The Healthcare Management Trust

Alexian Brothers Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The unannounced inspection took place on 16 February 2017 and had been brought forward due to some concerning information received.

The Alexian Brothers Care Centre is a 74 bedded care home, providing long-term care for older people who require residential support and nursing care. The home is set within mature grounds, in a secure, gated development. On the day of the inspection there were 68 people using the service.

There was a registered manager in place at the home. 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.

The last inspection was undertaken in March 2015 when the service was rated as Good overall. During this inspection we found four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 with regard to safe care and treatment, dignity and respect, complaints and good governance.

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

People told us they felt safe at the home and we found the building and grounds to be secure.

Safeguarding policy and procedures were in place and staff were being given extra support in the area of safeguarding to help ensure timely reporting of incidents. Staffing levels were sufficient to meet the needs of the people who used the service. Staff were recruited safely through a robust recruitment programme. There was a robust induction programme and a comprehensive programme of training for all staff.

Medicines systems were robust and safe. Oxygen cylinders were not always used and/or stored safely. The fire risk assessment was out of date and some of the radiators were extremely hot and posed a potential risk to people who used the service. The registered manager agreed to ensure a new fire risk assessment was implemented. Radiator covers were installed immediately to the affected radiators. Water temperatures were tested and some were found to be very hot, presenting the risk of scalding to people who used the service.

The environment was cluttered in places and a number of notices made the environment feel clinical. The premises could have been enhanced with fewer notices, more dementia friendly signage and better lighting to help people orientate around the home.

We observed the mealtime experience on two of the units. Although there could have been some improvements to how the tables were set, we saw that staff were attentive and assisted people respectfully when needed. People told us they enjoyed the food and were given plenty choice. Food and fluid charts

were not all completed as required.

The home was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). However, recording of capacity could have been improved.

People who used the service, and their relatives, were positive about the kindness shown by staff. We observed friendly and respectful interactions throughout the day.

We saw a few instances throughout the day where people's dignity had been compromised. Confidentiality was also compromised by people's personal records being kept outside people's rooms where any visitor to the service could potentially view them.

People who used the service felt the staff were responsive to their needs and they were given choice, though some felt staff rushed them.

There were a range of activities on offer. People from the community joined in the mass at the chapel, attended the lunch club and used the hair salon. This gave people in the home the opportunity to mix with people from the locality.

No evidence was available to show that complaints were responded to appropriately. People told us they would be able to raise an issue if they needed to. The service had received a number of compliments.

People told us the management were approachable and staff felt well supported. Supervisions and team meetings took place on a regular basis.

A number of audits and checks were regularly carried out by the service. Where issues had been identified, we found little evidence that these issues had been addressed.

The service had good links with the local community and worked in partnership with other organisations to share good practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe at the home and the building and grounds were secure.

Safeguarding policy and procedures were in place. Staffing levels were sufficient to meet the needs of the people who used the service. Staff were recruited safely through a robust recruitment programme

The fire risk assessment was out of date and some of the radiators and some of the water temperatures were extremely hot and posed a potential risk to people who used the service. Medicines systems were robust and safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The premises were cluttered, the environment felt clinical. There was a robust induction programme and a comprehensive programme of training for all staff.

We observed the mealtime experience and staff assisted people when needed. People told us they enjoyed the food and were given plenty choice. Food and fluid charts were not all completed as required.

The home was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service, and their relatives, were positive about the kindness shown by staff. We observed friendly and respectful interactions throughout the day.

We saw a few instances throughout the day where people's

dignity had been compromised.

Confidentiality was also compromised by personal records being kept outside people's rooms where any visitor to the service could potentially view them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People who used the service felt the staff were responsive to their needs and they were given choice.

There were a range of activities on offer and people from the community joined in the mass at the chapel, attended the lunch club and used the hair salon. This gave people in the home the opportunity to mix with people from the locality.

