The Orders Of St. John Care Trust

OSJCT The Coombs

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

Summary of findings

Overall summary

This inspection took place on 5 and 6 April 2016 and was unannounced. The Coombs can provide accommodation and care to up to 40 older people, some who live with dementia. At the time of the inspection there were 30 people living there. The service also provides nursing care with nurses on site at all times.

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

During this inspection we found three areas of regulation not fully met. These related to the arrangements for: ensuring people had received their medicines as prescribed, identifying and recording people's nutritional risk and recording what action was taken to address these risks and the maintenance of accurate and relevant care plans. You can see what action we told the provider to take at the back of the full version of the report.

People were at risk of medication errors, for example, not having received their medicines because staff were not accurately maintaining people's medicine administration records. We found several gaps over a short period of time where staff, after successfully administering a person's medicine, should have signed to confirm this was the case. Arrangements were not in place to sufficiently monitor these gaps and to find out the reason for the gap.

People received help to eat their food and drink and they were provided with choice. However, the process of assessing people's levels of nutritional risk and then updating relevant guidance for staff was not always happening and resulting in inaccurate information being recorded. Other risks to people were identified, managed, monitored and recorded, for example, their risk of falls or developing pressure ulcers. Shortfalls in the maintenance of some care plans meant staff and visiting professionals could not always rely on people's care plans to give them accurate and up to date information on people's care needs or care delivery. Some care plans however gave detailed information so this indicated that some staff required additional training in this area. Although this had not had a negative impact on people, it did put people at potential risk of not having their nutritional needs and others needs appropriately identified or met. The management team took some action to address this during the inspection and other action, such as further staff training, was to be organised.

People were protected from abuse because staff knew how to report relevant concerns. Robust recruitment practices protected people from those who may not be suitable to care for them. There were enough staff on duty to support people's needs. This was supported by the regular use of agency staff. These staff usually worked regularly at The Coombs so were well aware of the routine and people's needs. People had access to health care professionals when they needed this. Care and treatment was given with people's consent

and where people were unable to give consent, they were protected under relevant legislation. People's decisions and choices were respected and met.

Staff were well trained and supported to provide personalised care and where needed additional training was provided. People were cared for as individuals and their diverse needs were acknowledged and met. People or their representatives were involved in planning and reviewing care and their preferences, likes, dislikes and goals were well identified. Staff knew the people they were looking after well and this made a difference to them. Staff delivered people's care with extreme kindness and compassion and their dignity and privacy was respected at all times. People received extremely good end of life care from staff who had been specifically trained to deliver this. People were provided with many opportunities to partake in activities which were meaningful to them. Where people wanted to be more independent they were supported to achieve this.

People benefitted from the service having a strong leader who was committed to people's quality of life and well-being. The registered manager was clear in her expectations and the staff worked together to ensure these were met. They were collectively committed to the people they looked after. There were quality monitoring systems in place so the registered manager and provider could assess the service's performance. Actions were taken to address any shortfalls and improvements were made. However, some areas of shortfall identified in this inspection still needed to be effectively addressed.

People and staff contributed to how the service was run. They had opportunities to meet together to be updated and feedback their ideas and suggestions. People had opportunities to raise areas of dissatisfaction. Complaints were listened to, investigated and responded to with a view of resolving the issue. The registered manager was keen that the service learnt from any form of feedback received. Arrangements were in place to ensure staff and practices met with best practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not as safe as it could be. This related to the management of medicines. Arrangements which could confirm that people had received their prescribed medicines were not robust enough to ensure this were the case.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

Risks to people were identified, managed and monitored in order to protect them. This included personal health risks and environmental risks.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

Is the service effective?

Requires Improvement

The service was not as effective as it could be. Although people received support with their eating and drinking, there was potential risk of people's needs in relation to this not being properly identified and assessed.

People received care and treatment from staff who had been trained to provide this. There were arrangements in place to help staff develop their learning and skills further.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

People had access to health care professionals and to attend health related appointments when needed.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind and thoughtful.

People's care was personalised and their preferences and wishes were met wherever possible. People were supported to be independent.

People's dignity and privacy was maintained at all times.

Staff helped people maintain relationships with those they loved or who mattered to them.

At the end of people's lives they and their family received care which was based on best practice and delivered with compassion.

Is the service responsive?

Requires Improvement

The service was not always responsive. Staff knew what care people needed because information about this was verbally handed over and senior staff provided additional support in practice. People's care needs and the care they received however was not always accurately reflected in their care plans/care records. This was despite people and their representatives being involved in a care review process.

People had opportunities to socialise and partake in activities. There were established links with the local and wider community.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Good

The service was well-led. People were generally protected by a quality monitoring system which picked up shortfalls and addressed these.

