The Orders Of St. John Care Trust

OSJCT Chestnut Court

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

This unannounced inspection took place on 11 and 12 April 2017.

Chestnut Court provides nursing, residential, and respite care for up to 80 people in four households Two households cared for people living with dementia. At the time of our inspection 75 people were living there. The home is purpose built over two floors.

There had been no registered manager in post for 18 months. 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. An interim manager was currently managing the service and had recently decided to apply to CQC to be the registered manager.

There were four breaches of legal requirements at the last inspection in December 2015. Following this inspection the provider sent us an action plan detailing how they would address the shortfalls that had been identified. At our comprehensive inspection on 11 and 12 April 2017 the provider had followed their action plan which they told us would be completed on 31 August 2016 with regard to the use of the Mental Capacity Act to protect people, improving their quality assurance systems although further improvements were needed, providing sufficient training for staff and ensuring there were adequate staff to protect and care for people.

At this inspection we found that people were not always protected against the risks associated with abuse and improper moving and handling. We could not always be assured that care staff understood their duty to raise safeguarding concerns as part of the providers 'whistle blowing' policy.

People were not always protected against the risks associated with the unsafe management of medicines. There were errors and inconsistencies in some medicine records and medicine was not always available on time.

People were not always protected against the risks of falling. Risks were not always reviewed and measures recorded to prevent further accidents.

People were not always protected against the risks associated with meeting their nutritional needs. Some records were inaccurate when assessing people's nutritional risk and one person was at risk from choking due in part to the support plan not being followed..

There were varying opinions about staffing levels from staff, people and relatives but the provider had assessed people's dependency levels every six months and provided some additional staff hours. Additional hours for activity staff had been implemented since the last inspection. As a result there was an improvement for people in the activities they joined in with six days of the week. We have made a

recommendation to continually monitor people's dependency levels to provide sufficient staff to support and care for people safely.

In view of the shortfalls in this report it was evident that the quality assurance systems had not been fully effective. We have made a recommendation the systems for assessing the quality of the service be more robust and continually reviewed by the provider and the manager to ensure safe care and treatment for people.

People were able to make some choices and decisions and staff supported them to do this. Healthcare professionals visited when required and clear records were kept of the visits. There was evidence of communication from the mental health team and palliative care team and their guidance was followed. People were supported by staff that were well trained and had access to training to develop their knowledge.

People were treated with kindness and compassion. We observed staff engaged with people in a positive way and they were caring when they supported them. Relatives felt welcomed in the home and told us the staff were kind. People had a range of activities to choose from which included cookery, quizzes, ball games, arts and crafts and musical entertainment. Community links included people visiting the local church and shops nearby.

Staff meetings and resident/relative meetings were held and they were able to contribute to the running of the home.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

People were not always safeguarded as staff did not always ensure safeguarding concerns were effectively actioned.

People's medicines were not managed safely There were errors and incomplete records.

People were not always protected from the risks associated with their care when risk assessments were not adequately reviewed.

People needs were met by sufficient staff but we recommended continual assessment of people's needs to ensure there was always sufficient staff.

Staff were thoroughly checked during their recruitment.

Is the service effective?

Requires Improvement

The service was not always effective.

People's dietary needs were at risk of not being met for their well-being.

People had a choice of meals and when they required assistance they were given time to eat.

People were supported by staff who had completed their training and regular updates were planned. Individual staff meetings had not been completed regularly to monitor staff progress and plan additional training.

Where people were unable to make decisions they were protected by the Mental Capacity Act and decisions were made in their best interests.

People had access to social and healthcare professionals and their health and welfare was monitored by them.

Is the service caring?

Good

The service is Caring

People were treated with compassion, dignity and respect.

Staff treated people as individuals and engaged with them positively.

People were supported and encouraged to be independent.

Is the service responsive?

Good

The service was responsive.

Peoples care plans were personalised and usually regularly reviewed .

People took part in activities and had some individual engagement with staff. Improvements to supporting people with going out could be made.

Complaints were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

There had been no registered manager in post for 18 months. This had led to inconsistency and improvements were required.

Regular resident meetings and six monthly reviews enabled some people and their relatives to have their say about how the home could be improved.

Staff mainly felt they were supported by the new management team and were able to give their feedback in staff meetings.

Regular quality checks ensured that issues were highlighted and improvements continued to be made.

