Sisters Hospitallers of the Sacred Heart of Jesus CIO

St Augustine's Care Home

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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

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

About the service
St Augustine's Care Home is a residential care home providing accommodation and personal care to up to 52 people. The service provides support to people living with physical and mental health related care needs, older people and people living with dementia. At the time of our inspection there were 42 people using the service. The home is divided into four units, A, B, C and D. Unit B specialises in providing care to people living with dementia. The service places a strong emphasis on the teachings of the Catholic Church with support also being provided by the religious sisters who live in the adjoining convent. People have access to the on-site chapel.

People's experience of using this service and what we found
People's records were not always consistent, up to date and detailed enough to ensure staff had clear guidance on all of the individual needs and risks. People received safe care as staff knew them well and the management ensured there were robust handovers and summary records available. The provider did not always effectively manage infection outbreaks and infection prevention and control in the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, appropriate applications for deprivation of liberty when people required constant supervision and could not leave the home on their own were not always in place. People's consent for care was not always appropriately recorded.

The provider did not always have fully embedded and effective governance systems in place. Some improvements had been achieved in recent months, for example, around staff training, recruitment and management of medicines. However, other identified shortfalls had not been successfully addressed yet and there was limited assurance around how the management team maintained an effective oversight of the quality and safety of people's care.

There were enough staff to support people safely and new staff had to undergo a range of checks to ensure their suitability. People and their relatives told us they felt the home was safe. Staff knew how to raise concerns and felt able to speak up when needed. People received safe support with medicines and eating and drinking.

Staff supported people in person-centred way. People were encouraged to do what they liked. Staff knew their individual preferences, wishes and lifestyle choices and provided care in a respectful and caring way.

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

Rating at last inspection
This service was registered with us on 02 February 2023 and this is the first inspection.
The last rating for the service under the previous provider was requires improvement, published on 03 February 2023.

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about infection prevention and control. A decision was made for us to inspect and examine those risks.

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

We inspected and found there was a concern with the provider's response to an outbreak of an infection in the home, so we widened the scope of the inspection to become a comprehensive inspection which included all 5 key questions.

Enforcement and Recommendations
We have identified breaches in relation to infection prevention and control and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

St Augustine's Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
St Augustine's Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Augustine's Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

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

Notice of inspection
This inspection was unannounced. We visited the home unannounced on 12, 30 May and 7 June 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people and 7 relatives about their experience of the care provided. We spoke with 10 members of staff including the registered manager, deputy manager, head of care, senior care staff, care and ancillary staff. We reviewed a range of records. This included 9 people's care plans and multiple medicines records for people. We looked at recruitment checks for 3 staff members. A variety of records relating to the management of the service, including training, staff rosters, audits, meeting records and an action plan were also reviewed.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. On the first day of the inspection the home was in an outbreak of an infection. Staff rosters we viewed showed 10 out of 13 infected staff returned to work sooner than stated in the national guidance. The provider did not carry out formal observations of staff adherence to proper hand washing techniques to be assured that that they understood how to do this. There were no infection prevention and control (IPC) audits done to maintain oversight of the IPC practices in the outbreak. This put people and staff at risk of avoidable spread of the infection.
- We were somewhat assured that the provider was responding effectively to risks and signs of infection. Although the provider took appropriate action in individual infection cases, the registered manager reported the outbreak to the local public health protection team with a delay. This put people and staff at risk of infection spreading as there was no robust whole-home outbreak management plan implemented in a timely manner. However, there was a high level of engagement with the local health protection team, as well as an integrated infection prevention and control team since the onset of the outbreak.
- We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Whilst the first case of infection occurred on 27 April 2023, the registered manager first placed a notice on the entrance door to the home on 02 May 2023, advising visitors of the current outbreak, and that visitors should refrain from entering at the time unless in emergency. A subsequent email with the same information was sent to all family contacts on 08 May 2023. This put visitors at risk of infection. However, we saw visitors to the home went straight to people's bedrooms and donned personal protective equipment for the duration of their visit.
- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. We were told there was no increased cleaning rota initiated in response to the outbreak of infection. One member of staff told us, "There was no increased cleaning during the outbreak, we just don't have the staff." However, we observed that the home was clean and domestic staff were cleaning floors, surfaces and frequently touched points throughout the day. The laundry area was well organised, kept clear of clutter and potentially infected linen was washed separately in red soluble plastic bags at a high temperature.
- We were somewhat assured that the provider was using personal protective equipment (PPE) effectively and safely. On the first day of inspection,10 out of 12 people affected by the infection did not have any clinical waste bins in their rooms. This meant staff had to walk a distance in order to change their PPE, thus increasing the risk of cross-infection. However, by the end of the inspection, clinical waste bins were placed in each infected person's room. We observed staff wore their PPE appropriately and there was a plentiful supply at various stations around the premises.