Arrangements were in place for staff to be supported and for learning to happen. Staff were committed as a team to improve the services provided.

The management team were open to people's suggestions and comments in order to improve the service going forward.

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Detailed findings

Background to this inspection

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

This inspection took place on 5 and 6 April 2016 and was unannounced. One inspector and an expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the care of an older person and involvement with dementia care services. The last inspection of The Coombs by the Care Quality Commission was completed on 16 July 2014. The service was found to be fully compliant in the areas inspected. A report of that inspection was seen to be available for people to read.

Prior to visiting The Coombs we looked at the information we held about the service. This information included the statutory notifications the provider had sent to the Care Quality Commission (CQC). A notification is information about important events which the service is required to send to us by law. We reviewed information local commissioners had shared with us. We reviewed comments that people and relatives had made on a national website designed for people to feedback their views and experiences. A Provider Information Return (PIR) had been completed in 2015. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make in the next 12 months. The fact that the PIR was submitted last year and not prior to this inspection was taken in to account when considering its content.

During the inspection we spoke with 10 people who live at The Coombs and seven relatives. We also spoke with the registered manager and nine members of staff. We reviewed seven people's care records and 12 people's medicine administration records. We reviewed the recruitment records of three members of staff and the service's staff training record. We reviewed various records relating to the management of the service. These included the staffing rosters, the service's Statement of Purpose (a document which outlines what services The Coombs provides and to whom), complaints and compliments file, minutes of various staff meetings, a selection of quality monitoring audits and the service's most recent provider quality monitoring report. We also asked the provider to forward to us a copy of the service's training record which

they did.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not always managed safely. Nine people's records had a gap where staff should have signed to indicate that they had administered the person's medicines. In total there were 13 gaps in the space of four days. It was not therefore clear if people had received their medicines as prescribed. The arrangements in place were not robust enough to ensure staff signature gaps were followed up to check if the person had received their prescribed medicines. We informed the registered manager of our findings immediately.

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

Straight after our visit we received confirmation of actions which were to be taken immediately to address this. We will follow these actions up in the future to confirm that they addressed this shortfall. Other areas of medicine management were managed well. This included appropriate safe storage, access to medicines in a timely manner, including end of life medicines and the management of self-administration.

People told us they felt safe living at The Coombs. They told us the building was safe and secure and they felt well supported by staff who could meet their needs. Comments from people included: "I feel utterly, utterly safe, no worries at all" and "I feel very safe. Another person said, "They always check on me many times, day and night". One relative told us they were happy with their relative's safety and they said they "never had any concerns" about this.

People's needs were met when they needed them met. We observed call bells being answered without too much delay. We also saw people who preferred to be in their rooms or who were confined to bed receive regular visits from staff throughout the day. Two relatives said, "Staff are around and available to talk to when I visit" and one person spoken with told us they did not have to wait for staff when they rang their call bell. Only on one occasion a call bell rang for six minutes before it was answered. This rang just after a staff hand-over meeting at 2pm and when some staff were starting to prepare afternoon drinks. We fed this back to the registered manager so they could be aware of this. In 2015 two complaints had been received relating to call bells not being answered in a timely manner. The registered manager explained the circumstances behind these particular incidents but also told us a review of how and where staff were working, at busy times, had taken place. This had resulted in some changes in how the lay out of the care home was covered by the staff. During our last inspection we reported on communal areas in particular not being adequately supervised and people not having the means to summon help when needed. This had also been addressed by allocating staff to ensure areas were regularly monitored and more call bell units had been purchased and installed. During this inspection we observed communal areas being well monitored and people receiving support.

The care home had been regularly using agency nurses to ensure there were enough staff on duty to meet people's needs. We were told that the usage of agency staff had reduced over the last four weeks but the duty rosters still showed a need for regular usage. In one week of the four week rolling duty roster there were

several nurse shifts to cover through agency usage. We spoke with one member of agency staff who, like others, worked fairly regularly at The Coombs. They told us they enjoyed working at The Coombs and worked frequently enough to know the routine and the people well. One member the home's management team explained that ways of better utilising staff skills were being looked at. Arrangements had started to support and up-skill some experienced and well trained care staff so they could better support the nurses. The aim was to be able to free up the nurses from some tasks so they could concentrate on attending to people's nursing needs.