OSJCT Chestnut Court

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 11 and 12 April 2017 and was unannounced. The inspection team consisted of two adult social care inspectors, a nurse specialist dementia care adviser and an expert by experience. An Expert by Experience is a person who has personal experience of caring for someone who uses this type of care service.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We received a Provider Information Return (PIR). 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.

We spoke with the manager, the area operations manager representing the provider, the quality and compliance manager, three nurses, the deputy manager, three care leaders and seven care staff. We also spoke with, a chef, the training co-ordinator and the activity organiser. We spoke with nine people who used the service, four relatives and three healthcare professionals who were visiting the service. We looked at information in ten people's care records, three staff recruitment records, staff training information, the duty rosters and quality assurance records. We checked some procedures which included medicines and safeguarding adults. We also contacted social and healthcare professionals that visited the service to obtain their view of the service.

Requires Improvement

Is the service safe?

Our findings

People were not always protected against the risks of potential abuse. Staff had completed safeguarding adults at risk of abuse and/or neglect training to have the knowledge to protect people from any form of abuse. The service also had a safeguarding procedure and 'whistle blowing' policy which guided staff to inform someone if they had any concerns. Care staff told us they were aware of their responsibilities to report allegations of abuse, however some staff felt safeguarding concerns they had raised were not acted upon. For example, one member of the care staff raised concerns to us regarding information they had passed to care leaders. The information was regarding inappropriate moving and handling of people with one member of staff when there should have been two staff according to people's care plan. They felt their concerns were not acted on. They informed us how they tried to pass the same concerns to the manager of the service, however they felt the manager was not approachable to listen to their concerns. These concerns were discussed at the inspection and were passed to a representative of the provider to investigate. One concern was substantiated whilst we were completing the inspection. We could not always be assured that people were kept safe by robust safeguarding practices. Care staff did not fully understand their duty to raise safeguarding concerns as part of the providers 'whistle blowing' policy, if they felt their concerns were not acted upon to ensure people's safety. One comment from a staff member was, "I don't feel I can report concerns."

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always safely managed. We checked medicine management in all four households and there were errors and inconsistencies in three. There were some gaps in the medicine administration record (MAR) where staff had not signed they had given the medicine. Some medicine had not arrived from the pharmacy and there was a delay in the person receiving them. The medicines had been checked in by staff the previous week but it was too late to order any missing medicines required for Monday morning when this process was completed at the weekend. An unidentified code letter was used on one person's handwritten MAR. Specific codes are used to indicate the status of medicine administration such as 'declined'. These codes are set out on the MAR.. The handwritten MAR had only one signature and best practice is that two signatures would be seen to verify correct transcribing. Two spot checks of numbers of tablets we completed were incorrect as the previous amounts had not been carried forward. Therefore we could not check if a person had been given their medicine. The deputy manager agreed to look into the error.

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

The service was attempting to monitor and improve medicine management practices. We looked at how medicine errors had been looked into and there were clear records of some incidents and what action had been taken which included informing the person's GP when required. In one household where gaps in recording of people's medicines had been identified by staff, appropriate action was taken to ensure people

had received their medicines as prescribed. Action had been taken to improve medicine administration and learn from the errors however from our inspection there were continuing shortfalls that needed to be addressed.

We observed people were supported in a calm and patient manner when they were administered their prescribed medicines. Quarterly medicine audits were completed, one of the four household were checked each month. An example for one household we looked at was 77% correct in April 2017. The shortfalls in the medicine audit were discussed at the next nurses meeting and specific action taken where required. For example a new blood glucose testing kit was purchased that did not require calibration for accuracy.

People were not always protected from the risks associated with their care. For example falls documentation for one person was incomplete. The person was a high risk of falling and the last review was in February 2017 but a fall was recorded in March 2017. The reviews had been monthly from September 2016 until February 2017 however no review had been completed following the fall in March 2017. A care staff member told us the person was continually monitored by one member of staff so falls were minimised. The person was a high risk as their medical condition meant their bones could easily fracture should they fall. The record said staff should be vigilant of this when carrying out any post falls assessment'. One fall for the same person was recorded but there was no date for when it happened. Another person had several falls since the end of January 2017, mainly at night and there was no reference to these incidents in either their mobility care plan or falls care plan to indicate measures were now in place for monitoring this person later in the evening after staffing levels reduced for the night.

