Orders of St John Care Trust

OSJCT The Meadows

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

We visited The Meadows on 22 December 2014. The Meadows is registered to provide accommodation for up to 68 older people who require nursing or personal care. At the time of the inspection there were 65 people living at the service. The home is arranged into three units; Bluebell, Poppy and Primrose. This was an unannounced inspection.

We previously inspected the service on 14 May 2014. The service was meeting the requirements of the regulations at that time.

Prior to this inspection we had received concerns about how people's pressure area care was managed, the levels of staffing, and the cleanliness of the home.

A pressure ulcer (also known as pressure or bed sores) is a wound that can develop due to pressure on that part of the body. People were not always protected against the risk of developing a pressure ulcer because some people's pressure relieving mattresses were not on the

Summary of findings

correct settings, repositioning charts were not consistently completed and processes were not in place to ensure people had creams applied that promoted their skin integrity as prescribed.

People liked the food. Mealtimes were relaxed and unhurried. People who had lost weight were referred for specialist advice. However, staff were not always knowledgeable about the diets people required and some records relating to this were inaccurate. Some improvements were required to ensure all people had their nutritional needs met.

Some people told us there were not enough staff to meet their needs. Call bells were answered promptly most of the time but staff did not always assist people straight away when they answered the bell. People told us this sometimes meant their dignity was not upheld as they could not get to the toilet in a timely way. The service had experienced a high turnover of staff in the last year. There was an ongoing recruitment campaign and shortfalls in the rotas were covered by agency workers.

Staff felt supported and benefitted from the supervision and appraisal process but gaps in training meant they were not always supported to improve the quality of care provided to people.

Some care plans did not provide sufficient instructions to staff on how to support people. Other records in relation to people's care were not consistently completed. On one unit information about people was not managed in a way that protected their privacy.

People felt safe and told us they liked living at the home and were treated in a caring and friendly way. People and their relatives were complimentary about staff. Some people and relatives felt the high use of temporary staff sometimes impacted on the quality of care they received. People were supported with their personal care discretely and in ways which upheld and promoted their privacy and dignity.

People were supported to make decisions about their care, to remain active and to maintain their physical and mental health. Where required staff involved a range of other professionals in people's care to ensure their needs were met. Staff were quick to identify and alert other professionals when people's needs changed.

Medicines were stored and administered safely. People were protected against the spread of infection and the home was clean and tidy.

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

The registered manager had a clear understanding of the changes and improvements that were required. People, their relatives, visiting health professionals and staff recognised that improvements were taking place.

Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions. Where restrictions were in place for people we found these had been legally authorised.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we took and what action we told the provider to take at the back of the full version of the report.

Summary of findings

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

Some aspects of the service were not safe. People sometimes had to wait for long periods for staff to assist them.

People told us they felt safe. Staff were knowledgeable about the procedures in place to recognise and respond to abuse.

The service followed safe recruitment practices. People were protected from the risk or spread of infection.

Is the service effective?

Inadequate

<Findings here>

The service was not effective. There were gaps in training for both new and existing staff.

People were not protected against the risk of developing a pressure ulcer because staff were not knowledgeable about some aspects of peoples pressure area care.

People liked the food. People who had lost weight were referred for specialist advice. Staff were not always knowledgeable about the type of diet people required and did not always support or encourage people to eat.

People were supported by staff who acted within the requirements of the law. This included the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not always caring. People sometimes had to wait to be assisted and told us this had impacted on their dignity at times. Information about people was not always kept in a way that protected their privacy.

People were complimentary about the care they received. Staff were caring and treated people in a friendly way. People were assisted with personal care discretely and in ways which upheld and promoted their privacy.

People were supported to be independent.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs. Care plans and assessments did not always provide instructions on how to support people. Other records relating to people's care were not recorded consistently or accurately.

Activities were tailored to suit people's interests and preferences. There was regular entertainment on offer.

Summary of findings

Is the service well-led?