There was no evidence to demonstrate that complaints were responded to appropriately. People felt they would be able to raise an issue if they needed to. The service had received a number of compliments.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People told us the management were approachable and staff felt well supported. Supervisions and team meetings took place on a regular basis.

A number of audits and checks were regularly carried out by the service. Where issues had been identified, there was not always recorded evidence that these issues had been addressed.

The service had good links with the local community and worked in partnership with other organisations to share good practice.

Alexian Brothers Care Centre

Detailed findings

Background to this inspection

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

The inspection took place on 16 February 2017 and was unannounced. The inspection team consisted of three adult social care inspectors from the Care Quality Commission (CQC) and two specialist advisors. A specialist advisor is someone with appropriate skills and experience in a field related to the service provided at the location to be inspected. One specialist advisor for this inspection had skills in nursing care and the other in social work.

Prior to the inspection we looked at information we held about the service such as notifications, safeguarding concerns and whistle blowing information. We also received a provider information return (PIR) from the provider. This form asks the provider to give us some key information about what the service does well and any improvements they plan to make.

During the inspection we spoke with 18 people who used the service, eight relatives and one other visitor. We also spoke with two members of care staff, the chef, the hairdresser, two activities coordinators and the registered manager. We observed care during the day and reviewed records at the home including five care files, two staff personnel files, meeting minutes, training records, health and safety records and audits held by the service.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe at the home. One person said, "I feel safe, there is always someone to help". Another told us, "I feel safe here, definitely". Other comments included; "I feel happy, content and safe here"; "Feel safe here, the staff are amazing, they know what they are doing, very efficient, very caring"; "I trust people [staff] here and that makes me feel safe"; "I am not threatened by anyone and would go to staff if I was, so that makes me feel safe".

A relative told us, "The staff have said, 'You can stop being carers now, we will do that, now you can be daughters again'". Another said, "My [relative] is safe here I can see it in her, she looks better, more relaxed. She was very vulnerable at home". Other relatives' comments included; " They really know [relative], she can be difficult, especially with bathing but the staff know now how to re-assure her"; " Oh yes he is safe here, when he first came to [the home] I did not think he would last the weekend and that was six years ago".

Staffing levels were sufficient on the day we visited to meet the needs of the people who used the service. People we spoke with felt there were enough staff around and relatives agreed that staffing was sufficient in the home. On each floor staffing reflected the current needs, whether nursing or residential care was provided. We saw within care plans that people's dependency levels were assessed to help inform staffing levels. Only one relative said, "They might need more staff. Some of the agency staff are not used to 12 hour shifts. It is hard working here".

We looked at staff personnel files and saw that a safe system of recruitment was in place. The recruitment process helped to protect people from being cared for by unsuitable staff. Each file included a completed application form, references and proof of identity. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with vulnerable people and informs the service provider of any criminal convictions noted against the applicant.

We looked at the safeguarding policy and procedure and this included references to whistle blowing and Deprivation of Liberty Safeguards(DoLS). There was a comprehensive safeguarding file with relevant contact details for all surrounding local authorities included. There was guidance for staff to follow and there were safeguarding files for staff to use on each unit.

Following a recent safeguarding issue, which had not been reported as expected by staff, extra supervisions and training were being given in this area to try to ensure they would report any issues immediately in future. The specific allegations were being addressed appropriately via the service's own procedures and other relevant agencies' protocols.

The building was secure, with keypads on all floors and locked gates at the edge of the grounds. We looked around the home and found it to be clean with no malodours in any areas of the building. We saw that the home followed the national colour coding scheme for cleaning materials to minimise risk of cross contamination. For example, mops and buckets were colour coded so different ones were used in the kitchen areas, bathrooms and laundry areas. People who used the service, and their relatives told us they

felt the home was clean. One relative said, "That's one of the things I noticed when we were looking for somewhere for [relative], how clean it was and there is never any smell".