We were unable to find any record of reflective practice on the computerised falls records to identify patterns and therefore put in place actions to minimise further accidents. The manager was able to show us only two hand written examples where staff had reflected on accidents to consider preventative measures when there had been 20 falls in February 2017 and 27 in March 2017.

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

People had some risk assessments for their personal safety in the care plans, for example; f moving and handling and skin deterioration from pressure. The risks were usually reviewed monthly and any changes were noted and action taken. One person's risk assessments provided guidance on how staff should assist them to move safely, including the equipment they needed to ensure the person was safe and comfortable.

At our comprehensive inspection on 16, 17 and 18 December 2015 the registered person had not ensured people who use services were protected against the risks associated with inadequate staffing levels. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our comprehensive inspection on 11 and 12 April 2017 this requirement had been met. There were six monthly assessments of peoples dependency using the Capability Tool to identify the level of staff hours required but there was little variation in the staffing levels in each household. Since the last inspection activity staff had increased and were deployed to cover six days of the week and this had made a big difference to the amount and quality of activities provided. The activity coordinator hours had increased and the deployment of staff provided people with activities six day a week. The activity person told us they were able to provide more individual sessions with people as the activity team had increased. We also looked at a record of the 'Capability Tool' where people's dependency levels were assessed and recorded. From this information the staffing hours were calculated for each day. The staff hours provided exceeded

what was calculated as required by the Tool.

The deputy manager informed us they were times when additional staff were deployed when people's dependency levels were higher, for example when people were near the end of their life or presented behaviours that challenged the staff. The Admiral Nurse employed by the provider as a nurse specialist in dementia care had completed observations throughout the last year to monitor whether people had sufficient support and engagement with staff. One record came to the conclusion that more engagement with people could be provided during times in the early evening when people felt restless and distressed, sometimes called 'Sundowning'.

There were varying opinions about staffing levels from staff and relatives. Three people, two staff and three relatives said more staff were needed. One person told us they had to go to bed early when there was a shortage of staff and another person said, "Personally I don't think there are enough nurses" and "they are always busy." One staff member commented "We do have enough staff now. We have five in the morning and four in the afternoon. If we have six in the morning it's too much. We have time to spend with people" and "There are enough staff each day." Another staff member on Willow household told us, "We need more staff …", "only four in the afternoon, it is still busy in the afternoon and we have people who need us to monitor them – especially when 'Sundowning' occurs." One care staff member said, "I love working here I couldn't have wished for a better place to work but staff shortages sometimes make it hard for us to safeguard residents. We have a lot of residents here that we cannot share enough of our working hours with. They all need our attention equally but it seems that sometimes there is just not enough time per shift to do that. So they miss out." and "The management should down size the amount of residents so that we can look after them better." One nurse told us "As long as we have six staff in the morning we can usually manage." One person was continually supported by an agency care staff member and we were told they knew the person well and were able to support them. We recommend changes in peoples dependency be continually monitored to ensure staffing levels are correct to support and care for people safely.

Recruitment procedures were followed and correct checks had been made. People were cared for by suitable staff because satisfactory recruitment processes were in place. There were checks of staff criminal record histories using the disclosure and barring service (DBS). People's employment history had been explored and any gaps in employment were discussed. Many staff had left in the last 12 months and agency care staff and nursing staff were used. A New Starter booklet had been devised to give new staff information about their induction training and about the service generally.

People were protected against the risks associated with infection control. There were infection control procedures for staff to follow and we observed staff using personal protective equipment to prevent cross infection. The home was clean and people and their relatives told us it was always clean. On healthcare professional told us, "It's always clean here, there are no full bins or linen on the floor."

There was a comprehensive maintenance programme to help ensure the service was safe.
Safety issues were identified by staff and the maintenance person was there daily to ensure they were completed. Other more major improvements were scheduled and completed. We saw an email where recent urgent maintenance issues had been identified and reported to the provider's maintenance team by the manager. These included decoration of bedrooms, two dining rooms and a carpet replacement. The maintenance staff had completed a monthly health and safety compliance check list which included all areas and installations. There was an issue brought to our attention by a relative about an ensuite wet room where water collected. We asked the manager to look into this problem again as the relative was not satisfied with the modifications.

We looked at the certificate checklist completed by maintenance staff and all areas had been checked and the last certificate date of when equipment and systems were serviced was added. Additional monthly checks by the maintenance staff included the safe storage of substances, fire safety, emergency lighting , window restrictors and Legionella disease checks of the water systems. An outside company was also used to check the water safety. All hoist slings used by people were checked every six months and were tagged as suitable for use. Each person had their own hoist sling which had been measured for their personal use and kept in their bedroom.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. There was a detailed business continuity plan which covered emergencies for example, power failure, loss of information technology and adverse weather conditions.