The service was well led but some improvements were required. Quality assurance systems were in place and had identified some of the issues we found during the inspection however some of the identified actions had not been started.

The registered manager had worked to change the culture of the home. They demonstrated strong leadership skills and had a clear understanding of the changes and improvements that were required.

People felt confident to raise any concerns they might have about areas of poor practice.

Requires Improvement 

OSJCT The Meadows

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 checked whether the provider was 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 the 22 December 2014. It was unannounced. The inspection team consisted of three 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.

Prior to our visit we reviewed the information we held about the service. This included notifications, which is information about important events the service is required to send us by law. We also received feedback from five health or social care professionals who regularly visit people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with 12 people and six of their relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the registered manager, the deputy manager, 11 care staff, six ancillary staff, and the chef.

We looked at records, which included 15 people's care records, the medication administration records (MAR) for 49 people at the home and four staff files. We also looked at records relating to the management of the service.

Is the service safe?

Our findings

People told us they felt safe living at The meadows. Comments included, "I am safe" and "I feel very safe." A relative told us, "When I leave here I know that my Dad will be safe."

Before the inspection we had received concerns from visiting health professionals and relatives about the staffing levels. The provider used a dependency tool to calculate staffing levels in line with people's needs. The calculated levels of staff were met and any shortfalls were covered by agency staff, bank staff or existing staff working long shifts. There had been some recent occasions when an agency nurse had not arrived for their planned shifts. This had resulted in reduced cover for a short period of time until a replacement was found. In the last six months there had been a high number of staff vacancies at the service. There had been an ongoing recruitment campaign and several new staff had been recently employed. Three new members of staff had been recruited the week before our inspection and interviews were also being held on the day of the inspection.

People on Bluebell unit told us there were enough staff. Their call bells were answered quickly and their needs were attended to promptly. People on Primrose and Poppy units did not feel there was always enough staff. People said, "They are rushed off their feet and they haven't got time." and "They don't have enough staff and they can take a long time to attend to me." A relative said, "There are not enough staff around to help. There is a very long call bell response time." During the morning of the inspection we observed call bells were answered promptly but staff did not always assist people straight away. This was because they were engaged in other tasks or waiting for another staff member to help them. People told us that it was common practice to wait for staff to return to assist them. We observed one person became anxious because although their call bell was answered but staff did not return to assist them for 20 minutes. A relative told us that earlier in the day they had asked staff to assist their mother but it had taken them an hour to return. During the afternoon when one member of staff was taking their break on Primrose unit the call bells were not always answered promptly. One call bell rang for ten minutes before being answered. We discussed this with the registered manager who told us they would investigate why the delay had occurred and if necessary review the dependency of people on these units.

Safe recruitment procedures were followed before new staff were appointed to work with people. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role.

Care and ancillary staff had good knowledge of the provider's whistleblowing and safeguarding procedures. They knew how to report any safeguarding concerns and said they would immediately notify the manager or area manager if they had concerns about a person's safety or the way care was delivered. The manager had recently raised a safeguarding alert appropriately for a person where a risk to their safety had been identified. Immediate steps were taken to ensure the safety of this person.

Medicines were stored and administered safely. Staff supported people to take their medicine in line with their prescription.

The service had plans in place to keep people safe during an emergency. A 'grab folder' was kept that contained important information about people and their mobility needs as well as an emergency evacuation plan for use in the event of a fire.

Equipment used to support people's care, for example, hoists, stand aids and specialised baths were clean, stored appropriately and had been properly maintained. The registered manager kept a range of records which demonstrated equipment was serviced and maintained in line with nationally recommended schedules.

Before the inspection we had received concerns about the cleanliness of the home. During this inspection we checked to make sure people were protected by the prevention and control of infection. Effective measures were in place to ensure the home was clean. Communal areas were clean and tidy. Staff followed Department of Health guidance for storage and use of cleaning materials. The service had adequate stocks of personal protective equipment for staff to use to prevent the spread of infection and these were used in line with the services policy on infection control.