There was some cleaning in progress and signs were put up where this was taking place in communal areas. The last infection control rating received by the service was 82% and issues identified had been addressed.

We saw that personal protective equipment (PPE), such as disposable gloves and aprons, were available on corridors and we saw evidence that staff were using these appropriately. There were a few minor issues, such as some missing hand washing guidance signs and a missing waste bin. However, these were addressed on the day of the inspection.

Personal Emergency Evacuation Plans (PEEPS) were available in care files, with a separate copy kept on each unit in a PEEPS file. However, these did not always match and we spoke to the registered manager about the need to review all of these to ensure they contained current information. This was done, and evidence produced, immediately following the inspection.

We looked at a fire risk assessment from 2015 which placed the service at the highest risk rate, ie intolerable. We saw from the action plan that some action had been taken to reduce the risk, for example, the position and disposition of fire equipment was ticked as completed, but other actions were not. For example, the report recommended 'albacamats are a possible solution for non-ambulant persons, but there was no corresponding recording. We were shown that evacuation chairs were stored on each unit to assist people with limited mobility to manage stairs in case of emergency. This actions had not been recorded on the risk assessment and we were told the next fire risk assessment would be due by 31 March 2017.

We recommend that the service ensures that all outstanding actions are completed in a timely manner and a full up to date fire risk assessment is made available.

We saw that weekly fire tests were carried out, including all key points and bedroom smoke detectors. The last fire drill recorded was on 14 February 2017.Information viewed showed all appropriate services had been carried out and fire appliances, such as extinguishers, alarms and smoke alarms had been serviced on 05 September 2016. All profiling beds had been checked in March 2015 and, where repairs or replacement requirements had been noted, there was evidence that these actions had been carried out. They were due for further inspection in March 2017. The lifts were serviced in January 2017 and the boiler serviced in July 2016. Portable appliance testing (PAT) was on-going.

We tested the water and found that some of the temperatures were high, the water in one bedroom hand basin registered at 48 degrees Celsius. This was also identified in another area of the home and could present a risk of scalding to people who used the service.

This was a breach of Regulation 12 (2) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

On the first floor, in the shower and toilet area the radiator was extremely hot and the radiator in the same area on the ground floor was also very hot. The radiators throughout the building were regulated via temperature control knobs. We informed the registered manager who agreed to turn one down but some remained extremely hot. The maintenance officer agreed to disconnect these radiators and, following the inspection, photographic evidence was supplied that radiator covers had been installed to all affected radiators.

We looked at medicines management within the home. We spoke with the nurse in charge of one of the units who explained the systems to us. The medicines policy was available but the nurse struggled to find it in the medicines room. The British National Formulary (BNF) on the unit was old and out of date.

We observed the nurse administering medicines and they were able to describe to the person who used the service what the medicine was and what it was for when asked. We saw that the nurse washed their hands, measured the dose correctly for liquids, explained the medicines and gave a drink to wash down tablets. The trolley was checked and locked when the nurse was momentarily called away. We looked at five medicine administration record (MAR) sheets and saw photographs were included on three, not on the other two. Photographs help staff ensure the medicines are given to the correct person.

There was a protocol for medicines used as and when required (PRN) and we observed a care worker requesting paracetamol for an individual. The nurse in charge asked why and checked the MAR sheet before agreeing and administering the drug.

Checks were made each night by night staff to ensure medicines levels were correct and, if any discrepancies or errors, these were noted and followed up. Medicines trolleys were secure and stored in a locked medicines room. Only a senior nurse held the key throughout the shift. The temperatures were recorded for the room and for the medicines fridge and both were within the recommended range and were consistent. We saw there was no excess stock held and returns were documented and returned to the pharmacy.

The controlled drugs (CD) cupboard was secure and we checked with the CD register which was signed and countersigned as required. Anticipatory drugs were clearly marked for three people. Creams were administered by care staff and there were body maps and separate topical MAR sheets completed and signed.