Requires Improvement

Is the service effective?

Our findings

People's dietary needs were at risk of not being met. For example, one person was admitted to hospital following an episode of choking. Guidance from the hospital stated the person required 'a pureed meal at all times'. However there was no referral to the Speech and Language Therapist (SALT) regarding the person's dietary needs. A member of care staff informed us the person did not always receive a pureed meal and on the day of our inspection they had received a meal which had not been pureed. We raised this concern with a representative of the provider who took immediate action. A care leader made a referral to speech and language therapists to ensure the person's dietary needs were assessed and to provide current guidance. We spoke with a chef and they agreed to put people's names on the plated pureed meals they prepared for the households. Dietary forms recording people's special diets and preference for each household were provided every three months. The chef told us they had a weekly verbal update when there were changes to people's diet but no record of changes were provided.

People's nutritional needs were not accurately monitored. A nutritional screening tool used (MUST) had not been completed accurately and improvements were recorded when there were none. For example one record inaccurately recorded a person had gained 1kg and it was 0.1 Kg and the tool score was altered from 3 to 2 (indicating an improvement in weight) which was incorrect. A care staff member told us the person eats well some days but not others and their food was fortified and offered throughout the day. They said, "If (the person) is not feeling well he doesn't eat much. "Another person in the nursing dementia household had lost 7.2Kg from February 2017 to March 2017 and their overall risk on the MUST tool was recorded as 'Low'. The care plan review stated, 'Needs to be prompted to continue with meal. …..(name) falls asleep eating on occasions. No change to diet at time of review'. We questioned this with a care staff member and they said the weight must be wrong and the person agreed to be weighed again and they had only lost 3.4kgs since February and this was on 11 April 2017. The person's weight was reasonably stable between November 2016 and February 2017. Therefore the weight loss of 7.2kgs (almost 1st 2lbs) would appear to be an anomaly that staff had not noticed.

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

A variety of food was provided and people told us they liked the food. People we spoke with agreed the meals were tasty and "Like home cooking". When assisting people with meals they were given a choice by the staff. However staff did not use plated meals to help people make an informed choice. People living with dementia could be further assisted by being shown the actual food rather than just being given a verbal choice. We observed a mealtime on the dementia nursing household was well organised and people were assisted in a calm and unhurried manner. Fluids were available throughout the day, both in the lounge areas and to people in their rooms. Two people were overheard talking to each other in the dining room at coffee time mid-morning. One person said "This is a good canteen; you can get anything you like here." The other person replied, "Yes, bit like the NAAFI canteens. I like a good old chat." Six people we spoke with told us they liked the meals provided.

At our comprehensive inspection on 16, 17 and 18 December 2015 the registered person had not ensured people who use services were protected against the risks associated with insufficient training for staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our comprehensive inspection on 11 and 12 April 2017 this requirement had been met. Staff had received regular training updates and there was a clear system to monitor training and inform staff when their training was due. All new staff had completed the Care Certificate induction training. The training coordinator told us all staff completed a dementia awareness course and progressed to a two day course about supporting people living with dementia. Staff had completed a range of training to include dignity and respect, health and safety, moving and handling, infection control, fire safety, first aid and food hygiene. All night staff had also completed Assistant Fire Marshall training as the risk at night was greater with less staff. Over a quarter of the staff had completed either an NVQ level two or three and three new staff had just started a diploma in health and social care level two. Nurses and care leader completed medicine competency test every three years. The trainings coordinator told us that staff involved in minor medicine errors had to redo their medicine competency observation. Nurses had training to ensure they were updated in their professional competency in for example; wound care, catheterisation and management of a syringe driver. One staff member commented, "There is quite a lot of training, something all the time. We are all able to ask for training." A training report completed by the training coordinator on 31/3/2107 outlined improvements where moving and handling and safeguarding staff training numbers had risen. There had been a decline in bedrail training but this was being completed during our inspection.

