Morleigh Limited

St.Theresa's Nursing Home

Inspection report

St Therese Close
Callington
Cornwall
PL17 7QF

Tel: 01579383488

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this unannounced comprehensive inspection of St Theresa's nursing home on 1November 2016. We undertook this visit as we had received concerns in respect of the care and welfare of people using the service. We looked at the concerns raised, plus we checked what action the provider had taken in relation to concerns brought to the commission's attention during our last inspection in January 2106. At that time we found a breach of legal requirements, in that new staff were starting work at the service without a satisfactory Disclosure and Barring Service (DBS)check in place. We received information of concern prior to this inspection that a person had been allowed to work alone with vulnerable people before required checks had been completed. We discussed this with the manager who confirmed this to have occurred. A record showed a DBS check for a staff member appointed in August 2015 had not been requested until June 2016. The failure to complete necessary checks before allowing staff to provide care exposed people to unnecessary risk. This was a repeated breach of regulation requiring action to be taken from the comprehensive inspection in January 2016.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Theresa's Nursing Home on our website at www.cqc.org.uk The provider for this location is registered under the legal entity of Morleigh Limited which is part of a group of nursing and residential care homes.

St Theresa's is a care home which provides accommodation for up to 45 people who require nursing care. At the time of the inspection 22 people were living at the service. Most people who lived at St Theresa's required general nursing care due to illness. Some people were living with dementia. St Theresa's is a purpose built single storey building with a range of aids and adaptation in place.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. St Theresa's has been without a registered manager since March 2014. Since that time five managers have been appointed. Two of those managers left after a short employment period at St Theresa's. One was moved to manage another service in the group and then left. One was moved from another service in the group to manage St Theresa's on a part time basis and the current manager commenced in October 2016.This has meant there has been no management stability at the service. The current manager told us they had submitted an application to the commission for registration. However, this could not be verified at the time of the inspection visit and was not found to be the case following the inspection.

Medicines were not being managed safely. Handwritten entries were not always double signed. There were gaps in records of when creams had been applied and not consistently signed as given. There were inaccurate records of the amounts of medicines being stored. Medicines were not being returned to the pharmacist as required. Medicines requiring cold storage were being stored at above the recommended temperature range. This had been identified by the manager but not acted upon.

The premises and equipment were not being maintained in a safe and secure way. The collection of soiled laundry from bedrooms and cleaning procedures did not ensure suitable standards of cleanliness. There was no designated facility to wash commode bowls effectively. A broken shower door was propped against a wall in the bathroom. Water temperatures were inconsistent with one hot bath tap supplying water at a temperature above the safe range. A door to a store room which contained cleaning products was left open and accessible.

Systems and processes to ensure good governance were not being effectively operated. Records relating to managing the health and care needs for people were not always being updated or completed by staff. People's fluid intake was not being recorded as instructed in the care plan. There were gaps in records where people needed to have their position changed regularly to prevent pressure sores. Wound care records were not accurate according to the care required in the care plans. Care records did not always contain records of external healthcare professional visits.

We identified a person had needed support with pressure relief and regular turns in bed due to risk of pressure damage to their skin. However, there had been a delay of five days in seeking appropriate specialist advice which meant the risk of suffering further skin damage was increased.

At the last inspection we found that the manager had not informed the CQC that a Deprivation of Liberty Safeguard (DoLS) authorisation had been granted, as they were required to do by law. This notification had still not been submitted to CQC at the time of the inspection.

Staff told us they felt supported by the manager. However, the records relating to staff supervision and appraisal were incomplete and did not demonstrate that staff were being supported.

The staff had daily handover meetings to discuss the day's events. These meetings discussed people's care and information was shared with staff coming on duty. However, the records were not always accurate. The information was not always visible because of the way the record had been copied.

Prior to this inspection we received information of concern regarding a poor culture at the service. We were told people's choices in relation to their care needs were not always respected. During the day of our inspection visit most staff were observed to be supporting people sensitively. However, we did observe a senior staff member speaking in an overbearing and harsh tone to a person requesting support. The person was made to wait for a period of time before their request was met.

We had received concerns equipment was not suitable and some was faulty. Hoists and equipment had recently been serviced and were in working order, although staff told us an additional hoist and stand aid would help them to support people without having to move equipment around the service.

We had received concerns about the quality of food. People had mixed views about this. Some people told us they liked the food and others said it could be improved. In general we found that the quality of food was adequate though not of a high quality.

Care plans contained risk assessments for a range of circumstances including moving and handling, nutritional needs and fall. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately in order to minimise risk and keep people safe whilst maintaining as much independence as possible. Some people required slings to support them when using hoists. There was evidence slings were being inappropriately shared.