Whilst we found oxygen hazard notices were displayed we did see, on one nursing unit, that there was an oxygen concentrator on the corridor plugged in and running, as the room it was meant for was small and cluttered. Another individual was in bed, in a small room cluttered with equipment. There was an oxygen concentrator in the room with flex and oxygen piping trailing around the room posing a trip hazard for staff and visitors.

Requires Improvement

Is the service effective?

Our findings

When asked if staff were efficient and competent we received the following comments from people who used the service; "Fabulous here. I haven't walked for three years, they get me into the chair every day. Great care, they [staff] are all good pals"; "Better care than I would get at home"; "I don't like it. The place is nice, the staff are lovely, but you want to be at home"; "I couldn't ask for anything better. They do everything for you and they get some rotten jobs"; "Staff do not know what they are doing, they do not sit down and talk with us"; "When I ask a question they look at me blank".

Relatives told us, "Staff go out of their way to help, giving encouragement, the personal care is wonderful"; "Excellent on every level"; "[Relative] can be difficult and demanding, they handle him effectively, they know what they are doing"; "The staff have been awesome, [relative] has been transformed since she came here. She can now use a fork again and is eating proper food. [Relative] now has conversations, she is alert, she is a transformed woman. This place has dispelled the myths. They are like a family. I don't have any worries. Visiting is flexible which is good".

We looked around the home and saw that appropriate notices were displayed in the reception area and throughout the building, such as the latest CQC report and rating. Pictures on the wall were relevant to reminiscence for people in their 70s and 80s, for example, pictures of the Beatles. There was a popular, pleasant and well fitted, large hairdressing salon, decorated in red and black. Staff in the salon told us, "When someone comes to live at the home I find out by talking to the relatives what sort of music their loved one enjoyed, then I download this when a resident comes to the salon". The room had a number of tactile and sensory objects for people to make use of whilst they were waiting to have their hair done and relatives were also encouraged to make use of the salon. It presented as a friendly and welcoming place where people could enjoy a pleasant experience.

We observed a number of notices placed around the corridors and communal rooms, which made the home feel quite clinical rather than homely. Some of the corridors were cluttered, with rails of clean laundry which was not put away all day. There were plastic skips full of hoists, slings and other items. These were not moved all day and made the home look unsightly and unwelcoming.

The registered manager made it clear that the service does not specialise in dementia care and said they do not accept people who are living with dementia. However, there were some people who were living with the early stages of dementia, or some confusion. The signage around the home could have been clearer to ensure people with the condition were able to be orientated around the home. We also noted that the lighting on some corridors was poor, which could also cause problems for people who were living with dementia. Older people or those living with dementia require where possible natural light or bright electric lighting.

Staff were required to complete an induction prior to commencing work. They were given general training, role specific training for their position and were required to familiarise themselves with policies and procedures. The staff induction pack given to new staff included the policies on diversity, safeguarding and

whistle blowing. Staff were subject to a three month probationary period in which they were mentored by a more experienced member of staff.

There was a dedicated training room used by staff. We looked at the training matrix which evidenced that staff had undertaken training in all appropriate areas, such as moving and handling, whistle blowing and safeguarding adults, Gold Standard Framework (end of life care), fire awareness, challenging behaviour, activities, infection control, first aid and medicines awareness.

We saw the staff supervision matrix which evidenced regular one to one meetings. Some staff were having monthly supervision sessions, others less frequently, depending on need. The registered manager told us they were about to introduce leads amongst the staff for areas such as 'End of Life' and Nutrition'.

The home had a food hygiene rating of 5 Stars, which is the highest possible rating. The home had a four week menu cycle. People spoken with told us the food was very good. One person said, "There's plenty of choice". People told us there was always a cooked breakfast if they wanted it and night time snacks were available. Snacks included sandwiches, toast and a choice of hot milk drinks.