Minutes of a night staff meeting held in February 2016 stated that staff had raised the need for additional help at the beginning and end of their night shift. These were what staff called twilight shifts (hours in the early evening up to when people retired to bed and when people started to wake up and until the day staff started), so for example 7pm to 11pm and 7am to 8am. The registered manager explained this request had been taken to the provider and they were waiting for the provider's response. They explained that the care home unusually had several vacant bedrooms which, along with people's levels of need and the layout of the building, had to be taken into consideration when reviewing staffing numbers. The staff rosters also confirmed that staff were being flexible in how they worked so as to be able to pick up additional shifts and swap shifts to help out. The registered manager said, "Staff are very proud to work at The Coombs and will help out whenever they can".

Other staff supported the service and they included catering, domestic, maintenance and administrative staff. We spoke with one member of an ancillary team who told us there were enough members of their team to carry out their tasks.

People were protected from being cared for by staff who may be unsuitable because robust staff recruitment processes were in place. The recruitment files inspected showed that two new staff had been recruited recently and that appropriate checks were carried out before any staff started work. Clearances from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers and in particular, when past jobs had been with another care provider. Employment histories were requested and the reasons for any gaps explored at interview.

People's risks were assessed, managed and monitored and where possible risks were explained to people as well as the measures that could be taken to reduce these risks. One person's records showed they used a wheelchair but refused to use footplates to reduce potential injuries to their feet. The record showed that the risks of not using footplates had been explained to them and that they had still made a decision not to use them. This independent decision had therefore been incorporated into the relevant care plan and risk assessment. Other people had been assessed as being a high risk of falls. It was therefore important there were enough staff in the right places at the right time to supervise and support these people. There were arrangements in place to ensure this happened. One person lived with dementia and their incidents of falling had been reduced through good application of these arrangements. This person had experienced less falls since September 2015 because the risk management strategies had altered and improved. For this person these had included the introduction of an alarmed pressure mat by their bed. This alerted staff to the fact the person was attempting to stand and they were able to respond to this with the appropriate support. The person's care plans showed how the person was to be further supported. Problems had arisen in how best to support the person's desire to be independent, in particular walk to the toilet independently, with their inability to always know and be able to accept help when they needed it. Staff support was sometimes met with resistance so staff needed to know how to introduce this in a way which the person could accept. We observed staff following the person's care plan in practice. This involved the person being approached in

a kind way and staff suggesting they walk with them to the toilet. It also included staff remaining in the immediate vicinity to provide further support if needed. It was the case during our observation that a steadying hand and a wheelchair was needed for the person's return journey. This support had also involved an agency member of staff who was well aware of the person's risk of falling and how to approach them. Other risks such as those relating to the development of pressure ulcers were assessed, managed and monitored.

People were protected from abuse. Many residents living at the Coombs were extremely vulnerable and had complex needs and relied on staff to keep them safe and protect them from abuse. Staff knew how to recognise abuse and how to report any concerns they may have. One person said in relation to this, "I feel very safe any problems I can talk it through with them (staff). I get good emotional support when I need it most". Staff were aware of the provider's safeguarding policy and procedures and the subject was discussed openly in various meetings. Staff were aware of their responsibilities to report any concerns they had in relation to this. Staff knew which agencies were responsible for safeguarding people and how to contact them if they needed to. These included the local County Council, the Police and the Care Quality Commission. Information about safeguarding concerns or allegations were appropriately shared with external agencies and fully investigated. We did not observe any behaviour which could be perceived as challenging, however staff we spoke with were aware of possible individual triggers and prevention strategies to prevent situations escalating and people being potentially abused or put at harm.

People lived in a safe environment. Staff carried out numerous health and safety checks to ensure this remained the case. A specialist person carried out an in depth inspection annually on behalf of the provider and actions were implemented where improvements were needed. We saw well maintained records which recorded frequent monitoring and servicing of various systems and equipment. Appropriate risk assessments had been completed so that staff knew how to manage specific health and safety issues. Contracts were in place with various service providers and maintenance companies. For example, a specialist company serviced and maintained all lifting equipment, which included passenger lifts, care hoists and slings. Similar arrangements were in place to maintain the nurse call system, emergency lighting, fire alarm system and fire safety equipment.

The environment was clean and we observed domestic staff going about their tasks. They followed specific cleaning schedules and recorded what cleaning they had carried out so this could be audited. They were aware of how to prevent the spread of infection whilst cleaning. Infection control was taken seriously by all staff who followed the provider's policies and procedures in relation to this. For example, care staff wore protective aprons and gloves when delivering care. They also wore protective covering when delivering food and drinks. Staff were observed washing their hands between tasks and hand cleansing gel was available for visitors. Arrangements in relation to the management of soiled laundry reduced the risks of cross contamination. Where people required to be moved by a hoist, individual and personal slings were in use also preventing cross contamination between people. The kitchen staff had obtained a rating of '5' from the Food standards Agency. This is the top rating awarded and means the kitchen was found to have 'very good' hygiene standards (www.food.gov.uk). Individual kitchenettes were also found to be clean and tidy.