The provider had failed to effectively assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider identified lessons learnt following the outbreak to minimise risks to people in the future. All staff had received infection prevention and control training and handwashing competency checks since the onset of the outbreak.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

Visitors were able to see their loved ones without any undue restrictions. One relative told us, "There are no restrictions with visiting, its easy access you can come and go as you like." Relatives we spoke with were made aware of the recent outbreak and were required to take precautions during visits.

Assessing risk, safety monitoring and management
● People received safe support as staff knew their individual risks. One relative told us, "Yes, I feel [person] is safe because the permanent staff know her very well. They know the signs if she's got [an infection]. They showered her the other day and read her that she wasn't herself. They pick it up quickly if there is something wrong, those who have been there a long time. [Person] had a couple of falls a while ago and they put a sensor mat down straight away."
● People told us they felt safe when staff supported them. One person said, "Staf always look after me well." We saw people were supported safely during the inspection, for example, when moving and transferring. People had required care equipment in place when needed, including appropriately set pressure relieving mattresses or sensor mats.
● Staff knew how to recognise if risks to people had changed and what to do. One staff member said, "If I noticed a deterioration, I would go to senior (carer)." The registered manager implemented a care needs summary to monitor people's changing needs. The management team also received handover information on a daily basis which enabled them to monitor people's risks and to ensure appropriate action was taken to support them safely.
●However, not all risk assessments records were fully up to date or included in people's care plans. The management team were in the process of updating people's care records. We addressed this in the well-led key question in this report.

Systems and processes to safeguard people from the risk of abuse
● People were protected from abuse and neglect. People and their relatives told us they felt the home was safe. One person said, "I feel safe here because of the way staff treat me. I know that staff come when I ring my call bell." Relatives told us, "[Person] is definitely safe because the security is good. She feels safe and secure there."; "I know [person] is in safe hands if I can't get there."
● Staff knew how to recognise and report concerns and felt confident to do so. One member of staff said, "I would go straight to the registered manager or head of care. If not acted upon, I would report to area manager; local authority and CQC. If I knew something was going on I would not hesitate (to report it)." Staff received appropriate training in safeguarding.
● The registered manager knew their responsibilities to report and investigate any safeguarding concerns and had done so. Action was taken to protect people where required.

Staffing and recruitment

● There were enough staff on duty to ensure people received safe and timely care. People told us they could call staff who would attend to them when needed. One relative said, "Yes, [person] is safe because there are always lots of staff around." Another relative commented, "There are lots of staff and I know that they would come if she was in need."

● The provider undertook robust recruitment to fill any vacancies and had recently employed multiple new staff. They also reviewed staffing levels and increased them in the week before the inspection to meet the needs of all people living in the home. We saw staff were available around the home, spent time with people and answered calls for support timely on all three days of the inspection.

● Staff rosters clearly showed how staffing was planned and where temporary staff were needed to fill in any gaps in the team. However, some relatives and staff told us there had been times when staffing was challenging, and this affected how much attention people got and how staff were able to ensure people could always access support. We addressed this in the well-led key question in this report.

● Staff were recruited safely. The provider completed robust pre-employment checks, including an interview, review of the candidate's employment history, right to work, professional references and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● People received safe support with their medicines. People told us they were supported with their medicines when they needed them. People's relatives confirmed this saying, "As far as I know she gets her pills morning and evening like she is supposed to."; "[Staff] has explained what all the medications are for, there are no problems there."

● Staff who supported people with their medicines were knowledgeable, trained and their competencies were checked. Staff completed medicines administration records (MAR) as well as regular stock checks. The management team had good oversight of the management of medicines in the home.

● Staff knew how to support people safely when they needed time critical, 'when required' or topical medicines. High risk medicines were annotated as such in people's MAR and staff were aware of any side effects people may experience and what to do. There was clear guidance for staff when people required any specific support around their medicines.

Learning lessons when things go wrong

● Some opportunities to learn lessons from adverse events in the home could be missed. This was because the systems in place to analyse those events and identify any trends and patterns were not fully established and embedded. We addressed this in the well-led key question in this report.

● The registered manager identified some lessons learnt from incidents, accidents and events in the service. These were shared with staff during handovers and daily meetings. For example, action was taken following an incident to ensure the building was secure or to change people's support to protect them from avoidable harm.