There was a tree diagram of who was responsible for staff individual supervision meetings and a plan of when they were to be completed in each household. The individual meeting were now called 'Trust in conversations' a format for all staff to have with senior staff to replace the individual 'supervision' meetings. This was led by the individual and how they felt about their progress and what they wanted to achieve. The aim was to complete the conversations four times during a year. Some staff had insufficient supervisions in the last 12 months due to frequent management changes. This needed to improve and was in progress. One staff member commented, "I have had two supervisions since August 2016. Another staff member told us, "I haven't had a PDR (Personal Development Review) or supervision in ages. I was due one but it didn't get done."

At our comprehensive inspection on 16, 17 and 18 December 2015 the registered person had not ensured people who use services were protected by the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our comprehensive inspection on 11 and 12 April 2017 this requirement had been met. People had mental capacity assessments and best interest decisions recorded where necessary and Deprivation of Liberty Safeguards (DoLS) had been applied for where required and reviewed as directed. People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People were encouraged to make day to day decisions about the care and support they received. Staff were knowledgeable about the importance of gaining consent from people when supporting them with personal care. People's care records reminded staff to provide people with choice and options about their care. One

staff member supporting people living with dementia commented, "We never assume that people don't have capacity. Majority of them can make their own simple decisions. We give them support to do that." The records we looked at showed people had a mental capacity assessment and a 'best interest' record. The new Best Interests booklets were in place and these were fully completed.

The manager, provider and representatives of the provider ensured where someone lacked capacity to make a specific decision, mental capacity assessment and if necessary a best interest assessment was carried out. For one person a best interest decision had been made as the person no longer had the capacity to understand the risks to their health if they were to leave the service unsupervised. The provider made a Deprivation of Liberty Safeguard (DoLS) application to the local authority for this person. 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).

People's care records showed relevant health and social care professionals were involved with their care in the main. Healthcare professionals visited when required and clear records were kept of the visits. There was evidence of communication from the mental health team and palliative team and their instructions were followed. We spoke with three healthcare professional during the inspection and all three were positive about the care people received. One healthcare professional told us, "I always found the staff to be professional and wanting to work collaboratively to help manage any challenges that they may have by using a patient centred approach." Another healthcare professional told us they were impressed with the wound care and staff had alerted them when they had any concerns about wounds healing. They also told us that other healthcare professionals were involved with people they visited for example the diabetic specialist nurse and one person had been referred to the Vascular Clinic.

Good

Is the service caring?

Our findings

People had positive relationships with staff and their privacy and dignity were respected. Staff knocked on doors before entering and ensured there was privacy when people received personal care. Care staff engaged with people in a kind and compassionate manner. There was a calm and pleasant atmosphere in the home and people and staff had a good relationship. We saw that staff were friendly and respectful in their approach to people. Care staff adapted their approach and related with people according to their communication needs. For example, we observed staff assisting people with their daily needs. Care staff engaged with people in a caring and positive manner. It was clear staff knew them well and spoke of their past careers and families. They provided people who became upset with reassurance. Care staff were attentive to people's needs. For example, When people expressed that they were thirsty or hungry, care staff immediately responded and offered them a choice of drinks or food. People's choices were respected and acted upon. People had personalised their rooms with their own creature comforts and memorabilia from their own homes.

We observed care staff in a lounge engaged with two people appropriately. There was a lot of encouragement to play the game Connect with cheers and congratulations from staff to inspire people who in return displayed enjoyment. Another person sat watching a cartoon on one of the television channels saying, "I don't like cartoons they're not my cup of tea." The staff appeared caring and spoke to people politely, calmly and with clearly spoken words. The lounge was small but uncluttered with few chairs to maximize the space.

One person who had just suffered bereavement told us they felt safe in the home and the staff were, "Brilliant" and "All of them were lovely." Another person told us, "The staff are all nice and friendly." Relative comments included the following: "The care staff are second to none", "I watched the two girls this morning. So caring, you can tell they care", "Care is fantastic", "We regard it like a big family", "24/7 good care", "It's homely" and "We get peace of mind."

A person had their birthday party organised by the catering staff so their friends and relatives who had travelled a long way had a party to celebrate with them. The relative told us everyone had helped them organise the party and the maintenance person had put up balloons. They said the staff were kind and compassionate and always cheerful and made the party a great success for the person.

One relative raised concerns with us about the person's diverse needs with regard to their age and culture. The relative told us the person had been given assurances when they first came that arrangement to meet their cultural needs would be regularly met to meet people of the same age and culture outside the home. We discussed this with the manager and the provider's representative and they were looking into the concerns raised. The deputy manager had already ensured the person would be provided with the resources temporarily to meet their needs.