Some people required aids to support continence. People were prescribed continence aids which met their individual needs. However, we found packs of pads throughout the service which were not named for the individual and were being shared communally. Net pants used to secure continence pads were also shared communally.

The service had a system to report any maintenance issues. A weekly maintenance report was submitted to head office by the manager and some repairs carried out. Faults and defects were not dealt with in a timely manner. For example a toilet seat in need of replacement had been on the maintenance report for three weeks without being addressed. There were areas of the building which were in need of decoration due to previous water damage and this work had been outstanding since out last inspection in January 2016.

Staff had access to training in order for them to develop their skills. The registered provider told us many staff carried out e-learning training, a computer based way of learning. This type of training is remote and there was no evidence to identify how much staff had understood the training. There had been some spot checks to look at staff practice but these observations by senior staff were taking place infrequently..

The service had a system of induction but it was not in line with current best practice. This is completion of a nationally recognised induction training programme. We discussed this with the manager who told us staff were being enrolled onto a diploma level programme and an assessor visited on the day of our inspection. There were systems in place to support staff through meetings and daily handovers.

There was no evidence people's views had been sought but the provider told us a survey had been sent recently to people and the families of people using the service. There was no information available to view this survey at the time of the inspection.

There were examples where the registered manager and nursing staff had responded to changes in people's needs. For example, when a person's health had suddenly deteriorated, staff responded by seeking urgent medical advice and support. This resulted in the person receiving emergency treatment followed by a hospital admission.

The service calculated staffing levels using their own assessment tool and we saw these numbers of staff were usually working at the home. People told us they thought there were generally enough staff to support them.

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at St Theresa's Nursing Home and the service has been rated as either Inadequate or Requires Improvement since the first rated inspection carried out in February 2015. The service has also not met the requirements of enforcement action which they are required to do by law. The Care Quality Commission has carried out six inspections (including this one) of the service since February 2015. At each inspection there have been breaches of the regulations. Given the history of the provider we have a lack of confidence in their ability or willingness to take the necessary actions to meet the requirements of the regulations.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

We are taking further action in relation to this provider and will report on this when it is completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Medicines were not being managed safely. Records were not accurate and were not being signed.

The service was not ensuring recruitments checks were in place before staff began working with vulnerable people.

The service was not ensuring potential hazards within the environment were being addressed.

Is the service effective?

Requires Improvement

The service was not always effective. People were not always satisfied with the quality and choice of meals.

Maintenance of the service was not always taking place as necessary.

Staff had access to training in order for them to develop skills in their role. However, there was no system in place to assess staff competencies.

Is the service caring?

Requires Improvement

The service was not always caring. People were not always treated in a respectful way when requesting care and support.

Staff understood the need to protect people's privacy and therefore their dignity.

Some people who used the service and some relatives were positive about the care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive. There were gaps in some care records which meant staff did not always have the information to respond to people's needs.

Care plans did not always provide staff with clear information about how to respond to a person's needs.

Care plans were not always updated which meant information may not be accurate and affected how staff responded to people's needs.

The range of activities available to people was limited and not always meaningful, specifically where people had dementia care needs.

Is the service well-led?

Inadequate

The service was not well led. The provider has a regulatory history of multiple breaches of regulations and required enforcement action which continue.

There has been no continuity in the management of the service due to frequent changes of manager. A registered manager is a condition of the registration of the service.

We found a number of concerns during our inspection which had not been identified by the provider or manager. This showed a lack of robust and effective quality assurance systems.

Records relating to the management and running of the service and people's care were not consistently maintained.

St.Theresa's 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 unannounced inspection took place on 1 November 2016. The inspection team consisted of three inspectors and a specialist advisor. The specialist advisor was a person with professional experience of this type of service.

Before the inspection we reviewed information held about the service and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with the provider, Moreligh's operation manager, the manager at St Theresa's and the duty nurse. Seven care staff, the cook and one member of the domestic staff team. We also spoke with a visiting professional.

Not everyone who was living at St Theresa's was able to tell us their views about the care and support they received due to their health needs. We spoke with five relatives and four people using the service. We also observed staff interactions with people.