Requires Improvement

Is the service effective?

Our findings

People's nutritional needs and risks were not always recorded accurately. Staff were aware of which people needed support to maintain a healthy nutritional intake and people received the support they needed. However, records relating to this were not always maintained accurately. Mistakes were seen in the completion of some nutritional assessments. We fed back our findings to the registered manager who was aware some staff needed further training in the use of this tool. One person's weight record showed a loss in weight but there was no record of why this may have been or what staff had done about it. The nutritional assessment tool had not been updated to reflect this loss. The relevant care plan had not been altered to reflect the current situation or to give new guidance to staff. When speaking with a senior member of staff however, they explained this person's health had generally deteriorated. This, including their loss of appetite, had been discussed with their GP.

People's weights were monitored and issues relating to these were discussed with the person's GP. This sometimes led to a food supplement being prescribed or a referral to the speech and language therapist if the problem was thought to be related to a swallowing issue. Sometimes it had been decided that the person's food intake should be more closely monitored. By doing this over a few days an accurate picture could be gained and an appropriate health care professional could make a decision about what nutritional support the person required in the future. This had been the case for one person whose weight had fluctuated. Their nutritional care plan stated that a food intake chart was to be maintained. We reviewed the intake charts for the days of the inspection period. One form had nothing recorded on it and the other had inconsistent entries as well as an incorrect date. On checking with a member of staff as to whether the care plan was still relevant they confirmed that it was and the intake record should have been maintained. In this case an accurate picture of the person's intake could not be identified.

We fed back the above findings to the registered manager as these shortfalls potentially put people at risk of not having their nutritional risks and needs fully identified and properly addressed.

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

Some of these issues were addressed immediately; such as putting arrangements in place for the person's intake to be recorded.

People told us about their ability to make choices about what they ate and they confirmed they had access to snacks and drinks when they wanted them. Comments from people included: "The food is very good. The chef comes round and asks us what we like" and "If you want a snack, cup of tea, carers (staff) will get you one any time" and "I enjoyed my meal today. Hot, tasty and the sort of food that I like". One relative said, "Mum loves the food". During a resident meeting one person said, "The menu is very good. Alternatives are available. Always a meat, fish or veggie (vegetarian) option". The chef informed us that people who lived with dementia were supported to make choices, sometimes on a daily basis by being given a visual choice at the meal table. Throughout the inspection we saw staff using the kitchenette areas to make people drinks

and snacks. The main dining room and other smaller dining areas had been made to look inviting and attractive through the use of a small flower arrangement, table cloths and napkins on the tables.

We found three people had gained weight. In one person's case this had been since their admission and for another person, following an infection during which they had lost weight. Records showed that staff had identified people's likes, dislikes and particular preferences when it came to food and drink. For example, one person's care plan had been added to by stating they preferred a cooked breakfast and small meal portions. We found there was good communication with the kitchen staff in relation to people's preferences and weights. The chef knew whose food required fortification by the use of additional butter, cream and dried milk powder. They were also aware of who required special diets such as reducing, low salt, high protein or diabetic diets. People who had swallowing problems had been referred to a speech and language therapist for a swallowing assessment. The kitchen staff were then made aware of who required different textured foods; such as pureed or soft. Work had been completed on identifying people's food allergies and catering staff were well aware of potential allergens in foods. Information on these was available.

People's care was delivered by staff who had received training and support to do this. A relative said, "I have no real concerns. The staff I can see, know what they are doing". When commenting about the staff another relative said "Good people, never once have I come across anyone who I feel isn't a good carer." The registered manager said, "Knowledge empowers staff to do their best". They said, "We are lucky here and have some exemplary role models in our team". When staff started work for the provider full induction training was provided and all staff were expected to attend this. Induction training gave staff an introduction to the provider's policies and procedures. It set out their expectations and staff responsibilities. Training subjects included fire safety, infection control, safeguarding adults, safe moving and handling. All staff learnt about dementia care and the Mental Capacity Act 2005. One fairly new member of staff told us they had felt "fully supported" during their induction by their team leader. In the future all new staffs' learning would be supported through the Care Certificate. This lays down a framework of training and support which staff can receive. Its aim is for new care staff to be able to deliver safe and effective care to a recognised standard once completed. New care staff at The Coombs were supported and mentored by experienced and qualified care staff. The main training record showed evidence of completed and planned training. Training was on-going and there were systems which ensured staff remained updated. Any missed training sessions had to be eventually attended. Staff received individual and group support (supervision) sessions. One member of staff told us the registered manager and other senior staff were very supportive and helpful. The registered manager explained that staffs' end of year performance reviews were due to be completed in the next couple of months. Staff had been informed about these so they could give some thought to the process.