We found for some people a food and fluid chart had been put in place to monitor their nutritional and hydration intake. We saw that these had not been completed as required. For example on the 16 February 2016 the records for seven people were left blank. On other days charts had been appropriately completed. Staff should be mindful of the importance of completing charts accurately.

We observed the lunchtime meal in two of the units. On one unit we saw that all individuals were addressed by name. Staff offered choices and helped people by cutting the food or by assisting some people to eat. Pureed meals were well presented, colours were separated and there was a variety in the texture of food. We saw that drinks were available throughout the day.

On the other unit we saw that the dining room tables looked uninviting and institutionalised. Table cloths were used, but the cutlery was place in a haphazard manner with paper serviettes placed under knives. There were no flowers on the tables or pictures of the food that people would be eating. People were asked the day before for their choice of meal. The menu forms were similar to those used in hospital with no pictures for residents to look at and have a discussion around.

Meals were served at 12.30, and at 12.15 people who required support were taken to their tables. Initially when food was being served there was minimum interaction as staff tried to ensure people were served quickly.

The atmosphere became more relaxed when the meals were all given to people. Some people started chatting with each other. The staff were notably more attentive and warm in manner, quietly coaxing those who needed verbal prompts to eat. We observed staff gently persuading three individuals who were not eating. The staff gave encouragement by talking with the people who used the service in a sensitive, caring manner. One person began shouting saying she did not want the food, a member of staff intervened, she showed dignity and respect to the individual, talking quietly to her in an attempt to settle her. A further staff member who was assisting a person to eat gave encouragement. She took her lead from the individual with regard to the pace and time needed to support him.

The meal choice was cabbage and potato soup, lamb curry with rice or steak, mashed potatoes with carrots and beans, apple pie or yoghurt. All the food presented looked favourable with adequate portions. Cold drinks were also given, but no tea or coffee. Relatives had earlier commented on the quality of the food, and

told us they had also been provided with meals on occasions. One relative said, "The food is really tasty, spot on".

People who used the service commented, "The food is nice. They really try and do you something you like"; "The food could be better. I like cheese and onion pie, the pastry is not what it should be"; "I eat what I want, the food is good, better than most places I've been to. They don't force it down you. If you don't like it they give you something else. It's always hot. There can be too much, my diabetes has improved in here, I have lost weight and feel better for it"; "The food is good, must be one of the best"; "I enjoy the food. If I don't like the menu they bring something else".

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 so that they can 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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The home was working within the legal requirements of the MCA and staff were aware of the principles, but recording of capacity issues within people's care files could have been better. For example, some relatives had signed consent form even though the person using the service was said to have capacity. There was no explanation as to why this was. Staff had undertaken training in MCA and DoLS, though some was due for renewal. The registered manager told us they had purchased a training video which would help staff's understanding in this area and assured us the paperwork would be reviewed and improved.

The local authority was behind with DoLS authorisations so some were now out of date. However, the service had evidence that these had been applied for in a timely manner in the form of e mails to and from the local authority. DoLS that were in place were appropriate and logged as required.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us staff were kind and caring. Comments from people who used the service included; "The staff are great [staff member] is really good, very pleasant, lovely smile; that in itself makes you feel better. Its hard work being a nice guy all day"; "I'm happy, the staff are smashing, they all help"; "They are very good; no complaints". All people who used the service and their visitors, that we spoke with, confirmed there were no restrictions on visiting.