We spoke with one agency care staff member looking after one person and they were well informed about the person and how to support them, They also told us they would be looking after the person for their

whole shift. We observed their engagement with the person was kind and attentive.

One healthcare professional told us all the staff seemed very caring and they were very appreciative of the help the person had received from them. An incident had been managed very well with the dignity of all involved respected. They said the staff had completed the relevant risk assessments and concerns were raised appropriately with the local authority safeguarding team.

Advanced care plans included people's end of life wishes. There was input from the person and their family where possible to ensure the person's personal preferences were taken into account. One relative told us the question about end of life care came up should it arise whilst the person was there. The relative told us they had spoken to the person and they had decided there was not to be any resuscitation. The relative said the subject came up again in the six monthly review but the decision of no resuscitation was not noted in the care plan so it was made clear again and recorded.

One person was admitted for end of life care and staff had used the pathway to record their needs and the medicine prescribed by the GP was in place for when they needed it. The Provider Information Return told us external training and the National Institute for Health and Care Excellence (NICE) guidance was used to develop End of Life care for people.

A relative had commented on the Carehome website about the person's care at the end of their life. They wrote, "Beech Unit, in particular, were fantastic, they gave my mum the most wonderful care. She was only with you for a short while but the manager and team made her stay a caring and loving time. When we as a family needed to be there towards the end of mum's life, we were made to feel cared for and welcomed. We could ask no more, you were all amazing."

Good

Is the service responsive?

Our findings

People received mainly person centred care responsive to their needs. The care plans were personalised and detailed and they reflected their needs. They provided staff with information about people's backgrounds. People's levels of independence were recorded and how they liked to be supported. There were 'accessible information sheets' that recorded the basics about people specific health conditions for staff to become familiar with. One staff member said they needed to be kept updated as they worked part time and didn't have enough time to read the whole care plan. People's needs and support requirements had been recorded about most aspects of their care. Care staff kept a detailed daily record of the needs and wellbeing of people. They recorded what people had done during the day, how they had assisted them or if there had been any concerns or incidents. These records enabled all care staff to have the information they needed about people's current needs and wellbeing.

People had a six monthly review where they were encouraged to comment on their care and any improvements they wanted. Relatives were invited to the six monthly review if the person wanted them to attend. One relative told us they had just had a six monthly review with the nurse and their relative and they were able discuss any concerns they had and were told they would be looked into. People's relatives told us they were informed if their relative's needs had changed or if there were any concerns. For example, relatives were informed if there had been any accidents within the home, or if a doctor had been called to visit the person. One relative told us, "We're always kept informed, the person in charge always rings."

The provider's dementia specialist Admiral Nurse and other visiting specialists had provided guidance which staff followed for example in relation to pain management and managing people's behaviours that challenged others. The Admiral Nurse had informed the consultant of their observations with regard to the effect of certain medicine for one person. The response from the consultant was not to increase medicine and they praised staff for their observations.

Bedroom charts had been used effectively to record and manage one person's agitation. People's change position charts were complete to ensure their skin remained intact. One person at risk from urinary tract infections and taking medicine for an infection did not have a complete record of their fluid intake and output recorded on the chart and nurses had not been alerted when there was a risk. An acute care plans had been completed for one person as a response to a urinary tract infection and included a link to the long term management of continence and the planned catheter replacement.

We looked at an acute care plan for a pressure ulcer not acquired at the service. Regular photographs were taken to record the healing progress and a tissue viability specialist had supported the staff. Clear records were maintained and the healing process was exceptional due to the dedication of the nursing staff and the person had only praise for their support and intervention.

End of life medicine management was well recorded so that staff were able to respond to one person's pain with instruction from the Clinical Nurse Specialist for palliative care. The person's plan was kept under review and pain was well managed.

One person living in the dementia care household had their bedroom door painted bright red to mimic their own front door when they lived at home. The activity organiser told us this was successful as the person recognised where she lived. There were plans to improve the environment on the dementia care household to add more colour and textures for people to enjoy.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Information was recoded on a handover sheet and included the assistance people would need in the event of an emergency evacuation. One staff member told us the handover information was good when they started a shift.

The home had procedures to ensure continuity of care across services. All care files included a transfer and discharge record which was completed when people arrived. The record was updated regularly to reflect a person's changing needs and preferences. This document was provided to paramedics when a person was admitted to hospital.

