

Livability

Livability John Grooms 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?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This was an unannounced, comprehensive inspection visit completed on 29 and 30 October 2018.

Livability John Grooms Court is a 'care home' providing residential care to people physical, neurological and or learning disabilities. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is registered to provide care to a maximum of 29 people. There were 22 people living at the service at the time of the inspection.

The service had a registered manager in post. 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.

At our last inspection completed on 19 and 20 April 2016 we rated the service as good for all five key questions.

During this inspection, we found that risks to people were not always identified or measures put in place to mitigate them. The service was not visibly clean throughout, increasing the risk of spread of infection and cross contamination. Incidents and accidents were not always well managed or action taken in a timely way as an outcome. Some shifts did not consist of the provider's minimum staffing levels in line with their dependency tool.

Quality audits had not identified area of risk and concern found during the inspection. Care records were not consistently being recorded to reflect completion of care intervention. Not all notifiable incidents and events had been submitted CQC or the local authority safeguarding team.

Staff received the necessary training for their roles and plans were in place for staff to attend refresher and role specific courses where applicable. People's mental capacity was assessed, with best interest's decision making in consultation with relatives and other professionals, however this needed to be incorporated more into people's care plans.

Staff supported people to maintain choice, control and involvement in their care and daily routine. Care plans indicated people's individual preferences for showers or baths. People's care records identified individual key needs and risks, and contained guidance for staff to follow to ensure provision of consistent standards of care. People engaged with activities, education and employment onsite and in the community.

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

Risks to people were not always identified or measures put in place to mitigate them.

The service was not visibly clean throughout, increasing the risk of spread of infection and cross contamination.

Incidents and accidents were not always well managed or action taken in a timely way as an outcome.

Some shifts did not consist of the provider's minimum staffing levels in line with their dependency tool.

Is the service effective?

Good 

The service was effective

Staff received the necessary training for their roles and plans were in place for staff to attend refresher and role specific courses where applicable.

People's mental capacity was assessed, with best interest's decision making in consultation with relatives and other professionals, however this needed to be incorporated more into people's care plans.

Staff supported people to access healthcare services in a timely manner.

Is the service caring?

Good 

The service was caring

People were treated with kindness, respect, dignity and compassion.

Staff supported people to maintain choice, control and involvement in their care and daily routine.

Care plans indicated people's individual preferences for showers or baths.

Is the service responsive?

Good ●

The service was responsive

People's care records identified individual key needs and risks, and contained guidance for staff to follow to ensure provision of consistent standards of care.

People engaged with activities, education and employment onsite and in the community.

People and staff told us they felt confident to raise concerns and make complaints.

Is the service well-led?

Requires Improvement ●

The service was not always well-led

Quality audits had not identified area of risk and concern found during the inspection.

Care records were not consistently being recorded to reflect completion of care intervention.

Staffing levels were not always achieved to offer consistent standards of care.

Improvements were needed in the level of managerial oversight of incidents and accidents.

Not all notifiable incidents and events had been submitted CQC or the local authority safeguarding team.

Livability John Grooms 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 was an unannounced, comprehensive inspection, which took place on 29 and 30 October 2018. The inspection team consisted one CQC inspector.

Before the inspection, we asked the provider to complete 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 looked at information we held about the service, including previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to send us by law.

Prior to the inspection, we had received intelligence from external stakeholders, sharing concerns in relation to aspects of the service including the accuracy of risk assessments and care plans in place and staff knowledge of safeguarding procedures. Management, reporting and analysis of accidents and incidents, staffing levels and managerial oversight particularly out of hours. The provider had implemented an action plan and had shared this with CQC prior to the inspection visit. This information, along with subsequent actions taken by the provider were reviewed during this inspection.

During the inspection we spoke with five people living at the service and observed care and support being provided in communal areas. We spoke with 11 members of care staff including the registered manager, the locality manager, senior support workers, support workers, housekeeping and kitchen staff.

We reviewed four people's care records in detail including their daily records, fluid and turn charts where

applicable. We checked six people's medicine administration records (MAR) while observing part of the morning medicine round, and reviewed the medicine management procedures in place. We looked at three staff recruitment files as well as training, induction, supervision and appraisal records. We attended two shift handover meetings, and observed lunchtime meals on both days of the inspection. We reviewed policies and procedures relating to the running of the service.

