relatives said they felt

able to raise concerns if required and staff knew how to manage them.

Requires Improvement

Is the service well-led?

Our findings

The new provider had just implemented their quality assurance system which had not had time to be fully embedded into practice. There were also some instances when shortfalls had been identified but action had not been taken. The registered manager told us they had not had time with all the changes underway to complete all the audits and checks. This had resulted in some areas of the service with shortfalls and breaches of regulations that had not been identified.

For example, there had not been an audit to check if people met the criteria for a Deprivation of Liberty Safeguard; this had resulted in several people potentially being deprived of their liberty unlawfully. A medicines audit in June 2017 had identified some shortfalls but there was no action plan detailing who was responsible for ensuring these were addressed. We also found shortfalls in medicines administration during the inspection. More regular audits of medicines would ensure practice improved. The last audit of the controlled drugs register was in March 2017; more frequent auditing would have highlighted the need to be more proactive in disposing unused controlled drugs. There had been a care plan audit in June 2017 but only four records were checked. Given that we found shortfalls in the assessment and care planning process, this should be more robust.

We saw there had been meetings and questionnaires to obtain the views of people who used the service and their relatives. However, we found some issues that were raised in meetings and surveys had not been addressed, for example name badges for staff. There was a timetable for the quality monitoring programme on display in the entrance but no record of the action the provider had taken in response to any issues raised or shortfalls identified, for example in a 'You said, We did' format. There was an audit file with various templates to use but these had not been started yet.

Not having a robust quality monitoring system which consistently identified shortfalls in records and other areas and action plans to address them was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Despite the shortfalls in the quality monitoring process, we could see that the provider had concentrated on making environmental improvements to the service. There was a refurbishment and redecoration programme underway and parts of the service were looking very smart. Relatives told us they were aware of plans to change the corridor carpets and to start refurbishing bedrooms. We identified improvements needed to some areas of the environment during a tour, such as more drying racks in sluices. The registered manager told us these would be addressed.

We spoke with the registered manager about the culture of the organisation. They told us they felt supported and able to raise concerns with the new provider. There was a new organisational structure which was in the process of being implemented and would provide tiers of support for the registered manager. A director of the service and two senior managers were present for the inspection feedback. They have assured us that support will be available to the registered manager to ensure shortfalls in quality

monitoring are addressed. Staff told us they felt very supported by the registered manager who had an open-door policy and made themselves available to staff.

People who used the service and their relatives knew who the registered manager was, which indicated to us that they made themselves available to people to answer queries. Staff and people who used the service confirmed the registered manager completed occasional shifts as a nurse and also walked around the service each day to speak to people and check that everything was alright. Comments from people who used the service included, "[Name], the manager is very good" and "I would talk to [registered manager's name]; she's great." One person said, "I don't really know the senior staff, only the carers."

Relatives said, "It's an excellent service. I'm always aware of what is going on and asked what I think. They couldn't really do anything better" and "I would speak to [registered manager's name] or [deputy manager's name] if I had any concerns." We saw a relative had suggested a coffee machine for the lounge area; this had been purchased and was used regularly. Relatives and staff were working together to ensure this would be maintained and funded.

When asked to comment on whether the service was well-led, visiting health and social care professionals made the following comments: "They have professional, knowledgeable and clear focussed goals in respect of maintaining quality and care standards. They promote the value of ensuring individuals are treated with dignity and respect", "Appears to be well-led and professional" and "In my opinion it appears to be well-managed."

We found the registered manager was aware of their registration responsibilities and notified appropriate agencies of incidents which affected the safety and wellbeing of people who used the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people's care plans included full information about how their needs were to be met in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not consistently acted in accordance with the Mental Capacity Act 2005 in relation to when people were unable to give consent because they lacked capacity. Also they had not consulted with the local authority when there was the possibility some people met the criteria for a Deprivation of Liberty Safeguard.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not consistently ensured that medicines were managed safely and that people received their medicines as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured adequate systems were in place to monitor and improve the quality of the service delivered to people.