Relatives and visitors comments included; "The girls (staff) are really very good, pleasant, whatever I want they come. I couldn't fault them"; "They are very caring here, after seeing other homes, this one is the best. Every one of the staff are polite to [relative], no one gets impatient with her. If and when my time comes I would be happy to live here"; "They go out of their way to pander to [relative's] needs, he can be very demanding"; "They are loving, caring excellent staff"; "[Relative] is comfortable with them allowing staff to shower her"; "When [relative] came in she was depressed wanting to stay in bed all day. Now she looks better, is eating well ,her health is better"; "Staff respond to [relative] well, the furniture is a bit old though but I feel the care is good that is the main thing"; "All the staff are great from the cleaners who are warm and friendly, all the way up"; "Yes I would say the staff are caring, when I came once my [relative] was in the toilet, I waited outside but could hear the staff member talking to her in a very kind and caring way, she did not know I was behind the door"; "It's given [relative] two years extra (moving to this care home). All the girls are lovely, can't fault it. If all the homes were as good as this… I can't fault it".

We observed throughout the day that staff treated people kindly and were friendly and polite. We saw that a lot of people on the nursing units were in bed. However, those who were dressed and up were well groomed and well-presented wearing personal items such as jewellery and watches.

There was a suggestion box in the reception area for people to use to put forward ideas for service improvement. There was evidence within the care plans that people who used the service and their relatives were asked their opinions about issues such as, care, food and menus, activities and outings.

Information was available for people who used the service and their relatives, in the form of the Statement of Purpose, which set out the aims and objectives of the service. The Statement of Purpose stated that people would be treated with dignity. However, we saw for one person that their dignity was compromised. This person was in bed and was not dressed in any appropriate clothing, therefore was very exposed to being seen in this state by people walking passed their bedroom. On checking this persons care plan there was clear instruction written about this person preferred attire which clearly was not being adhered to.

In one of the lounges we saw that kylie sheets were on most of the chairs. A kylie is protective cover to absorb urine and protect the chair cushion. We asked the registered manager why there were sheets on all chairs as this may compromise people's dignity, indicating problems with continence. The registered manager felt these were unnecessary and removed them at once.

This was a breach of Regulation 10 (1) of the Health and Social Care Act (Regulated Activities) Regulations

2014.

We saw a person who used the service having their hair blow dried by a member of staff. This person was sitting in a wheelchair on the corridor outside their room. This did not afford them any privacy.

We saw that people's room files were kept outside their bedroom doors on a handrail on the corridor. This meant that anyone could access the file and read confidential information. Files kept at the unit manager's station were also accessible by anyone entering the unit. We observed that there was a handover sheet with a list of resident's names, diagnoses and nursing needs including level of continence, a folder containing all the fluid balance charts for the unit and a folder with the food diaries for each individual on the unit all on a dining room table for at least five hours with no one in attendance. This again compromised people's right to privacy and confidentiality. This was discussed with the registered manager who agreed to address this immediately.

Requires Improvement

Is the service responsive?

Our findings

We asked if the service was responsive to people's needs. Comments we received from people who used the service included; "I don't wait long when I ring the bell. I've no complaints"; "Sometimes they are very busy and I have to wait, but I appreciate that"; "The priest comes every night, the brother comes to say goodnight. It's nice to be able to keep up my religion"; "I like the staff, they know I like spending time in my room, then I go into the dining room to eat"; "They rush me in the morning saying, 'There are other people to see to, I have to get you downstairs in so many minutes' and they say to me, 'Come on you are not the only person I have to see to'. I don't complain because if I do I know what they will say, we are told they cannot change things. Sometimes this is said in a kindly way but not always"; "I used to wait ages before they would take me to the toilet, I complained to [staff member]. Now they take me when I need to go but the staff are always rushed"; "Oh yes, if I press my buzzer at night they come to see me, no I don't wait long"; "I was constipated I told staff and they give me tablets, I am much better"; "If I need anything I just tell staff and they sort it"; "I was supported when I had a shower by a man. I didn't like it and told staff, now I always have a girl".