Requires Improvement

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- Staff worked within the principles of the MCA and completed relevant training. People and their relatives told us staff sought consent for care and enabled them to make their own choices. One relative said, "I can see that staff offer choices."
- Staff told us how they ensured people's rights were protected. One staff member said, "I would always wait for permission to enter people's room. I always explain what I am about to do and ask 'would you like…?'. Normally I assist them and ask them to choose."
- Staff supported people in line with the MCA, but people's records around consent and MCA were not always consistent. People's care plans included some information around their capacity and consent. However, where people might have lacked capacity to make specific decisions, this was not always consistently and clearly recorded.
- Where people had legal representatives, there was evidence kept within people's care documentation for some but not for all. However, the management knew who needed to be included in decision making when people might have lacked capacity and had done so.
- There were gaps in records on how people's consent was obtained and further work was required to ensure all DoLS applications were re-applied for when needed. The registered manager was aware of that and started updating the records as part of the care records review for all people supported. Those shortfalls did not impact on people, as staff knew how to protect their rights and supported them in the least restrictive ways. We also addressed this in the well-led key question in this report.

Adapting service, design, decoration to meet people's needs

● The home had some adaptations which enabled people with a physical disability to use all facilities. For example, there was a lift, access to the garden, adapted bathrooms. People's rooms were personalised.

● People's relatives told us the home was suitable for their loved one's needs. One relative said, "The home has got a bit of character compared to a modern home. It's like home from home rather than a medical facility."

● We were told and observed people could orientate themselves, but the environment could be made more dementia friendly and supportive for people with sensory impairments which were the needs of some of the people living in the home.

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

● The management team assessed people's needs, involving them, their representatives and any other relevant health and social care professionals before people moved in. We received very positive feedback from people who had recently moved in, their relatives and social workers. One relative told us, "We had two meetings when mum moved into the home to discuss things."

● A social care professional told us, "(The day person moved in) did not feel rushed or pressured and each client (person) was made to feel welcome, and carers ensured clients were supported to settle in their new home. Carers spoke with [social workers] to ensure they knew our clients' individual needs and how best to support them. Family members were encouraged to get to know the layout of St Augustine's and carers ensured they were aware of activities, and they were invited to partake if they wished to."

● The management team completed extensive pre-admission assessments which included information around people's health and physical needs and risks but also preferences, wishes and social needs. This also included information around their interests, relationships important to them or religion and culture.

Staff support: induction, training, skills and experience

● Staff were competent for their roles and received appropriate training and support. People and relatives saw staff as overall competent for their roles. One relative told us, "From what I've seen, [staff] seem well trained."

● Staff completed a range of face to face and online training courses. This included practical courses in safe moving and handling, first aid and fire safety. Other training was also provided, for example around end of life care, nutrition and hydration, dementia, learning disabilities or person-centred care. Some senior staff recently completed 'train the trainer' courses to be able to support other staff with good practice.

● New staff were supported with induction training in line with the Care Certificate which is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. They received in house induction, orientation and were competency assessed by more senior staff.

● Staff told us they felt supported by the management and had opportunities to discuss their roles, professional development and any individual support needs during their supervisions.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to have regular nutritious meals, snacks and drinks throughout the day and offered choices. People told us they liked the food. One person said, "The meals are very nice and you also get drinks whenever you like."

● Staff supported people to have regular drinks and to eat their meals where they needed physical assistance. Staff knew people's intolerances, allergies and likes and dislikes. Staff were also aware when some people required encouragement due to risk of malnutrition or different texture of food to enable them to have their meals safely.

● People's dietary requirements were addressed in their care plans. The recent food survey showed people were overall happy with the food choices on offer.

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

● People received support to access healthcare services when needed. Staff were aware of what to do in emergencies and supported people to attend regular healthcare appointments and to contact their GP when needed. One relative told us, "[Person's] hearing was deteriorating, and the home arranged a visit to the doctors. The optician and chiropodist visit the home regularly and a hairdresser weekly."

● Staff escalated any changes or concerns to healthcare professionals when needed. One staff member told us, "If I have any problems on this floor, I will ask for the GP to see [person]. There is not a problem to get people seen by the GP."

● People's care records included referrals made to their GP and specialist services, such as speech and language therapy, occupational therapy and physiotherapy, continence specialist services, mental health community services.