We looked at care documentation for five people, medicines records, staff files, training records, maintenance records and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

During a number of previous inspections at this service we had identified concerns that the service did not have robust recruitment procedures in place. At this inspection we found recruitment checks were not robust. We received information of concern prior to this inspection that a person had been allowed to work alone unsupervised and that a Disclosure and Barring Service (DBS) check had not been carried out for them. These are used to help ensure staff are suitable to work in the care sector. In addition references used to assess the employee's suitability for the role had not been asked for. We discussed this with the manager who confirmed this had occurred. A record showed a DBS check for a staff member appointed in August 2015 had not been requested until June 2016. We asked to see this person's recruitment records but were told by the manager this information was currently held at the providers head office where Disclosure and Baring Service (DBS) checks were completed. The failure to complete necessary checks before allowing staff to provide care exposed people to unnecessary risk. This meant the provider did not have the information required in respect of all employees as specified in Schedule 3(2) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

This was a continuing breach of regulation 19. There have been repeated breaches of this regulation found at both inspections on 25 January 2016 and on 6 August 2015. At the inspection of 6 August 2015 an enforcement warning notice was issued. This demonstrated the provider's inadequate response towards meeting the requirements of legislation.

We checked the medicine administration records (MAR). They showed that staff had signed when they gave prescribed medicines. However, where staff had handwritten new medicines onto the MAR following advice from medical professionals, the entries were not always signed and had not been witnessed by a second member of staff. This meant that there was a risk of potential errors and did not ensure people always received their medicines safely. Some people had been prescribed creams and these had been dated upon opening. This meant staff were aware of the expiration of the item when the cream would no longer be safe to use. However, there were many gaps in all the records for creams where staff had not always document when they had applied the prescribed creams. This meant it was not always possible to establish if people had received these medicines as prescribed.

The service was holding medicines that required stricter controls by law. We checked the records kept against the stock of medicines held at the service, they did not tally. One item had been held since March 2015 but we were told they no longer required this medicine. The records stated 77 tablets of Tramadol, a morphine based medicine were held at the service. However, we found 66 tablets remained at the service. Therefore 11 tablets were unaccounted for. There were 10 other medicines which legally required stricter controls which were shown in the records as being held by the service but which were missing. These medicines could also not be accounted for by the service

Some people had been prescribed medicines which needed to be stored in a refrigerator and the service

used a medicines refrigerator. Medicines that required cold storage should be kept between 2 and 8 degrees centigrade. Staff had been recording the temperature of this refrigerator as reaching 17 degrees each day throughout September 2016. The manager and nurses had raised this concern with the provider but this issue had not been rectified. Staff told us, "Feel it, it is really hot on the outside, it isn't right." However, staff had not monitored the temperature of this refrigerator since the end of September 2016. This meant that medicines that require cold storage had not been managed safely.

The service was carrying our regular medicine audits. The last audit in September 2016 stated, "All handwritten entries are clearly signed, dated and countersigned." This was not found to be the case at this inspection visit. On 23 October 2016 a further audit of medicines that required stricter controls had been carried out and the records stated, "The stock balance is correct." This was not correct as stock held since 2015 was not recorded correctly and several other items were recorded as held when they were missing. At a recent staff meeting staff had been reminded to "Ensure topical MARS forms are signed for- they are a legal documentation." This demonstrated the audits and staff instructions had not been effective.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

This was a continuing breach of Regulation 12 from a previous focused inspection on 15 September 2015 regarding poor risk management and prevention of pressure wounds. Previously an in April 2015 had identified a breach of this regulation regarding poor risk management and an enforcement notice was issued. This demonstrated the provider's inadequate response in meeting the requirements of legislation.

Before this inspection CQC received concerns that slings and handling belts were 'too big' for people. We identified some people required slings to support them when being supported to mobilise. Staff told us people had their own slings in their rooms which were suitable for their height and weight. We checked this and found individual slings in people's rooms where they needed a hoist to support them from a bed to a chair. When checking the slings we found that in five instances the sling was different to the recorded room number on a recent service record. This indicated slings were being shared at times meaning there was a potential risk of cross infection. A staff member told us, "We could do with more of the smaller slings. Most are medium or large." This meant there was a potential risk of people being supported to mobilise with equipment which was not suitable for their individual needs.

Personal emergency evacuation plan (PEEP's) were not accurate. For example two people were no longer at the service and another person had moved rooms. This information had not been updated on the PEEP's. When we informed the manager of this they told us it would be addressed immediately.

Before the inspection we had been told staff had raised concerns regarding the safety of the environment due to the presence of trailing wires and extension leads in the building. A staff member told us it was difficult at times to move hoists due to wires and other necessary equipment being under the beds. This had been raised at a recent meeting. No action had yet been taken to address these concerns. However, the manager confirmed they were aware of these issues.

There did not appear to be an effective system for the collection of used laundry. We observed soiled clothing and bedding lying on the floor of peoples bedrooms prior to being collected in the laundry bags. Disposable bed pans were in use and were placed in appropriate machine for disposal after use. However, the commode pans that the disposables were placed in had not been adequately cleaned and there was no designated facility for washing them. A staff member said, "We rinse them out in the bathroom". There was no recording system in place documenting cleaning schedules. This meant the maintenance of standards of hygiene was inadequate.