Is the service safe?

Our findings

At our last inspection, completed 19 and 20 April 2016, safe was rated as Good. This was because, people were kept safe as risks had been identified, and managed appropriately. People received their medicines as prescribed and in a way, that took account of people's individual needs.

During this inspection, completed 29 and 30 October 2018, we found there were some environmental risks that needed to be addressed and had not been identified by the provider. The overall standard of care records and details around individual risk management was being reviewed by the new management team. We identified safeguarding incidents that had not been reported to the local authority safeguarding team or to CQC. We therefore rated safe as Requires Improvement.

Staff demonstrated a clear understanding of safeguarding practices and procedures, and recognising types of abuse. Staff completed mandatory safeguarding training and were booked onto refresher training as required. However, we identified incidents and safeguarding concerns that had not been reported to the local authority safeguarding team or to CQC to ensure people were kept safe.

Staff completed environmental safety audits, including infection prevention and control. However, we identified areas of the service where flooring was damaged and bathroom tiles cracked impacting on ease of keeping these areas clean. These risks had not been identified as part of the audit process.

We found one sling in poor condition, being stored with a person's hoist. We raised this as a concern with the registered manager who addressed this issue and put a replacement sling in place. We discussed the importance of staff monitoring the condition of equipment in use between maintenance visits. The registered manager confirmed arrangements were being put in place for a designated staff member to audit all equipment within the service so they were clear what each person had, its condition, who owned and maintained it.

John Grooms Court was not visibly clean throughout, with some areas including people's bathrooms and communal living areas being in need of cleaning and redecoration. Some people's bathrooms smelt musty due to poor ventilation. Some communal furniture, including seating in the dining room was stained.

We identified exposed hot water pipes in bathrooms, positioned next to toilets, sinks and in some ensuite shower rooms. This increased people's risks of experiencing burns and scalds. We requested for the management team to address these risks as a priority. These risks had not been identified in the service's environmental risk assessment.

The provider used a dependency tool to determine the level of staffing required on each shift. With a fixed minimum number of staff during the day and overnight. From reviewing rotas for four weeks leading up to the inspection, some shifts did not consist of the provider's minimum staffing levels in line with their dependency tool. Following the inspection visit, the management team provided assurances that in the event staffing levels dropped below their minimum requirement levels, they ensured a manager was present

to offer hands on care and support as needed. Staff told us they worked as a team ensuring people received consistent standards of care.

From our observations, staffing levels during the morning when assisting people with personal care, and during meal times we saw evidence of staff being unable to consistently meet the demands of their role. One staff member told us, "Staff are sometimes frazzled and overwhelmed, if short in the morning this goes across the whole of the shift. "

People told us that there had been a high turnover rate of staff. They said this impacted on the relationships built, on ease of communication and staff's knowledge of their needs. One person told us, "It is difficult building trust with new staff." Another person told us, "There are not always enough staff. Levels have gone down in the last 2-3 months, resulting in lots of waiting around for personal care. Staff taking longer to respond when I press my call bell, sometimes it takes 20 minutes for someone to come." A third person told us, "There are not enough staff at weekends, they don't get round to us quickly and it takes them [staff] longer to respond. It takes longer to get a shower when there are less staff around." From our conversations with people living at the service, no concerns were raised about staff response times overnight.

People living at the service told us of episodes where staff took a long time to respond to their call bells. Four people gave examples including times where they had been seated on the toilet for long periods of time waiting for the same gender of staff to assist them with completion of personal care tasks. We observed people waiting for over 30 minutes to eat their breakfast as they needed to have a staff member available to sit with them to monitor for risks of choking. We found one person in a distressed state, calling out for help as well as pressing their call bell. The inspector provided reassurance, went and found a member of staff to ask for their assistance, and then went back to stay with the person while waiting for a member of staff to arrive due to their level of distress. The registered manager attended to the person.

