The Orders Of St. John Care Trust

Windsor Street Care Centre

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

Summary of findings

Overall summary

This inspection took place on 1 and 2 December 2016 and was unannounced.

This care home was registered to accommodate up to 80 people and at the inspection there were 72 people living there. It predominantly provided care to the older person who had a physical illness or who lived with dementia. Six beds were designated to supporting people to return to their own homes following an accident, illness or surgery. These were called re-enablement beds.

People lived on different units; two of which provided nursing care and had nurses on duty. There were designated units to care for those who lived with dementia. The building was a new build when registered with the Care Quality Commission in 2013 and further adaptions had been made to meet the diverse needs of people. Each person had their own private accommodation comprising of a single bedroom, toilet with washing facilities. Each unit had its own care office, lounge area, dining room with kitchenette and communal bathrooms and toilets.

The care home's personal parking space availability could be limited but there was ample parking in the road outside. The front door was secured as were the individual units. People who were not deprived of their liberty under the Mental Capacity Act 2005 were able to leave these areas. Outside there was a secure garden which could be safely enjoyed by people who used a wheelchair or who lived with dementia.

There was a registered manager in post although at the time of the inspection they were managing another of the provider's care homes. Their deputy manager had become the care home's acting manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

During this inspection we found the provider had not ensured the accurate maintenance of some people's care and treatment records. People's care was planned with them where this was possible and relatives were able to speak on behalf of their relative and be involved in this process if needed. Care plans and other care records were not however, always fit for purpose or giving staff necessary information. This put people at risk of unsafe or inappropriate care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

We were informed by the management staff that the care home was adequately and appropriately staffed. However, challenges in the recruitment and retention of nurses had compromised the continuity of nursing care. Staff on one unit told us there were not enough allocated staff to meet people's needs. They had taken their own action to ensure people's needs were met. Agency staff were used to help meet people's needs. We recommended that the provider review their ability to safely provide nursing care under these circumstances.

Some improvements were needed to how the care home was being managed. Staff had not always felt able to raise their concerns about how some aspects of the care home had been managed.

There were systems in place to monitor the performance of the service and the standards of care. Audits were completed and an extensive action plan was seen to be in place. This process however, had not led to the accurate maintenance of some care records relating to some people's health. These shortfalls were discussed at the time of the inspection and the operations manager was going to address these.

There were arrangements in place to protect people from abuse and poor practice. Risks to people and staff were identified, managed and monitored.

The recruitment of staff was on-going and safe recruitment processes ensured people were protected from those who may not be suitable to care for them. Several new staff had recently been recruited and they were supported to gain appropriate skills and knowledge through the provider's training and support systems.

There were arrangements in place to keep the care home clean. Cleaning routines were altered when cleaning staff were not available, due to leave or sickness to ensure the environment remained clean. Infection control arrangements ensured people were protected from the risk of infection by means of cross contamination. People received their medicines safely and as prescribed. Regular reviews of people's medicines were carried out by visiting GPs. Staff and visiting health care professionals worked hard to help people who lived with dementia do this well without the unnecessary use of some medicines.

People had access to regular medical support and were referred to specialist health care professionals when needed. Staff liaised with and worked closely with visiting professionals to help meet people's varied needs. Where needed, people were provided with appropriate equipment to support them. Staff promoted independence and helped people make day to day decisions. Where people lacked mental capacity to do this, any decision made on their behalf, was made in their best interests. Staff adhered to the principles of the Mental Capacity Act 2005. People's nutritional needs were supported and they were able to make choices about what they ate and drank.

People's care was delivered in caring and compassionate way. Staff supported people in a way which maintained their dignity. People were shown respect and listened to. People were afforded privacy and information about their health, care and treatment was kept confidential. Those who mattered to people; their family members and friends were welcomed and provided with support where needed. People had opportunities to take part in social activities which were meaningful to them. There were arrangements in place for complaints and areas of dissatisfaction to be listened to and addressed.

Meetings with people and their relatives were held on a regular basis and their feedback and ideas were listened to.

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 safe although some challenges needed to be addressed to ensure it remained safe.

People lived in a clean environment and where the risk of infection and cross contamination was reduced.

People were protected from those who may not be suitable to care for them by the use of robust recruitment processes.

People received their medicines safely and as prescribed. Regular reviews of people' medicines and an individual approach to people's behaviour and needs protected them from taking unnecessary medicines.