There was a programme of activities provided for people six days each week. People chose what they wanted to do every day and had many activities to choose from which included going out to the local church and shops. There were no trips further afield as transport was needed. One care staff member told us they took someone to the local shoe shop to but new slippers. The activity organiser told us the increased activity staff hours had worked out well for people. One staff member told us activities for people had improved. There were several volunteers who were completing their health and social care diploma. All staff and volunteers on Maple unit had recorded the individual engagement they had with people. We discussed with the activity organiser this could be used in all households as often good engagement with people took place but was not recorded. The activity coordinator assessed records to see where people needed additional individual engagement each week. One staff member told us the activity team worked hard to provide activities and individual engagement with people.

There were records of what group activities people joined in with and what happened every day. People were asked if they wanted to join in. One relative told us they ticked the activities the person liked, as they were unable to talk, and staff ensured they were taken to the ones they liked which were musical activities and the sensory garden. The relatives told us staff also helped the person play Bingo and join in the gentle exercises. The activity coordinator told us the residential dementia household staff did things with people to engage them for example read the newspaper to people. People were making salt dough the day we visited. One relative told us the person's hobbies were making things and gardening but they were offered bingo and board games. The relatives told us they didn't think the person's interests had been considered when providing activities for them.

A 'Wish Tree' wall frieze in each household had ideas of what people wanted to do written on the leaves. Predominantly the wishes were to go out more often. Fund raising had started to provide a mini bus for the home. One member of staff told us, Some ladies would love to go out." There were plans to cover the bare walls with murals to provide interest and discussion points for people. The activity coordinator had joined an activity organisation that provided them with information about new and interesting activities they could offer people. Each household was provided with activities for staff to use to reengage with people or for people to interact with.

The April Newsletter had many coloured photos of people enjoying their activities and included what they did on special days for example Easter, Red Nose day, a Mother's day celebration and St Patricks day. Staff achievements were celebrated and people were informed of planned events. A popular event which was to be repeated was Zoolab where a snake, Iguana, rat and a hamster had visited for people to touch. The

chance to meet birds of prey and rabbits were planned.

Complaints were recorded and dealt with within time scales and to the complainant's satisfaction. There was a complaints procedure which provided all the relevant information for people and their supporters. Two relatives had recent concerns they shared with us and with the relatives permission these were shared with the manager who agreed to look into them. Complaints were investigated and responded to. The service had received four complaints in the previous 12 months. We looked at the responses the service had given and they were detailed and addressed the issues raised. The relatives we spoke with knew how to make a complaint. One complainant had recently written a letter of compliment and praised the improvements. We read three letters complimenting the staff on their care and kindness to people.

One relative told us there were are no restrictions for visiting family and friends. They said visitors can visit any time throughout the day or night, and the freedom to do so is supported and encouraged by both management and nursing staff.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection on 16, 17 and 18 December 2015 the registered person had not ensured systems and processes to monitor the service were operated effectively. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our comprehensive inspection on 11 and 12 April 2017 we found there had been some improvements and this requirement had been met. Quality assurance systems were now in place. Various audits had been completed for example; medicines, infection control, catering, and health and safety. Some audits had not taken place during 2016 as planned but since the beginning of 2017 many had been completed. However further improvements to the robustness of the process were needed. For example the action plans from the audits were not always clear to monitor progress. Some of the shortfalls found at this inspection had not been identified.. We recommend the provider seek guidance from a reputable source on maintaining robust systems for assessing quality and they are continually reviewed by the provider for effectiveness to help ensure safe care and treatment for people.

The service has been without a registered manager for more than 18 months. The provider was not complying with the registration condition with regard to having a registered manager in post. Various staff had been in charge since the last inspection and this had caused a period of instability and staff morale had been affected and their leadership was inconsistent.

The new deputy manager had been in post since October 2016 and the new manager from November 2016, both were recruited from other OSJCT services. The plan for both the managers to remain at Chestnut Court had recently been implemented and it was the manager's intention to apply for registration with CQC. One relative told us, "The management changes have been difficult."

Staff felt supported by the management team most of the time. Three staff we spoke with told us the new manager was approachable and listened to their concerns. One staff member told us their concerns regarding a safeguarding incident were not listened to by the manager. Another staff member told us, "We don't get any management support down here" and "Since (name of manager) has been here there has been some improvement. More consistency. I don't know who my line manager is at present." One staff member said, "There needs to be strong leadership, leading by example and setting standards. There isn't at present" and "We have a dementia lead, we should see them more frequently, we hardly see them," and "I don't feel we can ask for things, I think communication is poor."