Cleaning materials were not always stored securely when not in use. We found cleaning materials stored along with full disposable clinical items in an area which was easily accessible to people that used the service. People living with dementia were seen moving around independently in this area and could access these items.

In one bathroom we found the glass shower doors were broken and detached from the shower unit and were propped against the wall posing a potential hazard to people. The door to this bathroom was open and fully accessible to people.

At previous inspections we found the water temperatures of water running from hot taps was not being regulated safely. At this inspection we again found water temperatures to be inconsistent. One hot tap in a bath had a temperature reaching 45 degrees centigrade. This meant people were at risk from unregulated hot water temperatures.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered provider had previously been in breach of Regulation 15 from an inspection in April 2015 regarding poor maintenance of equipment. This demonstrated the provider's inadequate response in meeting the requirements of legislation.

The manager identified staffing levels using a dependency tool to calculate the numbers of staff required for each shift based upon the dependency levels of people using the service. There was a skills mix on all shifts meaning a nurse was on duty as well as experienced and less experienced care staff. The manager was able to request bank staff were necessary although it was the registered provider who arranged this. The service used a regular nursing agency to cover gaps in nursing availability. Rotas showed this was mainly to cover night shifts. The previous week an agency nurse had worked on three of the seven nights. It was the same nurse on each occasion which meant people were supported by staff who were familiar with their needs.

Staff told us that generally there were enough staff to care and support people but that it could be difficult if they were short staffed. On the day of the inspection there were two staff absent. Comments included, "If someone is unwell we haven't enough staff." A staff member told us they felt, "hot and bothered" during times of staff shortage. Although the staff team were low in numbers on the day of the inspection call bells were responded to quickly and a medical emergency was responded to immediately. Throughout the day staff were available in numbers to meet people's needs. Where people required two staff to support them this was met. Staff members were observed talking with people at various times of the day. Two staff members did tell us it was a busy day because, "We are two staff down today. It's not always like this" and "We have been busy today but still try to stop and talk." However, we found it was difficult to talk with staff at various times of the day as they were busy. People told us, "No, there are not enough staff today. One did not turn up and one had to take someone to hospital." It is important that where staff shortages take place that these gaps are filled so that there are always appropriate numbers of staff on duty.

The environment was generally clean and hand washing facilities were available throughout the building, there were no unpleasant odours. Personal protective equipment (PPE) such as aprons and gloves were available for staff however they were not always used appropriately. Staff were seen throughout the inspection visit, carrying out personal care for people without using aprons. Aprons were stored in a linen cupboard and staff assured us that they had sufficient supplies.

Some people using the service had limited verbal communication. In these instances relatives and friends were spoken with. People told us they felt they or their relatives were safe when being supported with their

care.

Accidents and incidents that took place in the service were recorded by staff in people's records. Such events were audited by the registered manager. This meant that any patterns or trends would be recognised, addressed and the risk of re-occurrence was reduced.

The service held personal money for people who lived at the service. People were able to easily access this money to use for hairdressing, toiletries and any items they wanted to buy. The money managed by the manager.

There were systems in place to manage health and safety in the service. However, the most recent fire service report had identified a number of areas of noncompliance with fire regulation. We were told that work had not yet been completed on meeting the requirements of this report. Fire alarms and equipment were checked by staff and external contractors. Service certificates were in place to evidence equipment and supply services including electricity and gas had been serviced as required.

Staff knew the action to take within the service, if they had any concerns or suspected abuse was taking place. They were aware of the whistleblowing and safeguarding policies and procedures.

Requires Improvement

Is the service effective?

Our findings

We had received concerns about the quality of the food being served. The information received stated food orders were not being supplied by the provider as requested and there were occasions when staff had to go to the shops to buy more. The cook told us there had been times when some items were not delivered but that, "It's generally OK." Regular food orders were being delivered at various times during the week. This included fresh and dried foods. Kitchen staff told us there had been a recent change in menu where pictures of meals were made available to help people to make informed choices. However some pictures were not yet ready so the availability was currently limited. The staff member told us, "More are coming on board." The cook visited each person during the morning to identify their choice of lunch.

There were various comments about the quality of the food being served. They included, "The food leaves a lot to be desired, it's not the cook's fault, the raw materials are not good, the meat is gristle and fat," "I have tasted better lasagne" and "If you like roasts and casseroles and things like that you would be in your element." However, other people spoken with during lunch time stated they were enjoying their meal. One of the inspectors sampled a lunch option and found it to be unappetizing and bland. Another option looked unappealing. We noted that one person was not served vegetables as they had run out. This demonstrated people's choices and preferences were not consistently met.