Good

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

● People were treated with kindness, compassion and respect. People told us why they felt so, "Staff knock on my door and really respect me as a person, as someone who is glad to be here and they tell me they are glad I am here and that I am important."; "Staff treat me so well."
● People's relatives told us staff were caring. Comments from relatives included, "The staff are very kind, caring and helpful. They are really friendly and the way they talk to other people too, they are very courteous, kind and caring."; "We feel there is a lot of affection and [person] likes a lot of the staff and feels well cared for. She has a good relationship with a lot of them. She likes to tease them and have a joke and it makes her feel like they know her."
● Staff treated people with respect. We saw positive and respectful interactions between staff and people during the inspection, for example, when one staff supported a person to eat with great patience and understanding of their needs. A relative told us, "They call [person] by her full name, they don't rush her. If I'm there talking with one of the staff, [person] is included."
● People's privacy and dignity were maintained. Relatives told us how staff achieved that, "They are respectful, they walk at a slow pace with her when she's walking."; "They are definitely respectful, the way in which they speak to her. They don't patronise her; they treat her like an equal rather than a forgetful old lady. When the staff interact with her, it is with kindness and respect. They've never said anything that would worry me."; "They keep him private. If he needs changing, they do it and I leave the room."
● People were encouraged to do things for themselves. People's care plans included information on what they could do for themselves. People's relatives told us, "[Staff] try to encourage her to walk on her own. They encourage her to do her hair."; "[Staff] encourage [person] to get dressed, feed herself and they help brush her hair."
● Staff understood how to support people to be as independent as they could. One staff member told us, "When it comes to personal care, dressing, we don't want people to lose their ability, so it is important to encourage as much as possible, likewise when eating."

Supporting people to express their views and be involved in making decisions about their care
● People and their relatives were overall involved in their care plans although further work was needed to enable people to express their wishes as part of the ongoing care records review in the home as not all people felt they had been consulted recently.
● People's representatives told us they were consulted around their loved one's care. One relative said, "I was involved with the care planning when mum moved in and there is always someone available to discuss

her care." Another relative said, "I was involved with the care planning on admission, but they will inform me on the phone if there is any change such as a [an infection]."

Good

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

● People received person-centred care. One person said, "It has been a very good result to come here. I know that I will get confident to speak about things I want." A relative told us, "They call mum by her name and they know her likes and dislikes."

● Staff knew people well and had access to care plans which included some information on people life stories, preferences, wishes and things important to them. Further work to gather information around people as individuals was being completed as part of care records review in the home. One staff told us, "I follow the care plans and risk assessments and ask [the person] what their preferences/likes/dislikes are. Everyone is their own person, so it is important to go by what they need or what they tell you they need. I always come back to the principle that it is people's right to choose. I don't expect people with dementia to be treated any differently in terms of person-centred care."

● People's advanced care wishes were included in their care plans and where people were receiving end of life care, there were detailed plans in place around their needs and wishes. Some improvements were still being made to ensure all relevant information was clearly recorded in people's care plans. Staff worked with other healthcare professionals and people's families to ensure people were comfortable and respected. Staff received training in end of life care.

Meeting people's communication needs

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

● Staff knew how to communicate with people and the management were aware of their responsibilities around AIS. People had individual communication assessments and care plans.

● We saw staff communicated effectively with people, including those who needed additional support to be able to understand the information provided. People who required aids such as glasses or hearing aids, were supported to wear and look after them.

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

● People were supported to do things they liked, to go out and to maintain and build social relationships. However, some of the people's relatives and staff felt this was hindered at times due to challenges in staffing

levels which we addressed in the well-led key question in this report.

● People could choose to attend home entertainment and celebrations, partake in games and quizzes, religious activities and services and other events organised in the home. We saw people were enjoying spending time together and those who needed help to be able to participate, had a care staff with them.

● One relative said, "[Person] is busy doing things – look, she is playing bingo now. [Staff] recognise that she needs to go off to her room for some quiet time. She likes to spend time in her room and is delighted with her TV." Another relative said, "[Person] enjoyed the school children visiting and things going on in the lounge. We can take our dog into the garden which is nice. She's been to the church on Sunday which she liked."

● Staff were aware of how to protect people from social isolation. One staff member said, "I don't always get time to chat but there are times like today when I have the time to sit and talk. One of [the people] wants to stay in their room today, so I have been able to pop in and out. This makes my job so enjoyable, and I learn something every time from chit chatting to them."

● Many people chose the home due to their religious needs and enjoyed the support of the sisters who volunteered in the home on a daily basis and the fact there were regular religious services held on site. One relative said, "[Person] is a catholic and goes to mass. The nuns (sisters) invite her to rosary. The nuns are fun and caring characters."