We spoke with members of staff who told us that they had taken part in dementia awareness training. The registered manager told us about one member of staff who had been passionate about the rights of people who lived with dementia. They had wanted to improve outcomes for this group of people at The Coombs and had therefore completed a dementia lead course. They now provided support and guidance to other staff in the care of people who lived with dementia. Two other members of staff had become dementia and dignity champions. This role promoted dignity in care and good outcomes for people who lived with dementia. Staff had opportunities to obtain further qualifications. We spoke with one member of staff who had completed a nationally recognised qualification in care. They were being supported to develop their skills and learning further in areas such as care planning, medicine administration and supervision of staff. Staff we spoke with were able to talk about their roles and responsibilities in a knowledgeable way. The registered manager described the learning and support given at The Coombs as "An opportunity to give staff their wings to fly".

People received care for which they gave consent. Where people were unable to provide consent they were

protected under the Mental Capacity Act 2005. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We observed staff adhering to the spirit of the Mental Capacity Act, encouraging people to make their own decisions. Where a person was unable to understand or process information we saw that staff used their knowledge of the person and the legislation to provide care lawfully. For example, one person was asked if they wanted personal care. They were confused but their behaviour indicated they needed to use the toilet. The member of staff encouraged them to go with them, talking all the way and explaining what was happening. One member of staff explained that if people became resistive to the suggestion of care they were never forced. The process of returning later to see if a person was able to be more accepting of care was discussed. One person said, "They are very good to me. If I want care they give it to me, nobody forces you to do anything you don't want to do."

One person had been unable to provide consent to live at The Coombs. This person also lived with dementia and the provider's Admiral Nurse had been requested to carry out a Mental Capacity Assessment. An Admiral Nurse is a specialist nurse experienced in providing support to people who live with dementia. They also provide guidance and support to those who look after people who live with dementia. The person had been assessed as lacking mental capacity to make this decision. A best interests decision had therefore been made on behalf of this person, by appropriate people/professionals that they needed to live at The Coombs in order to receive the care and treatment they required. This had been incorporated into the person's care plans. An urgent referral to the county council (the supervisory body) had been made under the Deprivation of Liberty Safeguards (DoLS). 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). Another example showed that a person had also not been able to give consent to live at The Coombs and a DoLS had been applied for. This person's care planning however also identified that the person was able to retain some information about their care and treatment. An assessment showed they could retain information, weigh it up and make simple decisions with support, so they were supported to do this.

People had good access to health care professionals. Records showed that local GP's visited as required as well as community nursing staff. Other specialists had been involved when needed such as tissue viability nurses (nurses who specialise in issues relating to the health of the skin as well as wound care and pressure ulcer prevention) and continence specialists. There was evidence of mental health specialists having been involved in people's care and treatment. People had access to regular chiropody, eye care assessments and dental care. The registered manager had close links with professionals in the hospice next door to The Coombs. Advice and support was therefore available during people's palliative and end of life care. During the inspection a doctor visited to review one of their patients and another person was supported by a member of staff to attend a hospital appointment.

People who lived with dementia also lived at The Coombs. The internal decoration was well maintained but not dementia friendly in that all areas were magnolia in colour. This would not be helpful in helping people to distinguish different areas of the building and therefore help them find their way around. We fed this back to the registered manager who took our comments on board as they had already considered there needed to be more colour. She told us they would take some advice on this to try and make the environment more dementia friendly.

Good

Is the service caring?

Our findings

People's care was delivered with kindness and compassion. One person said, "Staff always tell me what they are doing, that is so important when you can't see what someone is doing. Its little things like that which make the difference". Another person said, "I'm looked after really well, nothing to grumble about. Lovely caring people". One other person said, "Some of the carers (staff) I have known for a long time and they are friends. It makes a big difference to have people you know caring for you". Comments from relatives placed on a review website included, "All the staff are gentle, kind and respectful. It really does feel like a family and I am so grateful" and another had commented, "Staff I met were so welcoming and friendly, and there was a calm and loving atmosphere".

We observed several really kind and caring interactions from staff. In the mornings staff were predominantly focused on the task of helping people get up, washed and dressed but this was done in a personalised way. Staff knew the people they looked after well and were able to tell us about their particular needs and preferences. We observed staff listening to people's wishes and plans for the day and trying to fit their care around these. On several occasions we observed staff making care delivery a social event by talking with people about things they found interesting and by laughing and joking with them. In doing this staff remained respectful at all times. Staff tried hard to improve people's lives and to help them remain interested in things that gave them pleasure. One person liked to see the birds and they had been provided with a bird table. They told us they liked watching the birds and the occasional squirrel visit.