It is recommended that the quality of the food delivered to people using the service is improved.

People were supported by staff where necessary to eat their meals. The general routine was that when people finished their meals in the dining room the staff were available to support people in their rooms.

Some of the areas of the building were in need of redecoration and maintenance. A weekly maintenance report was submitted to Morleigh group head office by the manager. Requests were prioritised according to the seriousness of the defect. For example a number of leaks from the roof had been addressed and some repairs and redecoration had not been completed. However, a toilet seat in need of replacement had been added to the list for a three week period without being addressed. There were areas of the building which were in need of decoration following water damage. This work had been outstanding since out last inspection in January 2016. Some woodwork was damaged due to the use of hoists and wheelchairs. Also where fire protection work had been carried out, these areas needed painting and redecorating. Some people's bedrooms had very marked surfaces on the dressing tables and bedside tables, where items previously placed on them had left large discoloured marks. Carpets in some bedrooms and communal areas were marked and in need of cleaning.

There were no maintenance schedules available to inspect at the service as they was kept at head office. When work had been carried out it was signed for on a copy of the original certificate. They were kept in a loose leaf folder and were not in any date order meaning it was difficult to find information.

We had received information that the service's dishwasher had broken down on 29 September 2016. This had not been included in the maintenance report. The cook confirmed it had broken down and a new part

was subsequently ordered. They told us it was out of action for a period of a week. Staff said they had hand washed dishes during this period.

We had received information that some equipment was not in working order, affecting the way staff could safely support people. One piece of moving and handling equipment had been broken. This had been repaired and all other equipment had recently been serviced. Staff were observed using this equipment safely. There were two hoists and two stand aids available. Staff told us another hoist and stand aid would help them as the service was split into three distinct areas. Staff had to transfer equipment between the areas and they told us this could take some time. A staff member said, "It would help us a lot of we had more equipment. We have to move them (moving and handling equipment) around all the time. It takes up a lot of time when we could be doing other things." This showed that there was not enough equipment in relation to the layout of the building to meet people's needs effectively.

This contributed to the breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities 2014).

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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. Authorisations had been applied for and one had been granted. The service was adhering to the conditions attached to the authorisation. The service had a system in place to monitor the expiry dates of any authorisations and were aware of their responsibilities to seek re assessments from the local authority.

Bathrooms and toilets were marked with pictures and bedroom doors had name plates with people's name on. This supported the needs of people who were living with dementia, and needed prompts to help them to recognise their surroundings independently. People were able to decorate their rooms to their taste, and were encouraged to bring in their personal possessions to give their rooms a familiar feel.

Two visitors told us they thought their relatives were being cared for by staff who new them well and had the skills to support them. Comments included, "They (staff) know what they are doing. I've seen them helping people. Lifting them with that equipment. Very smooth," "I've seen new staff being shown how to do things with older staff" and "Feel very confident with the staff."

Staff had access to training in order for them to develop skills. Staff files included certificates for training which had been completed. However, in some instances several certificates were dated as having been completed on the same day. When we spoke with the provider about this they told us many staff carried out e-learning training, a computer based way of learning. This type of training is remote and there was no evidence to identify how well staff had understood the training. There had been some spot checks by senior staff to look at staff practice but these observations were not taking place regularly. This demonstrated systems to assess staff competence were not robust or effectively implemented.

The service had a system of induction but it was not in line with a nationally recognised induction training

programme. This is designed to provide staff new to care sector with the necessary skills and knowledge to carry out their role safely. We discussed this with the manager who told us the organisation had chosen the option to enrol staff onto a diploma level programme. Staff were supported through the programme by assessors. An assessor visited on the day of our inspection.

It is recommended that the service carry out checks to identify if staff are competent following training received.

Care plans contained risk assessments for a range of circumstances including moving and handling, nutritional needs and falls. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately in order to minimise risk and keep people safe whilst maintaining as much independence as possible. For example, what specific equipment and how many staff were needed to move someone safely. One person was experiencing discomfort when being moved and their care plan clearly stated that they should be provided with pain relief before being moved. Staff told us they followed this guidance.

Some people were at risk of losing weight due to a poor appetite or being unable to eat independently. People were weighed regularly according to the guidance in their care plans. These weight records were audited regularly to ensure that any loss of weight was identified and action was taken to address the concern.

Revalidation is the process where registered nurses and midwives are required every three years to demonstrate to the Nursing and Midwifery Council (NMC) they remain fit to practice. One nurse had been supported by the manager to successfully revalidate at the service.

Requires Improvement

Is the service caring?