We identified that for October 2018, there had been seven medicine related incidents. From reviewing the incident forms and speaking with the registered manager, we identified consistent themes relating mainly to the same people. There were repeated episodes of people's medicines being found in or around their bed when the housekeeping team changed their bedding and cleaned their rooms. The registered manager provided assurances that these incidents had been reviewed, and it was identified that staff had been placing all people's tablets in their hands in one go. Due to changes in manual dexterity, people were accidentally dropping tablets before placing them in their mouth. The registered manager confirmed that to overcome this risk, staff had been asked to place tablets one at a time in a person's hand and ensure they had taken it before giving them another tablet. Once all tablets had been taken, staff would then sign the MAR chart as completed.

We observed part of the lunchtime medicine round being completed on the first day of the inspection. Even though the member of staff was wearing a tabard with wording on it asking staff not to disturb them due to a medicine round being in progress, we observed staff interrupting the medicine round. This increased the risk of errors occurring.

Staff demonstrated understanding of accident and incident reporting procedures. There had been 29 incidents for October 2018. Records demonstrated staff followed the procedures in place, however, we identified that the sections of the form were not being completed to demonstrate consistent managerial oversight and final sign off. We also identified some incidents that should have been reported to the local authority safeguarding team and to CQC which had not been.

For one of the care records examined, we identified that the person's care plan stipulated for staff to

monitor the condition of the skin on their legs. From reviewing daily records, this information was inconsistently recorded, and not something the person would be able to do independently. The management team were therefore unable to source assurances that the condition of this person's skin was well monitored and maintained. This concern was escalated to the management team during the inspection.

The above information meant the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had an evacuation plan in place for use in the event of an incident such as a fire. These contained clear guidance for staff to follow. Plans recognised that people living at the service may not understand or react to noises such as fire. We did note some people had a copy of their evacuation plan on the back of their bedroom door, and we identified one person's plan related to someone no longer living at the service. This was escalated to the management team to address and asked them to check room based information was correct throughout the service.

Maintenance staff completed regular legionella water safety temperature checks, flushing of the water system and had a legionella risk assessment in place for the home. The service held an up to date legionella test certificate. We did note that the maintenance staff were not recording the water temperature readings, instead ticking the box to show the date completed. We suggested to the management team that they may wish to consider recording the actual temperatures to monitor for change.

People living at the service were expected to participate in keeping their home environment clean and tidy, with support from staff. Staff accessed aprons and gloves to use when completing personal care tasks to reduce risk of cross contamination or spread of infections. The housekeeping team told us that not all people respected their living environment, and that keeping people's rooms clean and tidy when cluttered was very difficult. Housekeepers were on site in the morning during the week, therefore between their visits it was staff and people's own responsibilities to maintain the condition of the service.

People living at the service told us they felt safe living at John Grooms Court. One person told us, "I feel safe living here, having people and staff around me." Another person told us living at the service made them feel safer, "I kept having falls when I lived in my own home, staff are here to help me if I have a fall."

The new management team had reviewed people's care records and identified shortfalls in the information. To simplify things, the management team had implemented one care folder containing risks assessments and care plans relating to key aspects of people's care and support needs. They had introduced a separate healthcare folder and clipboards were in people's bedrooms where staff needed to record completion of repositioning, or monitoring food, fluid and toileting. Care records included guidance on areas of care such as the management and safety needs for people living with communication difficulties, swallowing and choking risks, moving and handling needs.

Staff checked the condition of people's skin when offering support with personal care tasks. Many of the people living at the service were at high risk of developing areas of sore skin and ulcers. From attending shift handover meetings, staff discussed any concerns relating to the condition of people's skin and sourced support from the GP service.

The management team completed risk assessments jointly with staff, which contained guidance and techniques to follow when working with people with physical and behavioural support needs. Risk assessments detailed least restrictive approaches and reflected understanding of each person to encourage

participation in their daily routine.

The service had up to date fire and electrical safety checks in place and they completed fire safety drills regularly each year. Window restrictors were in place to maintain people's safety while having the windows open.

Equipment such as hoists, slings, profiling beds, bed rails and other electrical equipment were regularly maintained by an approved company to make sure they were in a good condition to be used. We reviewed a sample of risk assessments for people who had bed rails in place, these were detailed and weighed up risks in relation to people's safety, levels of confusion, risks of getting body parts trapped within the rails, and the style of bed and mattress in use.

Employment records examined contained character references undertaken before new staff started work. This helped to ensure people's safety by employing staff who were suitable to work in the care sector. Disclosure and Barring Service (DBS) information (which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups) was held at the provider's head office.