Care was also given in a way which maintained people's dignity. One person required support to eat their food. We observed a member of staff talking kindly to them and asking them if they were ready for more food before offering this. We also observed people being moved by the use of a mechanical hoist. When people wearing a dress or skirt were moved a blanket was placed over their legs so as not to expose undergarments and to preserve their dignity.

People's care was carried out in private and behind closed doors. Staff were seen knocking on people's bedroom doors before entering. Staff acknowledged that bedrooms were people's private spaces. Conversations with people, about any aspect of their care, were carried out quietly and away from other people's range of hearing. Staff reviewed and considered people's care between each other or with other professionals in private.

Care was provided in a way which encouraged and supported people to gain or regain independence. One person said, "Staff have encouraged me to become as independent as possible". This person explained to us that staff had helped them obtain equipment which they needed to be able to do this. They said, "This has made a real difference". They told us that before this they had needed to rely on someone to get them from one place to another. They said, "Before I had to rely on somebody and when you have been so independent that is really hard". Another person said, "When I came in I was very vulnerable and in a very dark place. The staff pulled me out of it and I got my life back. They have helped me to become independent".

Visiting by family and friends was unrestricted and we observed visitors being given a warm welcome when they arrived. People told us they appreciated this. Visitors confirmed they were supported to be involved in their relatives' care. One relative said, "We have been involved right from the start with (name) care. Things have worked out well but we still talk things through from time to time (with the staff). Another relative said, "I was involved with drawing up the care package. I can talk things through with the manager anytime. Communications are very good". Care records also showed that people's representatives, if appropriate, had been informed of changes in people's health or care or of incidents such a fall. One relative said, "If there are any problems they phone us straight away".

The Coombs was due to be assessed for accreditation in the Gold Standards Framework (GSF) in End of Life Care later in the summer. Staff had undertaken specific training and adopted a team approach to ensuring people have the best end of life care they can experience. It meant people were included in the planning of their end of life care and their wishes were met. To be awarded the GSF the service must pass and attain GSF standard in several areas of this area of care and maintain this over a period of time. If successful they are awarded GSF status in End of Life Care which is a national award and recognised as a beacon of best practice. People had experienced good end of life care. A relative had commented on the website, "Special thanks has to go to the carers (staff) who were there in (name) last moments" and "thank you for their compassion and love". Another relative had commented, "I could not have wished for a better place for Dad to spend his final weeks. All the staff were brilliant, very caring and attentive to dads needs while listening to and looking after the relatives".

Requires Improvement

Is the service responsive?

Our findings

People's care plans did not always accurately reflect the care they needed or were receiving. This put people at risk of unsafe and/or inconsistent care because updated information and guidance about a person's care was not always maintained.

People's needs were assessed prior to their admission to The Coombs. At this point, as well as people's care needs, their likes, dislikes, preferences, wishes and aspirations were initially explored with them. This information was included in the initial care plans devised for the person on their admission. Some of these plans then went on to give staff detailed guidance; some did not. The provider's expectation was for care plans to be reviewed and updated at least monthly and more frequently where care altered or new information came to light. This review process had taken place and some people told us they had been involved in this. One person told us they were fully aware of their care plan and they were always consulted before anything changed. Another person said, "Staff are always asking me if everything is working well or if I feel that anything needs changing about my care". However, sometimes, when new information came to light or alterations to someone's care had been made this was not always reflected in the actual care plan. For example, one person had been identified as being prone to a particular type of infection, which the care plan stated. However, the care plan did not go on to give staff guidance on what to do to try and prevent this, what to observe which may indicate an infection was starting and what to do when an infection was suspected. Another person had been identified as needing a hearing aid assessment on admission and the initial care plan, in December 2015, stated this. There was no recorded information to show whether this had been completed or planned for since. Another person's care plan, relating to their continence care, lacked specific detail and did not reflect the care or support staff told us they were currently providing.

In some cases a review of other care assessments indicated a need for an alteration to the person's relevant care plan. For example, as previously discussed in this report, one person had lost weight but there had been no reference to this in their care plan or the altered care which had been delivered. Short generic sentences were also used in some care plans which did not give staff specific personalised guidance. For example, in another person's continence care plan it stated "requires more support" but the care plan did not go on to explain what this was.

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

After discussion with staff about one person's continence care, their relevant care plan was re-written. On the second day of the inspection we were shown a detailed and personalised care plan which reflected the care the person was receiving. Permanent nurses were responsible for a number of people's care records. It was their job to ensure all care plans and relevant assessments were updated and corresponded with each other. A lack of the care homes own permanent nurses had compounded this problem. One senior member of staff explained that it was difficult for the permanent nurses to ensure that all care plans gave the detail they needed to. They were very supportive of up-skilling some care staff to be able to carry out this task as they considered them more than capable.