Our findings

One person told us, "They (staff) mostly have the time to see to me, but sometimes I have to wait." Another said, "You could not get better staff." We noted the person's spectacles were dirty and they were wearing short socks that were too tight around their swollen ankles. We also noted that staff did not always ensure people's personal appearance was given attention after meals. For example, we saw food around people's mouth and on their clothes. Staff did not seem to notice this or support people to address this.

Prior to this inspection we received information of concern stating people's choices in relation to their care needs were not always respected. We heard one person calling out in distress indicating they wanted their feet to be raised. A senior nurse approached the person and explained that their feet had only been down for six minutes and they needed to wait another twenty four minutes before they could be raised again. When the person continued to call out the staff member said, "Don't call out again my lovely." This was observed to be in a raised and overbearing tone of voice. The person continued to call out. When the staff member returned they knelt by the person and spoke quietly, but again harshly. We heard them say, "You wait until the girls finish with the feeds." This referred to people who needed support with eating as 'the feeds' and this was a disrespectful term. When the person asked to go to bed it was not responded to. The manager then observed the situation and with the same nurse adjusted the position of the person's legs to improve their comfort. The manager then asked another member of staff to assist the person to bed. This staff member then approached the person and said, "As soon as another pair of hands becomes available we will get you onto the bed for some rest." The person was then supported to their room. However the process had taken twenty minutes during which time the person had become quite distressed and they had been spoken with in a very disrespectful and overbearing manner.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were prescribed continence aids which met their individual needs. We found packs of pads throughout the service which were not named for the individual and were being shared communally. This meant they might not get the aid specifically prescribed for their size which could result in them not being properly protected. Net pants used to secure continence pads were shared communally and not named for each person. This did not respect people's dignity.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered provider had previously been in breach of regulation 9 following an inspection in April 2015. This was for regarding not meeting people's needs and preferences. This demonstrated the provider's inadequate response in meeting the requirements of legislation.

Some staff were aware of the need to protect people's privacy. They were observed knocking on people's doors before entering. When people were being supported to move around the building, staff were seen to assist people with the minimum of fuss and reassuring them. People responded positively to this support. People's bedroom doors were seen closed when care was being delivered. Generally staff were seen to

assist people in a reassuring manner.

People told us they were generally satisfied with the level of care they or their relative received living at St Theresa's. Relative's comments included, "The staff are OK," "My relative pulls their legs a bit and has a laugh with them" and "Care staff do a good job to the best of their ability." A visiting healthcare professional told us, "I feel very positive about it and people seem genuinely caring."

During the day of our inspection visit most staff were observed to be supporting people sensitively. Staff told us, "We know that when (person's name) gets agitated, it is for certain reasons and we know this" and "If (person's name) is shouting we know it's because they need the bathroom or their knee is hurting."

There were examples of good practice seen during the inspection visit. This included, staff supporting people to mobilise with the use of mobility aids. Where people were at risk of falling, staff were able to respond in a sensitive and caring way to support them. For example when walking with an aid a person became visibly tired. A staff member saw this and responded by supporting them to their chair. Where people needed support to eat their meal staff made the time to sit with them so they were not rushed. Where people needed specialist equipment to help them eat independently, this was provided.

Care staff demonstrated a basic understanding of dementia care needs. They told us there was a nurse working at the service that was able to provide them with guidance and information regarding supporting people when their health conditions led them to behave in ways which could be difficult for staff to manage.

Requires Improvement

Is the service responsive?

Our findings

Staff were required to complete daily records of the care provided to each person. However, there were some gaps where no record of care was recorded by care staff. This meant it was not possible to establish the person had consistently received the care they required.

Some people needed to have wound care dressings applied. The care plans did not provide clear information on what specific dressing was to be used and when the dressing should be changed. We were told the white board in the nurse's room contained the only information for all nurses to follow. The information on the board during the morning of the inspection visit was not correct. It did not provide an accurate reflection of the current needs of some people. For example, one person's dressing was recorded on the board as needing to be changed every three days. We were told this was in fact required to be changed daily. Another person was having a specific dressing applied which was different to that recorded in their care plan. We checked the care plans for four people who required dressings to their skin. Most were not having their dressing changed according to the direction in the care plan.

The handover records showed one person had a pressure sore. This person's care plan stated they should be re-positioned every two hours as they were unable to move themselves in order to protect them from further damage to their skin. The records in this person's room had gaps in them. For example, there were no records at all for 24 October and 29 October to indicate this person had been moved as directed in the care plan. On other days there were periods of up to eight hours when the person was not re-positioned. The care plan stated this person had, "Vulnerable areas of scar tissue from previous skin damage." The wound care plan for this person was last reviewed in August 2016 and stated, "Improvement noted, to continue." The nurse's notes on 20 October 2016 stated, "Deterioration noted," the next entry was on the 26 October 2016, "Need tissue viability referral." On the 28 October 2016 the dressing was re-applied but no comment made about the condition of the wound. The next entry was 31 October 2016, "Deteriorated, tissue viability review needed." An email was then sent to the tissue viability service seeking advice. There was a delay of five days in seeking appropriate specialist advice which meant the risk of further skin damage was not managed effectively. Sufficient action had not been taken to protect the person from an identified risk.