Visitors told us "We wouldn't worry if we missed a day [not visiting relative]. They let us know if there is anything"; "When [relative] had a urine infection they acted on this quickly, got the GP and phoned us to let us know"; "When [relative] fell and went to hospital they phoned us straight away.; "[Relative] is a Christian, not Catholic, but the priest checked and she takes holy communion each day now"; "Communication here is good with staff, you can ring the unit at any time, that is re-assuring for the family"; "When relative] fell they informed us promptly and one of us was able to go to the hospital to be with her"; "Everything I have asked staff to look into has been done, chiropodist, eye testing, the district nurse comes to see her if needed"; "[Relative] had a urine infection the staff got the GP to see her who then prescribed antibiotics for her, they phoned us. It was all done quickly, she is fine now"; "It is little things, I have seen staff responding to residents needs in a sensitive manner. Things like finding a station on the radio that a resident liked, like I say it is the little things that make a difference to people".

Care plans included information about people's preferences, for example, whether they preferred a bath or shower, food they preferred and daily routines. There was a section on socialising and well-being, which included a social history and background information. Mental health, cognition and communication were documented to aid staff in caring for people. We saw appropriate referrals to other agencies to aid people's independence and well-being. Guidelines from other agencies, e.g. speech and language therapy (SALT) on safe swallowing, were outlined within care plans we looked at. There was some evidence of involvement from people who used the service and their families.

We saw that people's spiritual needs were met with daily mass in the chapel and a weekly Church of England service. The chapel was open to the community, which meant that there were opportunities for people within the home and in the community to mix. The home had an activity room on the ground floor and people from upstairs were escorted down join in the activities if they wished. Activities included hand therapy, reminiscence, music for health, crafts, food tasting, dominoes, board games, singers and film afternoons and music and dance. Entertainers were also booked to sing at the home. One individual was in

bed with their curtains closed at 11.30 am. We spoke with this person and they told us this was their choice.

We spoke with two activity coordinators who worked 37.5 and 32.5 hours each. There was also another activity co-ordinator. They told us they [activities coordinators] used to run a day care unit which is now closed. Instead of being made redundant they now ran the lunch club and helped on the unit to assist people with meals. This also provided an opportunity for people within the home and in the community to interact as people who attended the club were encouraged to stay for the afternoon. The activities coordinators also managed the activities both on the ground floor unit and one to one with individuals. For organised activities people needed to be brought down from other floors.

When we visited two people were using water colour paints to colour a reproduced drawing. Others were sat around a large table having their nails washed and cut and hands massaged. There was a general relaxed friendly atmosphere. There was evidence of people's wishes being respected, for example one person liked to sit outside all day in the fresh air. We saw this person being wrapped up in a coat scarf and gloves before being taken outside.

We asked people who used the service about activities and things that were important to them during the day. People who used the service commented; "I go to mass every morning then I go to the activity room, play ludo, have coffee chat, come upstairs for lunch then I often go back to the activities room in the afternoon. I love the activities and my own TV where I can choose the programme I want and adjust the sound"; "Not as much going on as there should be. Sometimes you go up there [activity room] and there's nothing. I was lonely before, at home, but it's worse here, I can't even go out for fresh air"; "My own minister comes each Monday to see me"; "I like football. I get the newspaper delivered every morning and I have my telly" (this person had the day's newspaper on their bedside table and a large plasma screen TV): "I'm not keen on the day room. There is a TV at each end of the room, sometimes they are on different programmes". We observed that several people preferred to sit on the corridor rather than in their rooms or in the lounges. In each lounge/ day room there was a TV at each end of the room even when they were on the same channel, the sound was not synchronised.

Relatives we spoke with told us, , "[Relative] has her hair done every day, gets up each day washed and dressed, goes to mass each day always has he hearing aid and glasses on"; "Before [relative] came in staff asked about her personality, about her daily routine. We told the staff she used to like a daily drink of wine, so that is what happens now. I bring her a bottle of wine in and she has a glass a day which she enjoys"; "[Relative] has always been a loner, staff know this, she spends a lot of time in her room, staff keep an eye on her. Going to the hair dressers is important to her, she likes it. She has seen the chiropodist after we told staff she had not seen one"; "I have to say staff were amazing last time I came, they are so good with [relative], when the nurse call is used there is a prompt response."