Although care records sometimes showed a shortfall in what information was being recorded about people's care, people were not going without the appropriate care. There were good hand-over arrangements in place which provided staff with an update on people's needs and progress at the beginning of each shift. Nurses also gave staff guidance verbally and in practice about how to meet people's needs because they worked alongside them. Senior care staff mentored new staff and also gave advice and support to other staff about people's changing needs. We discussed our findings with the registered manager who was already aware that some staff required additional training in care planning and record keeping. This training was to be organised.

Since February 2015 a new activities lead had been in post. They were supported by several volunteers and provided people with a range of meaningful activities, social gatherings and entertainment. Regular weekly and monthly activities took place such as singing as a form of therapy for the brain, different ways to improve movement to music, a visiting dog through the Pets As Therapy (PAT) scheme and bingo. A monthly news magazine called the Coombs News showed people enjoying the various activities that had been on offer. The April copy was being prepared to go out during the inspection and it listed events due to take place from mid-April onwards, into May 2016. Important dates in the calendar had been previously marked and remembered for example by baking activities. Shrove Tuesday people had made pancakes and Welsh teacakes were made by people on St David's Day. Local trips out had been enjoyed for example to see the first seasons daffodils, to garden centres for plant shopping and coffee. One person said, "I've been out on a number of trips and I have enjoyed just getting out".

People were very much involved in the planning of various activities. We attended a residents meeting where several suggestions were put forward by people. People with limited mental capacity were also involved with the activities planning with the activities lead making sure that their voices were heard. One person who was a keen gardener asked if a gardening club could be organised. There was already access to garden areas and raised borders and the greenhouse was due to be cleaned and cleared out ready for the new summer growing season. Another person said, "Do you think that we could have a shopping trolley that comes round with cosmetics, sweets and small things that we could buy because people need to be reminded what it is like to shop. Not everyone will stay here; some people will go home and could forget what shopping is like. It is important for us to keep in touch with shopping". Both of these suggestions were supported by others and the activities lead said they would organise them.

Links had been made with community based groups and different types of activity specialists took up residency for a period of time at The Coombs. For example, a poetry group had helped people over several weeks produce poems which had been put up around the care home. From this a book of residents' poems had been completed and it was hoped that this would be published in the near future. Also from this the activity lead had continued poetry based activities. We attended one such session which was based on people's memory of clocks. A ten week dance residency had just been completed and people were looking forward to the next residency which was going to be drama based. People told us they had enjoyed taking part in various activities and that they felt that there was enough for them to do and be entertained by. Photographic evidence (with people's permission) was available and showed people taking part in and obviously enjoying a range of activities. One person said, "There's quite a bit going on here so I don't get bored very often".

During the inspection we saw a variety of activities taking place, including a quiz and art and craft activities. On a more one to one basis people were visited in their bedrooms and one to one activities also took place. One person had been provided with new transport and they told us the staff were going to escort them to the shops. We observed staff supporting another person's request to sit in the garden for a while. We also observed staff sitting and chatting to people when they were able to do so. One person said, "The staff make

sure that I don't feel socially isolated in any way". We also observed staff taking part in a game activity with two people.

People were able to raise a complaint and have this taken seriously, investigated and responded to. We saw a copy of the complaints procedure which was displayed prominently in the entrance hall. The registered manager told us they aimed to resolve complaints or dissatisfactions to people's satisfaction but sometimes that was not always possible. Two complaints relating to call bell response times had been recorded and records showed they had been investigated and actions taken to address the issues raised. Records showed that one person had given feedback that they were satisfied with the process and the new arrangements. One person said, "If I am worried about anything I talk to the staff and they fix things, it's only little things like my clothes get lost sometimes so they find it for me". One relative said, "Never once have I needed to complain about anything but I am sure that they would listen and act if we needed to". Another relative said, "If there are any problems they sort things out quickly". Another relative told us there were some things they were unhappy about and they were going to raise these with the registered manager. Staff were already working closely with this person and their family to try and support them.

Good

Is the service well-led?

Our findings

People, their relatives and staff spoke highly of the registered manager. One person said, "There is a very good atmosphere in the home. The manager often pops her head through the door for a chat" and another said "Lovely manager, she knows all about me". A relative said, "Any problems with things like paperwork and the manager is always there to talk things through with" and another relative said, "She is a manager who is always willing to talk to us and who is prepared to listen". One relative had commented on a review website, "The Manager is in this job because of her kind, caring and wonderful compassion she shows, this is immediately obvious. We were so impressed by her kindness and then could see what a fabulous team she had". Staff we spoke with said that the registered manager was supportive and that they felt that they were valued by her.