The Care Quality Compliance Tool completed by the provider in August 2016 was overall 76.1% compliant, the service was short of employees on the first day of the audit. The action plan was being worked through since then with many issues completed. For example, training records in place with training booked in advance and people had recently been involved in staff interviews for the head housekeeper.

The Provider Information Return (PIR) told us about improvements planned and one was the monthly governance meetings to monitor the quality of the service which started on 6 April 2917. The minutes were

unavailable. However the range of topics discussed included; the falls report, call bell monitoring, health and safety and the training report. The risk of people being more restless towards the end of the day had been highlighted in the falls report for March 2017 and the action plan was for two households to review staff deployment. One nurse had given a progress report for the governance meeting where one household had more falls at certain times when staff were busy. They highlighted people were sometimes left unattended in the communal areas when staff were busy assisting people to bed.

The manager and the quality compliance manager looked at all individual incident and accident reports. There had been 27 accidents in March 2016. Recently a more in depth review of falls had been recorded. Two bar charts had been produced to see what time of day the falls happened and where. The minutes from the governance meeting on 6 April 2017 had not been typed up but we saw one of the actions was the deployment of 'twilight' staff in the evenings as there had been an increase in falls then.

People and their relatives or supporters were able to comment and give feedback at meetings. At a meeting in March 2017 people and their supporters commented about the inconsistency of staff. The manager told people and their supporters they try to use the same agency staff and they had reduced the use of agency staff by more than 50 percent this year. One relative was concerned about the lack of nursing staff and the manager told them they were hard to recruit and care leaders sometimes ran the households. There was always a nurse in the home and the deputy manager and the manager were both nurses and could support staff. A new nurse had just been recruited. There was a need to ensure information from people during their six monthly reviews had been actioned and completed. There had been some improvements to the dementia care units but more were planned to provide a more dementia friendly environment. This was discussed at the last inspection. It was disappointing that the improvements had not been fully completed.

Regular staff and managers meetings were held to help improve the service. A staff meeting held in February 2017 asked staff to focus on the updated action plan for improving the service which was available in each household and in the staff room. The manager said there had been good progress with the action plan but the meeting was mainly about staff annual leave and a shortage of staff in the kitchen and maintenance when staff had left. During the inspection a chef told us they were still short of staff and were just recruiting. One care staff member told us they could not attend the last meeting but other staff told them what was going on. They said, "We get told a lot but often it doesn't happen for example a sensory room not done yet or activity room not done yet."

The monthly review visits by the provider's area operations manager looked at various aspects of the service. They included health and safety, accidents, medication, nutrition and care plans. The last visit on 7 March 2017 highlighted where people were at risk from weight loss and the records were either incomplete or incorrect. Medicine issues had also been a concern. The progress of the actions completed from the provider's August Compliance audit were also looked at every month and the previous issues of concern were followed up. Some actions were identified.

The provider had some quality feedback information from an internet website. Information on the Carehome internet website told us seven people had added a review about the service in the last year and it was rated an average of 8.8 out of 10. People and relatives had commented; the care was excellent and said, "My mother spent 25 happy years in Chestnut Court and during that time was encouraged to continue her love of gardening, internally by propagating and maintaining plants, and externally growing many flowers which were greatly admired", "Care provided to my mother was professional and caring in every way. I had every confidence that her 24 hour needs were provided by trained staff " and "On visiting a friend in Chestnut Court I found it to be clean and tidy. The staff are very friendly and helpful. The food always looks inviting and good to eat. My friend has really had a wonderful time in here and I would certainly recommend

Chestnut Court to others. Going to visit my friend here has certainly changed my views on care homes." One relative told us how the manager had supported them with concerns about another organisation involved in funding the person's care.

The notice boards informed people about community services, for example advocacy and the local council safeguarding team. The provider's values were available for all to see and were; dedicated to caring, empowering individuals, respecting each other, promoting communities and securing our future.

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 People who use services were not always protected against the risks associated with the unsafe management of medicines. and People who use services and others were not always protected against the risks associated with their care. and People who use services and others were not protected against the risks associated with not meeting nutritional needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were not protected against the risks associated with abuse and incorrect moving and handling.