Is the service effective?

Our findings

People felt cared for by competent staff. However, there was a risk that people were not cared for by suitably skilled staff who had kept up to date with current best practice. There were gaps in staff training for both new and existing staff. For example, 11 care staff who had been employed in the last six months and were working independently had not attended pressure area care training and 10 care staff had not undertaken nutrition training.

This was a breach of Regulation 23 Health and Social Care 2008 (Regulated Activities) Regulations 2010.

People were not always supported by staff that were knowledgeable about the care they required in relation to preventing a pressure ulcer. Three people had specialist pressure relieving mattresses in place but according to the manufacturers guidelines these were on the wrong setting for people's weight. One person's mattress on their bed was on the setting used for chair cushions. Staff caring for these people were not able to tell us what the mattresses should be set on and this information was not recorded in their care records. The nurse was aware of the correct procedure for setting the mattresses and told us the setting should be recorded in people's care plans. These people were therefore not protected against the risks of developing a pressure ulcer.

One person who was at high risk of developing pressure ulcers had a care plan that stated "apply creams at least twice daily" They were prescribed three different creams. There were no instructions in the care record or in the person's room to give guidance to staff so that they knew where and how to apply the creams. There was no form for staff to complete to document the creams had been applied. We spoke with two different staff who told us this person had two creams applied. They did not name the same creams. We were therefore not assured this person would have their creams applied as prescribed.

People were not always supported by staff that were knowledgeable about their dietary needs. For example, one person had been assessed as at risk of choking. They had been seen by a speech and language therapist (SALT) and their care plan and risk assessments reflected the recommendations made. However, their care plan said they should have a soft diet and single cream consistency fluids. Staff told us this person should have double cream thickened fluids and had thickened their drink to double cream consistency. Another person had their fluids thickened but there was no information recorded in this persons care record about the need for fluids to be thickened and no assessment from the SALT. We asked this person about their thickened fluids. They were not able to verbally tell us about the fluids but pointed to the cup of thickened fluids and pulled a face to indicate the drink was unpleasant. Staff told us they had been having their fluids thickened for three weeks and had been told this information at handover. There was a board in the nurse's office that listed people on special diets and thickened fluids. This person's name was on the list as requiring thickened fluids. However, the Deputy manager and nurse did not know why this person should be having their fluids thickened.

These issues were a breach of Regulation 9, Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people were prescribed milkshake style nutritional supplements because they had lost weight. People were supported to have their supplement but this was given as a drink with their lunchtime meal rather than between meals as a snack as recommended by manufacturers. Two people identified as at risk of malnutrition had not eaten their meal. Staff removed the meal. They did not offer these people any encouragement to eat or an alternative choice. They were however given a dessert which they ate. People who were at risk of losing weight had malnutrition universal screening tool (MUST) charts and these were accurately maintained. Where people had lost weight they were referred to the dietician or GP for review.

People's opinion of the food served in the home was mostly positive. Comments included "I like the choice of food. If you don't like something you can have something else. I like omelettes so they often make me one" and "Excellent food, I was losing weight in hospital but since I have been here I am starting to put it on." Mealtimes were relaxed and unhurried. People who needed assistance to eat were supported in a respectful manner.

People told us they had regular access to other healthcare professionals such as, chiropodists, opticians and dentists. People were referred for specialist advice for example, from the occupational therapist or physiotherapist, and we saw evidence this advice was followed. Professionals told us

Is the service effective?

they were notified of people's changing needs. Details of any professional visits were documented in each person's care record, with information on outcomes and changes to treatment if needed.

Staff felt supported and benefitted from regular supervision and appraisals. Supervision gave staff the opportunity to discuss areas of practice. Any issues or poor practice were discussed in supervisions, actions were set and followed up at subsequent supervisions. Staff were given the opportunity to discuss areas of development and identify training needs.

Staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions. Where restrictions were in place for people we found these had been legally authorised.