We examined six medicines administration records (MAR) while observing part of the morning medicines round. We used these to review medicine levels and adherence to administration procedures by the staff. Staff completed medicine administration training, with regular reviews of their competence to ensure they kept up to date with current practice. A designated member of staff completed monthly medicines audits and reviewed their findings with the registered manager. On the second day of our visit, a medicine error was identified. Staff completed all relevant checks and incident forms while liaising with the registered manager.

We observed part of the morning medicines round. The staff member explained to the person what medicines they were receiving. They followed protocols in place on how they liked to be given their medicine.

Some people had medicines given on a when needed basis (PRN). Written PRN protocols were personalised and kept with the MAR charts, making them accessible for staff to follow. We discussed use of pain scales, and this was something the management team were considering further to determine what style of scale would best fit the needs of the people living at the service.

Is the service effective?

Our findings

At our last inspection, completed 19 and 20 April 2016, effective was rated as Good. This was because, people benefitted from being supported by well trained staff who felt supported in their roles. The service was meeting its responsibilities under the Mental Capacity Act 2005. At this inspection, we found the service continued to be Good in this key question.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. No people living at the service were subject to DoLS.

Health folders examined contained decision specific MCA assessments, and examples of best interests decisions involving relevant professionals and relatives. Staff recognised the importance of least restrictive practices and balancing decision making relating to risk against people's wishes and preferences. However, this information was not referred to consistently within people's care plans and risk assessments. We suggested for the management team to ensure this information linked to all relevant sections of people's care records.

Employment records, staff meeting minutes and data held by the service detailed completion of regular staff supervision sessions. Supervision offered staff the opportunity to discuss their work, receive feedback on their practice and identify training and development needs. The service encouraged staff to develop through role specific training. The new management team were in the process of implementing a new annual, performance appraisal programme as this was a shortfall identified when they started in post. Clear timescales for this to be addressed were in place.

Staff completed the provider's mandatory training through on line and face to face sessions, including safeguarding adults, mental capacity and deprivation of liberty safeguards. New staff completed the Care Certificate as part of the induction process; the Care Certificate is a set of induction standards that care workers should be working to. Since the new management team had started, they had reviewed all staff training, and where gaps had been identified an action plan to address shortfalls had been implemented. Staff demonstrated implementation of training into practice and linked this information to people's individual care and support needs.

We observed the serving of lunch on both days of the inspection. Staff offered support while encouraging people to be independent. When needed, staff monitored certain people for signs of choking in line with their individualised risk assessments. The kitchen staff drew up menu plans in consultation with people living at the service. The chef demonstrated clear understanding of people's dietary needs, methods for increasing the calorie content of foods or making changes to its consistency and thickness to prevent risks of choking. We suggested for the kitchen team to contact the local health service as guidance on food and fluid thickness and consistency has recently been updated. This would also give care staff access to up to date information.

Staff recorded people's weights, and the management team were planning to introduce use of a monitoring tool to have greater oversight of people's weights on a monthly basis. Staff worked with families and the people living at the service to encourage healthy eating choices. As the kitchen has a serving hatch that overlooks the dining room, we observed people talking to the chef with fun banter and inhouse jokes.

People gave feedback on the quality of food. One person told us, "The food is ok, my favourite is bacon carbonara and cheesecake." A second person told us, "The food is alright, especially fish and chips." A third person said, "The food is lovely, especially the trifle."

The service made onward referrals to speech and language therapists and dieticians in consultation with the GP to source specialist advice and assessments for people when needed. Staff and relatives supported people to access GP and medical appointments as needed. The service had its own vehicles to enable staff to support people with attending appointments and accessing community activities to prevent social isolation.

Accommodation was fully accessible, with widened doorways, wet rooms bathrooms and equipment to aid bathing, moving and handling and positioning. There were people carrying lifts in situ. Some accommodation was designed to be used as self-contained flats if the person was assessed to have the skills and wishes to live independently.

Is the service caring?

Our findings

At our last inspection, completed 19 and 20 April 2016, caring was rated as Good. This was because, staff had good knowledge of the people they supported and delivered care in a respectful and caring manner. Care and support was provided by staff in a way that maintained people's dignity. At this inspection, we found the service continued to be Good in this key question.