Improving care quality in response to complaints or concerns

● People and their relatives told us they felt comfortable raising any concerns. The management of complaints in the service had improved in the recent months but communication with the families was still being improved at the time of the inspection. However, relatives we spoke with told us they would not shy away to place a complaint.

● The provider had a clear complaints policy and the registered manager logged all complaints and action taken to resolve them.The registered manager monitored any trends. Where appropriate, they met with the complainants to discuss any issues and seek solutions.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

- The provider did not assess all the individual people's risks and did not maintain accurate, complete and contemporaneous record in respect of each person's care. The provider was aware people's care records were inconsistent and did not always address people's up to date needs and risks robustly. At the time of the inspection this had not been rectified yet and people's records lacked information around their risks, some of their needs and what care they received.
- For example, one person lived with a respiratory condition but there was no specific plan on how staff supported them around this risk. Another person's needs changed significantly and not all parts of their care plan reflected their current risks, for example around moving and handling, skin integrity or continence. Third person could get distressed and react towards others, but this was not addressed in their care plan. There was limited assurance around how the inconsistencies and shortfalls in people's care records were being monitored and identified. This posed a risk to people as those inconsistencies were still present in the care records the management stated were updated only recently.
- It was not clear from people's care plans and daily monitoring charts why and when staff were to monitor their food and fluid intake or how often they needed support to change position to prevent skin breakdown. The daily care records did not correlate with people's care plans. Although we confirmed people were provided with safe care, their records did not always reflect that. This posed a risk to people of not receiving their care safely and as per their individual needs.
- People's care records did not always include evidence of people's consent, all relevant mental capacity assessments, and best interests' decision records. One person had complex needs and lacked capacity to make multiple decisions about their care but there was only one mental capacity assessment in place which was past it's review date. There was limited progress with review of MCA related records despite a significant lapse of time since this area for improvement had been identified by the provider.
- The governance systems and processes in the service were not always effective. Although some checks and audits were completed, there was a lack of structured systems to identify shortfalls and plan actions to address them timely. There was no written record of the management in house checks and audits of quality of care. There was no structured approach in how the managers monitored staffing levels in the service and call bell response times were not monitored. There was no system in place to include people's and staff's feedback on staffing to ensure staff were deployed effectively. The provider gathered relative's and staff feedback but was in the process of analysing the responses.
- Incidents and accidents were not routinely followed up. The data about trends and patterns in incidents was not yet regularly reviewed by the managers. There was no analysis for one person who had 3 falls within

a short time. Their risk assessment had been noted as reviewed only on one occasion. The lack of structured approach to management oversight posed a risk of not identifying lessons learnt and actions being missed or not addressed in a timely manner. This could negatively influence people's care and overall experience.
● The management team was working on updating all peoples records by the end of June 2023 and aimed to implement a streamlined electronic system to ensure people's care was adequately reflected in their records.

The provider had failed maintain an accurate, complete and contemporaneous record in respect of each service user and to operate effective governance systems. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team made some improvements to the home. They implemented a structured handover approach and updated a care summary of people's needs to mitigate risks to people. They successfully recruited more staff, improved the culture of the staff team and training, and provided staff with effective supervision. Management of medicines was improved since the provider's audit identified some shortfalls.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● There was a positive, friendly and welcoming culture in the home. One person told us, "I like it here." A relative said, "It is cosy and welcoming and joyful. Everybody is really friendly here. We are so welcomed here."
● People and their representatives were engaged in the day to day running of the service. The management team was newly established and still worked on meeting all people's relatives and improving the culture of the staff team. One relative said, "Things have improved recently.
[Management] all seem very nice and approachable. I've popped into [the registered manager's] room, and she's always made time to see me." Another relative said, "It's lacking in management but it's getting better. We receive up to date information by email."
● Staff told us they felt supported and engaged. One staff member told us, "We now have a new general manager and I find her to be so respectful. Her door is always open to us all regarding concerns and [the registered manager] always finds the time to talk to us. Both [the registered manager and head of care] are so approachable and work hard to make our home a better place." Another staff member said, "There is no difficulty to voice opinions or make suggestions."

Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The home worked in partnership with healthcare services in the area, social services and the adjoining convent.
● The management team were aware of their responsibilities under the duty of candour. People's records confirmed if adverse events happened and affected them, staff were open and transparent with people and their representatives.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to effectively assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed maintain an accurate, complete and contemporaneous record in respect of each service user and to operate effective governance systems.