Staff understood their responsibilities under the Mental Capacity Act 2005. We saw examples of this in people's care plans. For example, where people were unable to consent to the use of bedrails. Staff had followed good practice guidance by carrying out, and recording, best interest decision making processes.

Is the service caring?

Our findings

People were mostly complimentary about the home and the staff. Comments from people included, staff are "gentle" and "caring". One person said, "They're very good. They look after me one hundred per cent. It couldn't be better. Anyone that can get better care than we get would be very lucky." However some people and relatives felt the staffing issues and high usage of temporary staff sometimes impacted on the quality of care they received. A relative said**,** "The care is variable, good sometimes not so good at others. Continuity of care is a real issue."

People sometimes had to wait to be assisted once they had called for staff this had an impact on their dignity because they could not always get to the toilet in a timely way. People were not always supported to spend time where they wished. For example, one person had declined to attend the activity. They wished to remain in their wheelchair and so were positioned in the lounge so they were able to see the television. However, another staff member then asked the person if they wanted to attend the activity. The person declined again but the staff member did not respect their choice and still took them to attend the activity.

People's privacy in relation to care delivery was respected. However, there was a white board on the wall in the staff office on Primrose unit which could be seen from the corridor and the dining room. This displayed personal information about the health and care needs of people, for example, the medical conditions people had.

These issues were a breach of Regulation 17, Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were spoken to in a friendly and respectful way. There was a warm friendly atmosphere and staff knew people well. Staff referred to people by their preferred titles. Conversations were pitched appropriately for the individual and ranged from the more serious through to light- hearted banter.

People told us they were supported in their daily routines at their own pace. One person said, "They do their level best to make people happy. They ask what you would like and are very respectful. They always tap on the door before they come in." People were assisted with personal care discretely and in ways which upheld and promoted their privacy and dignity. Staff were sensitive to people's needs. For example, discreetly assisting people with the use of tissues. People were promptly assisted to adjust clothing if required. They were regularly asked if they were too warm or cold. One person said they felt cold and the staff member fetched them a cardigan and assisted them to put it on. Peoples rooms were arranged how they wanted and staff ensured photographs and personal items were displayed so they could be seen when people were in bed.

People were supported to make choices and decisions about how they wished to be cared for. Staff were knowledgeable about how people preferred to be supported. For example, if people preferred a bath or a shower or if they preferred a female or male member of staff to support them with personal care. People had been involved in decisions about what information could be shared with relatives to ensure they were kept informed of any changes to people's health. Relatives confirmed that they were told of any concerns promptly. People told us their relatives and friends were able to visit whenever they wanted and that staff were welcoming and friendly.

People were supported to be independent and were encouraged to do as much for themselves as possible. Some people used equipment to maintain their independence. Staff ensured people had the equipment when they needed it and encouraged people to use it.

Is the service responsive?

Our findings

People's care plans did not always provide sufficient instruction to staff on how to support people. For example, staff told us one person frequently displayed behaviour that may be described as challenging. Although their care plan identified they could display this type of behaviour there were no records to show how this behaviour was monitored to enable care workers to identify any triggers or patterns. There were specific management plans documenting how this person should be supported when displaying these behaviours. Staff who regularly worked with this person had identified trigger situations to this person's behaviour and had recognised certain interventions that helped to calm their behaviour. These interventions were effective; however, this information was not recorded in a care plan.

Some records relating to how people should be supported were not accurate. For example, each dining room had a printed document which contained information about people's dietary requirements. This did not match the information contained in some people's care records about the type of diet they required. For example, one person's care plan said they should have a soft diet. The dietary requirements sheet listed the person as requiring a pureed diet. Another person was eating a normal diet and this was in line with instructions in their care plan. However, the dietary requirements sheet listed the person as requiring a soft and mashed diet.