From observations of staff interaction with people, staff treated people with dignity, care and respect and were familiar with each person's care, support needs and preferences. We observed staff knocking on bedroom doors before entering. The service had policies in place to support staff with management of people's dignity in relation to protected characteristics including areas such as disability and sexuality. Staff supported people to make sure they were well presented before leaving the home to access the community.

People were encouraged to access the local community independently or with support from staff. Staff supported people to maintain their personal appearance and presentation, and encouraged people to make their own clothing choices whilst ensuring people dressed appropriately in relation to weather conditions.

People gave feedback on the care they received. One person told us, "We do what we can, we can have help with cleaning and laundry." A second person told us, "The staff are alright, they help me to get washed and dressed. There can sometimes be a long wait for a female member of staff to assist you with personal care." A third person said, "Staff assist me with keeping my apartment tidy. They help me with my personal care. I do not mind having male or female carers."

We saw staff position themselves to be at eye level with people when speaking with them. Staff called people by their preferred name, and adapted their communication techniques and approaches to accommodate people with communication and sensory difficulties. Staff gave reassurance and emotional support to people when they showed signs of distress or feeling unwell. Staff gave examples of techniques and approaches that worked well for each individual, for example use of communication books and signs.

Staff encouraged people to maintain contact with their relatives with telephone and video calls used. Staff demonstrated familiarity with each person and their relatives, and sourced feedback from people on their experiences of using the service, and suggested areas of improvement. The new management team was still getting to know some people's relatives and using engagement as an opportunity to source feedback on any areas of concern, and as a means of getting to know each other. Regular community meetings offered people the opportunity to raise concerns or share feedback. These meetings were run by volunteers involved with fundraising projects for the service.

People told us they would feel comfortable to raise concerns with staff members or the manager if they needed to. One person told us, "Community meetings are held twice a month, I would raise issues there if I needed to." Another person said, "I would tell the carers if I wanted to complain."

Staff supported people to maintain choice, control and involvement in their care and daily routine. Care records examined did not contain evidence of staff discussing them with people and their relatives to ensure incorporation of opinions into the development of their plans. This was something we suggested the registered manager may wish to consider when formulating the next set of care records on their computer system. People had personal effects in their bedrooms and choice over what to watch on television or what music they wished to listen to. People were encouraged to maintain personal hobbies and interests. One person told me about the films they enjoyed watching in the evenings.

Care plans indicated people's individual preferences for showers or baths, and staff placed value on completion of regular personal hygiene tasks to maintain people's comfort and dignity particularly where people experienced difficulties with continence management. However, some of the environmental concerns identified during this inspection could impact on the standards of care provided if these are not addressed.

Is the service responsive?

Our findings

At our last inspection, completed 19 and 20 April 2016, responsive was rated Good. This was because, care and support was provided in a personalised way that took people's wishes, needs and life histories into account. There was a wide range of social activities which was in response to what people wanted to do. At this inspection, we found the service continued to be Good in this key question.

Care plans and risk assessments had been reviewed and put in place since the new registered manager had started in post. This was due to the management team recognising the previous records were out of date. This was also in response to feedback from an audit completed by an external stakeholder. Interim care records contained key information needed for staff to provide care to people, they had not been developed collaboratively with people and their relatives due to time constraints to ensure plans were in place. Going forward, the registered manager planned to work collaboratively with people and their relatives to review information in place. Plans were person centred and holistic incorporating areas of personal importance such as people's spiritual and religious needs.

One care record contained a great piece of work that had been completed with the local church to enable a person to continue to receive holy communion, but in a thickened format to prevent risk of them choking. We observed staff providing care and support to a person to assist them to celebrate and remember the life of a deceased relative, staff were coming up with ways to make this important event special.

Where people were newly admitted to the service, or had been in hospital the registered manager completed an assessment to ensure they felt confident they could meet the person's care and support needs.

Staff, including a designated life skills co-ordinator, provided group and one to one activities, and trips into the community and to day services. People had access to activities during the evenings and at weekends and some people went off site or stayed with friends and family. Staff closely monitored risks and changes in people's abilities which could impact on their continued ability to safely access the community independently. One example of this related to reviewing a person's abilities to manage their finances while travelling independently as their ability to open their wallet had changed.