The registered manager explained their main expectation was that the residents (the people) were "at the heart of everything we do". They explained the one main behaviour they would not tolerate would be "staff putting their needs first". They were extremely confident that this was not the case and would never happen because of some staffs' "very passionate views on people's rights". They said, "Because of this, it would not be allowed to happen". They told us they were aware of the staff culture because they were in-touch, as was their deputy manager and senior care staff, with staff practices and views on things. They told us, and it was evidenced through recorded minutes that regular staff meetings were held. These were opportunities for the registered manager to pass on information and communicate her expectations but also for staff to voice their concerns, views and ideas. A regular Monday morning meeting was held with heads of departments so that any issues from the previous week and weekend could be discussed and the plans for the new week ahead.

The registered manager told us that they and their senior team aimed to support the staff team as well as they could. Part of this process was done by reflecting on people's care, thinking about what had gone well what had not gone so well. In particular following an upsetting death. They explained that staff were encouraged to be honest and share their feelings with other staff and for staff who were better able at the time to be supportive in return. Reflective meetings were also held following complaints as a learning process and to discuss how the service could be improved. The registered manager said, staff had been told that they must be open and transparent whenever a mistake occurs. They said, "If something has happened it needs to be acknowledged, discussed and a way to move forward found". This process had taken place following a medicine error earlier in the year. It had found that staff had not followed procedure following this and appropriate action had been taken. They told us they had an open door policy and anyone was able to approach her when they wanted to. One member of staff confirmed this as being the case because they had done so with a personal issue and had found her to be very kind and supportive.

On the whole people were protected against poor practices and unsafe care and treatment because there were arrangements in place to prevent this. We reviewed various recorded audits completed by the registered manager and her staff. These identified most shortfalls and gave actions for these to be addressed. For example, actions following a medicine error were seen in one audit. When we fed back shortfalls relating to some care records the registered manager told us she had become aware that there

was a training need in some of these areas which she would address. Care records had been audited and, for example, the registered manager had been aware that some staffs' care planning skills required further improvement. Further training for some nurses would help to address this and the up-skilling of senior care staff in relation to care planning would provide more staff who were able to write and maintain care plans. Further monitoring of people's care records, in particular care plans, would help senior staff track future progress on this and identify any on-going shortfalls.

Actions were reviewed by a representative of the provider during their regular visits and signed off as completed once they had evidence this was the case. The registered manager told us they received good support from the provider's representative. The provider also carried out their own quality monitoring. The service's performance and levels of compliance were assessed formally by the provider's quality monitoring team annually. A report with actions to complete was produced after this and the service received a percentage score. Depending on what this score was another assessment would be carried out in six months or a year. Prior to this assessment the registered manager carried out a self-assessment against the provider's requirements. This assessment was submitted to the quality monitoring team, however this assessment could be completed at any time by the registered manager to help her gauge the services performance. The last self-assessment had been completed in January 2016. They had done this because they had returned from a period of leave and wanted to assess where the service was. Some areas showed a need to 'catch up' for example; some staff still required a formal supervision session back in January 2016. This had prompted the registered manager to focus on these and complete them before staff were due for their annual appraisals. The registered manager told us it was a good process as it also helped them focus on what actions were needed to maintain compliance with various regulations and legislation. Local adult social care commissioners had carried out a monitoring visit in April 2015. Areas of required improvement had been re-visited by commissioners and found to have been addressed by July 2015.

The registered manager ensured their own practices were up to date by attending regular training sessions, reading professional journals and attending forums such as the professional forum held once a month at the hospice next door. This meeting not only focused on end of life care but saw many health care practitioners coming together to get clinical (nursing) updates and discuss latest best practice. The registered manager also attended the provider's regular manager meetings where general management issues and safety alerts were discussed along with the sharing of ideas and best practice.

People were encouraged to give feedback about their experiences informally during resident meetings, individual care review meetings and small discussions during informal coffee mornings. The registered manager explained that relatives and visitors often gave feedback when they saw them. People were also able to share their views about the service on a website which the registered manager regularly monitored.

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 did not take formal enforcement action at this stage. 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
Treatment of disease, disorder or injury	Arrangements were not in place to ensure people had always received their prescribed medicines. People's levels of nutritional risk were not always identified and assessed correctly. Regulation 12 (1) and (2)(b)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Arrangements were not in place to always ensure people's care plans were maintained accurately and gave relevant information and guidance to staff. Regulation 17 (2)(c).