This contributed to the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

The care plans were regularly reviewed but were not always updated to help ensure they were accurate and up to date. There was limited evidence of the person, or where appropriate their families, being given the opportunity to sign in agreement with the contents of their own care plan.
The files contained information sections to record a range of aspects of people's support needs including mobility, communication, nutrition and hydration and health.

There were examples where the registered manager and nursing staff had responded appropriately to changes in people's needs. For example, when a person's health had suddenly deteriorated, staff responded by seeking urgent medical advice and support. This resulted in the person receiving emergency treatment

followed by a hospital admission. The incident showed staff had worked in a coordinated and responsive way in the best interest of the person.

The service had a designated activities co-ordinator who worked two hours a day Monday to Friday. On the day of the inspection they were supporting people to join in with some craft activities and a short bouncing ball game. During the afternoon session one person was making woollen balls and told us he enjoyed the activity. The activity coordinator was assisting another person to cut out pictures of flowers from a magazine. The activities took place in the lounge area. There were board games available to use. People had activity diaries in their care plans. They showed what activities they took part in and when they refused. Records showed people confined to bed were not provided with one to one activities as directed in their care plan. According to the notes of the previous days only five people had been engaged in activities. The range of available activities was limited and did not appear meaningful or arranged, specifically for people who had memory issues or dementia conditions. Most people were sitting in the lounge areas sleeping throughout the day.

People we spoke with were generally not satisfied with the level of activities available to them. When we asked a person if they had time to speak with us. They said, "No problem I've got nothing else to do." Other comments about the range of activities included, "The activities coordinator has a heck of a job, only a couple of hours each day. How can they organise it" and "There is nothing that really interests me, they have a musician who comes in each month but the repertoire is the same each month." A relative told us, "I think activities have gone off the boil a bit."

This contributed to the breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People were supported to maintain relationships with their family. Visitors were always made welcome and were able to visit at any time. Staff were seen greeting visitors throughout the inspection and chatting knowledgeably with them about their family member.

People who wished to move into the service had their needs assessed to help ensure the service was able to meet their needs and expectations. The manager was knowledgeable about people's needs. A nurse told us that they did not admit people with behavioural problems associated with dementia as, "It would not be fair on our existing residents and may put them at risk". At the time of the inspection there were no reports or evidence of people living at the service whose behaviour may be challenging to others.

The service had a complaints procedure which was available in the services written literature. A copy of the procedure was also available on the notice board at the entrance of the service. However, an updated procedure had the accurate contact details of the local authority but the Service user guide contained a previous address and therefore was inaccurate. The manager told us no complaints had been made to them since they became manager of the service.

Inadequate

Is the service well-led?

Our findings

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at St Theresa's Nursing Home and the service has been rated as either Inadequate or Requires Improvement since the first rated inspection carried out in February 2015. The service has also not met the requirements of enforcement action which they are required to do by law. The Care Quality Commission has carried out six inspections (including this one) of the service since February 2015. At each inspection there have been breaches of the regulations. Given the history of the provider we do not have confidence in their ability or willingness to take the necessary actions to meet the requirements of the regulations.

St Theresa's has been without a registered manager since March 2014. Since that time five managers have been appointed. Two of those managers left after a short employment period at St Theresa's. One was moved to manage another service in the group and then left. One was moved from another service in the group to manage St Theresa's on a part time basis and then the current manager commenced in October 2016.This has meant there has been no management stability. The current manager told us they had submitted an application to the commission for registration. However, this could not be verified at the time of the inspection visit and was found not to be the case following the inspection.

These frequent changes in the management of the service have meant that the leadership of the service has been inconsistent. This also shows that the provider had repeatedly failed to retain managers long enough for them to become a registered manager. The provider has failed to recognise the risk to the quality of the service provided to people of not having consistent management.

The provider had failed to improve their centralised recruitment practices despite being required to do so at two of the organisation's other care homes. During an inspection at this service in January 2016 we found new staff were working before Disclosure and Barring Service (DBS) checks had been completed. As a result of these findings we met with the provider in April 2016 to discuss what action they intended to take to improve the recruitment procedures across all six of their care homes, including this one. Notes from that meeting recorded that the provider told us, "New systems have been put in place and explained to all managers. New staff will not be offered the job until the first part of the DBS check has come through and will not work unsupervised until the full DBS is completed."