The service had introduced a new project worker with a lead role in encouraging and supporting people to be more independent and develop life skills. Whilst this role was new, the staff member was working with people to set up an onsite shop. The shop will be run by people living at the service, offering opportunities to develop skills and confidence in handling money and experience of working in a shop. The project was intended to offer people experiences that could lead to work and voluntary opportunities.

Some people living at the service went to work during the week, attended community based activities and education courses.

People gave feedback on activities and accessing the local community. One person told us, "I enjoy going

out in the car with my family." A second person told us, "I sometimes go out into town on my own. I would like there to be more activities, I sometimes get bored, I would like to do cooking and baking." A third person said, "I would like more activities and to go out with the other people living here more." A fourth person showed me the Halloween decorations in the dining room and entrance hall as they were going to have a party. A fifth person told me about their job and working during the week.

Care records contained a summary sheet for staff to review, and then detailed care records for where additional information or clarification was required. Each person had weekly activity programmes, and some people had pictorial daily planners and diaries in their bedrooms so they knew what activities they would be attending each day. The service had purchased boards to be put up in communal areas to improve communication of information such as meal plans for each day. This was as an outcome of a nutritional audit completed by the management team.

The service had received some complaints, that from the examples reviewed, had been dealt with in line with the service's policies and procedures. Information on how to make complaints was accessible for people and their relatives. The registered manager provided written responses to complainants, and gave honest feedback where things went wrong, in line with their responsibilities under the duty of candour.

People told us what they would do if they needed to make a complaint. One person told us, "I would speak with staff if I had any concerns. Issues tend to co-inside with low staffing levels." One person expressed their frustration and not feeling they were kept updated about planned improvements to internet access within the service. They told us, "They promised wi-fi we want a date, they don't keep us updated."

Care records did not contain details of people's end of life care arrangements and how they wished to be cared for at the end of their life. There were three people with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in place. There was no one in receipt of end of life care and support at the time of the inspection. We suggested for the management team to review arrangements in place and to ensure people's wishes and preferences were clearly incorporated into their care records.

Is the service well-led?

Our findings

At our last inspection, completed 19 and 20 April 2016, well-led was rated Good. People were supported by staff that were happy in their work and felt valued. The service actively involved people in the development of the service. There were auditing systems in place to ensure a good quality service was delivered.

During this inspection, completed 29 and 30 October 2018, we found examples of incidents and safeguarding concerns that the service should have notified the local authority safeguarding team and CQC about. Whilst improvements to care standards and managerial oversight were in progress, many changes implemented needed to be embedded or refined. We therefore rated well-led as Requires Improvement.

The management team and designated staff completed quality audits including monthly health and safety, infection control, daily records and medicines management. Whilst overall standards of medicines management had improved, we identified seven medicine errors linked to administration where tablets had been signed as given, but not swallowed by the person.

Infection control and environmental issues had not been identified or fully mitigated by the management team and staff to maintain people's safety.

Improvements had been made to the care records, and the new management team had ensured essential information was available for staff to follow. However, we identified the need for information detailed in the summary sheet to also be recorded in the care plans and risk assessments. For example, some summary sheets contained details of people's posture and positioning during and after eating and drinking to prevent risk of choking and aspiration. This information was not repeated in the care plan and risk assessment.

Moving and handling plans contained details of the slings staff needed to use, but not which loops on the sling staff needed to attach to the hoist to safely use the equipment. Due to the complexity of people living at the service, different loops would be needed to achieve different body positions, therefore this was very important information for staff to be aware of. The management team confirmed they were liaising with an Occupational Therapist to enable them to add this level of detail to people's plans.

Additional information needed to be recorded in people's care records to ensure their wishes and preferences in relation to end of life care and support were in place. The management team provided assurances they would action this as an outcome of the inspection.

The registered manager was completing capacity assessments rather than encouraging the senior care staff to be involved. As the lead co-ordinators for each shift, the senior care staff needed to be supported and empowered to take more of a lead role with this aspect of people's care.

The management team monitored completion of care provided to people, to ensure this was to a consistent standard. However, gaps in the recording of turning and repositioning charts, and food and fluid monitoring forms had not been identified through these checks. Some of the people living at the service had high and

complex care requirements, and relied on staff to identify and meet their needs. Based on the care records and incident reports reviewed this appeared to primarily be a recording issue. We suggested for the management team to monitor this more closely.