We looked to see how the service managed complaints and saw a complaints policy and associated procedures were in place. The complaints procedure was prominently displayed. We saw there had been four complaints which had been recorded, however the recording was brief and there were no actions or outcomes recorded.

This was a breach of Regulation 16 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was one complaint that had not been logged as the registered manager told us they had run out of log sheets. We were shown evidence that this log had been updated immediately after the inspection.

We asked people who used the service about complaints and concerns and how these were dealt with. One person who used the service told us, "I was very ill when I came in. I thought I was going to die. It's been great. I'm quite happy. The staff are very good polite, well mannered, no complaints at all." Another told us, "[Registered manager] downstairs is in charge. But I would go to my nurses if there was a problem". A third person commented, "If there was a problem 'I would go to one of the girls, they are all very helpful. No problems at all". A relative said; "If I had any concerns I would go to [head of residential care] I am confident about that".

We saw a number of compliment cards. Comments included: 'To all the staff especially on St Joseph Ward. Thank you for the care and attention shown to my [relative]'; 'Thank you so very much for all the love, attention and compassion you have shown to my [relative]'; 'I write to each one of you to express my very sincere thanks for all your dedication and loving care of [relative] during the last years; '[Relative] talked to me about you all and was deeply appreciative of all that you did'.

Requires Improvement

Is the service well-led?

Our findings

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

People we spoke with told us the registered manager was approachable. From discussions with staff on the residential unit we were told they felt supported and well led by their head of residential care. We observed a senior member of staff, head of care on the residential unit, who was enthusiastic and energetic. She had an open door to her office and was very visible on the unit. People who used the service and their relatives all spoke highly of her. One person who used the service said, "The longer I have known [head of care] she has impressed me". Relatives commented, "Staff go out of their way to help"; "[Staff member] is always bubbly, I feel it is well-led [head of care] runs a tight ship"; "They are enthusiastic and care for mum well".

All the permanent staff we spoke with told us they enjoyed working for the organisation and caring for the people who used the service. Speaking about the head of the residential unit, one worker told us she felt [staff member] was efficient and approachable. A further member of staff said, "If there was an incident which I had concerns about I would go directly to our head of residential, if she wasn't there then I would go to the Matron. Residents and their safety are what is most important". A member of ancillary staff said, "I would have no hesitation in making a complaint if I saw something that was worrying me".

We saw that the service had corporate policies and procedures in place. Some of these were in need of revisiting and updating. All incidents, falls, pressure sores infections and admissions to hospital were recorded monthly and analysed by the provider for patterns or trends. This helped the service to continually improve service delivery.

We saw a monthly housekeeping audit which checked sluice rooms and kitchenettes. This audit had identified wear and tear of some equipment but we could find no signs of any follow up action. A quality assurance audit had been completed but there was no evidence of actions implemented.

This was a breach of Regulation 17 (2) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Health and safety monitoring was mostly done by the maintenance officer. Actions and policies were in place and cross referenced. We saw a premises action plan. There was a daily medication audit and a three monthly audit. No major concerns had been identified.

We saw that staff supervisions were held regularly and staff meetings took place when required. Service user feedback was sought via reviews and the suggestions box and informal conversations with the chef and activities coordinators. The manager operated an 'open door' policy so people were able to approach her and discuss any issues at any time. The last formal survey for both staff and people who used the service

had been completed in 2015.

The service had good links with the local community through their inclusiveness with the daily mass in the chapel, the lunch club and the hairdressing service. They had membership to NAPA (National Activities Provider Association : 'care and support setting to be full of life, love and laughter'. They also hosted the Manchester Care Home Forum's regular meetings. This provided an opportunity to share good practice.

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 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service was not providing care in a safe way, assessing risk and doing all that was reasonably practical to mitigate risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person was not operating effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

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 service did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;