Some people had charts to inform staff when they had been assisted to change position. There was a risk these people's pressure area care needs would not be met because charts had not always been completed. For example, one person's care plan stated they should be repositioned three to four hourly. We reviewed the previous two weeks positioning charts kept for this person. They were not consistently completed. On the day of the inspection we observed this person being assisted to move but no repositioning had been documented since the previous evening. Charts would therefore not inform staff whether the person was being assisted to change position in line with their care plan.

Some people required their food and fluid intake to be monitored however records were not always completed and did not include enough detail to inform staff if adequate nutrition and hydration had been taken. The total of fluid input and output was not always correct. This meant that records could not be used to determine if this person was eating and drinking enough and this information would not be available to inform the care provided by visiting health professionals.

These issues were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Before people came to live at the home their needs had been assessed to ensure that that they could be met. People and their families confirmed they were involved in the planning and review of their care.

People told us they enjoyed the many activities on offer and were supported to lead active lifestyles. Comments included "There is plenty to do here. I enjoy singing and going to Bingo. I have been to the shops and to garden centres. It's so nice to get out and about.' And 'I am doing things I didn't know that I could do.' Arrangements had been made for people to attend nearby religious activities and local church ministers or religious leaders regularly visited.

People knew how to make a complaint and the provider had a complaints policy in place. The manager checked if people were satisfied with the outcome of their complaint. Feedback from people and their relatives about the quality of the service was sought. For example, a residents and relatives meeting was held quarterly. Any actions identified following feedback or complaints were completed. For example, comments about the menus had led to the chef undertaking a survey to establish what food people would like to see on the menu. Some people had said the cutlery was too heavy to hold and so new light weight cutlery had been purchased.

Is the service well-led?

Our findings

There were a range of quality monitoring systems in place to review the care and treatment offered at the home. These included a range of clinical and health and safety audits. These had identified some of the issues we found during the inspection. There was a plan in place to address them but some of the actions had not yet been started and improvements had not been sustained or embedded.

The registered manager had been in post for 12 months and the deputy had been in post for six months. Since the registered manager and new deputy manager had been in post they had worked hard to change the culture of the service. The registered manager demonstrated strong leadership skills and had a clear understanding of the changes and improvements that were required. For example, improvements in the care delivered to some people and the planning and recording of this. The registered manager was ensuring that staff were more aware of their responsibilities and accountability through regular supervision and meetings with staff.

Staff and visiting health professionals told us they had recently seen positive changes that had directly improved the experience for people. One staff member said, “Things have changed. She [the manager] is a good listener, caring, firm and a straight talker.” Staff felt motivated to improve the quality of care they were delivering. People, their relatives and staff felt there was now an open culture in the home where they felt confident to raise any concerns they might have about areas of poor practice. Appropriate action had been taken by the registered manager to deal with concerns raised about staff performance and where necessary disciplinary action had been taken and some staff had been dismissed.

There was a clear procedure for recording incidents and accidents. Any accidents or incidents relating to people who used the service were documented on a standardised form and actions were recorded. Incident forms were checked by the registered manager to identify any trends or what changes might be required to make improvements for people who used the service.

We saw that people were actively encouraged to provide feedback. People were introduced to prospective staff when they attended for interview. We observed people asking questions of potential staff that had attended for interview and afterwards feeding back to the manager.

Feedback was also sought through regular residents and relatives meetings. A satisfaction survey was conducted and the results of these as well as the quality assurance systems such as audits and accidents and incidents were compared with other locations within the Orders of St John Care Trust. The management team reviewed the results and took steps to maintain and improve the homes performance.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure people always received care that had been planned or delivered in a way that met their individual needs or which ensured their safety and welfare. Regulation 9 (1) (b) (i) (ii) (iii).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not make suitable arrangements to ensure the dignity and privacy of service users. People were not always treated with consideration and respect. Regulation 17 (1) (a), (2) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person had not ensured that service users were protected from the risks of inappropriate care and treatment because an accurate record in respect of services users including appropriate information had not always been kept. Regulation 20(1)(a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Some staff had not received appropriate training. Regulation 23 (1) (a).**