The provider used a dependency tool to measure staffing levels needed on each shift, in relation to the needs and complexity of people living at the service. From the staffing rotas reviewed for the four weeks prior to the inspection, there were repeated episodes during the day shifts where required staffing levels had not been achieved. From feedback received from people, this impacted on the standards of care and responsiveness of staff to meet their needs. From the four care records reviewed, we found one written entry for October 2018, to indicate that a person had been unable to attend a physiotherapy appointment due to staffing shortages. It was positive that the record showed this matter had been openly discussed with the person, but it was still evidence that staffing levels were impacting at times on aspects of care provided.

Staff were completing incident and accident forms, but from those reviewed for October 2018, many lacked evidence of managerial oversight and final sign off. This did not assure us that the incident reporting process was being followed in its entirety.

The above information meant the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff provided daily updates, and shared findings from the support provided to people during shift handover meetings. The new management team had made improvements to the handover process, with a member of the management team attending each handover meeting until satisfied staff could complete this process to the expected standards.

The decision for this level of managerial scrutiny and changes to the duration of shift handover meeting resulted from a serious incident where a person's care needs were not effectively handed over between shifts. This incident along with others relating to medicine management found from our review of records, had not been reported to the local authority safeguarding team or to CQC. The procedures in place meant staff automatically referred incidents as an 'internal safeguarding' but once reviewed, this did not result in concerns being submitted to the local authority safeguarding team. We discussed the importance of sharing concerns with the local authority safeguarding team, and seeking advice and guidance where needed.

The above information meant the provider was in breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

The new registered manager and deputy manager worked between John Grooms Court and another smaller residential service. They effectively divided their time and workload to share managerial oversight of both services. We noted that the registered manager and deputy were working a number of additional hours to drive improvement within John Grooms Court but this level of input would not be sustainable long term.

The provider had implemented support at an organisational level to support the registered manager and deputy to address shortfalls identified. It was recognised that there had been insufficient oversight of this service prior to issues being identified and plans implemented to address them.

The service had a registered manager who had been in post for three months prior to the inspection. Regular community and staff meetings were held, and the management team used feedback from people and staff, to make improvements to the service. The management team were completing regular out of hours visits and varying their shift patterns to monitor staff performance. Plans were in place for the

completion of staff performance appraisals.

Each person's care records were stored securely. This meant that they were only available to people authorised to see them and protected people's privacy.

Staff told us they worked closely as a team, to offer high and consistent standards of care to the people living at the service and their relatives. Staff morale was mainly good, and staff spoke positively about their relationship with the new management team. Staff told us the managers had an open-door policy and offered hands on support when onsite. Staff told us they felt their workload was distributed fairly, with staff helping each other when needed to ensure people received compassionate, quality care.

We observed times where staff appeared under pressure, particularly during the morning and at lunchtime. The housekeeping team identified pressures with keeping the service clean as only onsite in the mornings, during the week. This feedback was shared with the management team.

Staff demonstrated awareness of the service's whistleblowing process to enable them to report concerns or areas of unsafe practice. Staff told us they felt confident to raise any concerns without fear of reprisals. There were no whistleblowing concerns under investigation at the time of the inspection.

The provider demonstrated awareness of staff performance management processes and gave examples of procedures being implemented to address concerns in relation to individual staff members performance. There was a staff member under performance management proceedings at the time of the inspection.

The service had good links with other care homes within the wider organisation, and with health and social care professionals. The new management team were using networking opportunities to implement improvements in care provision.

Staff understood their responsibilities in relation to the duty of candour, in the management of complaints, and acknowledgement of where things needed improvement.

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 18 Registration Regulations 2009 Notifications of other incidents The care provider was not always notifying stakeholders and CQC of incidents and safeguarding concerns. Registration regulation 18 (1) (2) (a) (e)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider was not always assessing risks to people and the environment or putting measures in place to mitigate risks to keep people safe from harm. Regulation 12 (1) (2) (a) (b) (d) (e) (g) (h)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider was not always ensuring good governance processes and procedures were in place, such as quality audits and checks to improve the overall condition of the environment and standards of care provided. Regulation 17 (1) (2) (a) (b) (c) (e) (f)