The Morleigh Group carried out annual surveys to gather the views of people living in each service and their families. When surveys were returned these were collected and collated centrally at the provider's head office. The manager told us surveys were given to people and their families to complete in September 2016. However, they were not aware of the results of these as this information had not been passed to the service. This meant the opportunity to make improvements to the quality of the service provided, as a result of feedback, had been missed.

Confidential personal information relating to the care of named people at the service and staff records were found in a main corridor, easily accessible by anyone using the corridor. This demonstrated people's

personal information was not being adequately protected.

Audits were carried out in a number of areas including mattress pressures, care plans, infection control, medicines etc., However, some of these audits were not effective. For example, the medicines audit had not identified some areas of concern found at this inspection. The pressure mattress audit carried out in August 2016 checked that the mattress setting responded to the weight of the person using the mattress. However, the latest audit carried out did not check these mattresses against the weights of people using them, only that they were working correctly. We found one person, whose weight was 64.4 kgs using a mattress that was set for a person of less than 30kgs. This meant the person was not protected from the risks associated with pressure damage to their skin.

Records relating to managing the health and care needs for people were not always being updated or completed by staff. For example, records to show people had been repositioned were not consistently completed. Wound care records were not accurate according to the care required in the care plans. This meant care and support was not being monitored effectively.

Some people were having their food and drink intake monitored to check they had sufficient intake. These records were not always completed by staff when people had been provided with meals and drinks. The records were not totalled each 24 hours and not recorded and there was no evidence they had been monitored. One person's care plan stated they were to have 2000mls of fluids every 24 hours. We checked this person's fluid records. They had taken a maximum of 500mls over the past several days. No action had been taken to address this concern.

At the last inspection we found that the manager had not informed the CQC that a DoLS authorisation had been granted, as they were required to do by law. This notification had still not been submitted to CQC.

People had access to healthcare professionals including GP's, opticians and chiropodists. Care records did not always contain records of external healthcare professional visits. This meant it was difficult to establish when people had been visited.

Staff told us they felt supported by the manager. However, the records relating to staff supervision and appraisal were incomplete. We discussed this with the manager who told us some supervision's had been completed but not yet documented. This demonstrated these meetings were not recorded in a timely manner which could affect their reliability and accuracy.

The staff had daily handover meetings to discuss the day's events. These meetings were an opportunity to share information about people's care and information with staff coming on duty. The meetings kept staff informed of any specific issues. For example if a person's health had deteriorated or how their diet had changed. Staff told us these meetings were useful and kept staff up to date with information concerning people. This helped provide the best care for people. However, the records were not always accurate. The copy provided to us had an incorrect date on the front sheet. Information was not always visible because of the way the record had been copied. The handover record was not signed by the nurse completing it. It is important accurate records are kept in order to maintain a clear audit trail of the care people have received and to inform staff that were not present at the handover meeting.

The food standards agency had inspected St Theresa's on the 6 September 2016. The report had underlined where they had found issues remaining which had been highlighted to the service in the previous inspection report. Such as staff not completing the necessary records related to food safety management procedures and food hygiene regulations. The inspection in September 2016 found that these records were still not

being kept appropriately and also cleaning of the kitchen was not robust. This meant that the service had not taken any action to address the concerns found following the food standards agency report.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014

The registered provider had previously been in breach of regulation 17 following an inspection in September 2015. This was regarding inadequate management and poor monitoring of quality and safety. This breach had previously been identified from an inspection in April 2015. This was for having poor systems for record keeping and auditing and an enforcement warning notice was issued. This demonstrated the provider's inadequate response in meeting the requirements of legislation.

Management and staff meetings were held on a regular basis to discuss operational issues and changes. For example the minutes for the most recent meeting introduced staff to the services new menu. Staff had been encouraged to offer people warmer breakfasts including poached eggs on toast which was seen during the inspection. The minutes for the most recent staff meeting included reminders for staff regarding the importance of weighing and recording weights for people. There was also a reminder for staff to record when creams had been applied. However as seen in the Safe section of this report this was still not occurring.

The manager sought people's views in a variety of ways. Staff had frequent informal chats with people about their views of the service. Families told us they felt their relatives needs and wishes were listened to and acted on and they were well supported. The registered manager told us they had an 'open door' policy and they were available to speak with relatives whenever they wanted or needed to. This was confirmed when we spoke with relatives.

The manager knew people well and understood aspects of the service including clinical practice, staff roles and responsibilities. We discussed the care of people who lived at the service with the manager and a senior staff member.