People were protected from abuse because staff knew how to identify this and report any concerns they may have. Arrangements were also in place to identify and eradicate poor practice.

Risks to people's health and welfare and potential environmental risks were identified, managed and reduced.

Is the service effective?

Good

The service was effective. Staff ensured people's health care needs were met. People had access to specialist health care professionals when needed.

People received care and treatment from staff who had been trained to provide this.

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

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Is the service caring?

Good

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

kind and who delivered care in a compassionate way.

People's preferences and what was meaningful to them was explored so care and support could be more personalised.

People's dignity and privacy was maintained.

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

Is the service responsive?

Requires Improvement

The service was able to be responsive to people's needs but inaccurate care records potentially put people at risk of unsafe and inappropriate care and treatment.

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

People had opportunities to socialise and take part in activities. The arrangements in place helped these activities to be meaningful and to accommodate people's individual abilities.

Is the service well-led?

Requires Improvement

Some improvements were needed to how the care home was managed to ensure issues raised by staff were listened to and addressed.

There were quality monitoring arrangements in place which helped the provider and current management team identify shortfalls and make improvements but this had not always been effective in identifying areas for improvement.

Feedback from people and their relatives was actively sought and ideas and suggestions discussed in order to further improve the service.

Windsor Street Care Centre

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 1 and 2 December 2016 and was unannounced.

Prior to the inspection we reviewed the information we held about the service since the last inspection. This included a Provider Information Return (PIR). This is a form asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

The inspection was carried out by one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case needing to personally use heath care services and caring for
elderly people who live with dementia.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with eight people and three relatives about the care provided. We reviewed four people's care records which included care plans and risk assessments. We spoke with nine members of staff as well as the acting manager, deputy manager, administrator, operations manager and one of the provider's support managers. We gathered the views of two visiting health care professionals. We reviewed three staff recruitment files as well as the staff training record. We reviewed records relating to health and safety checks as well as maintenance records. We reviewed a selection of audits and the care home's current action plan for improvement.

Requires Improvement

Is the service safe?

Our findings

We looked to see if the care home was appropriately staffed and found some improvement was needed to this. One challenge for the management staff was the recruitment and retention of permanent nurses. Another challenge, for one of the nursing units, was the fast turn-over of six of its beds. People were admitted into these beds in varying numbers and with different dependency levels and needs. The six beds were used for short stay admissions for re-enablement; a period of time spent by people in the care home receiving support to gain health and skills again to be able to return to their own homes; following illness or an accident. Staff explained the frequent changes in numbers and dependency levels meant that sometimes they managed to meet people's needs and other times they struggled to do this. The acting manager confirmed the admission pattern on this unit was "busy" with "constant changes". They said people were "in and out." Staff explained there were however, people on this unit, with long term and complex needs which had to be met whatever the numbers and dependency levels of those admitted for re-enablement.

The acting manager told us they continued to make arrangements to staff the care home appropriately. These arrangements included the regular use of agency nurses and care staff and on-going recruitment. They told us they considered it to be adequately staffed. We spoke to three members of care staff who told us there were not enough staff and they found it difficult to meet people's needs on their particular unit. One member of staff was tearful and said, "There are simply not enough staff." They told us they went home worrying about things, in particular, not recording everything they should have. They said, "There's no time to do this unless you stay late and over your set hours." They told us, they and some of their colleagues had done this many times. Another member of staff also confirmed they stayed late to complete records because they were too busy during their shift to do these. Another said, "It's too much. I do not take a break in order to make sure people's needs are met." Staff were making additional arrangements to ensure people's needs were met and that relevant paperwork was completed when they were at work.

We asked people if staff were available when they needed them. One person said, "They come when I call [the call bell]." Another person said, "There are enough [staff], but there will naturally be delays when it's busy." Two other people told us they thought all the staff disappeared sometimes and that staff were sometimes "borrowed" from other areas of the care home "at busy times". They were aware agency staff were used.

We were informed that 17 new staff had recently been recruited across the care home. We met one member of staff on their first day of work. Staff were moved between units, when needed, to ensure each unit had a safe number of staff present and a member of staff suitably qualified to provide leadership. One member of staff explained their unit may start the day with enough staff and then, because cover was needed somewhere else, their unit ended up short. On one day of the inspection a planned move between units, for one member of staff had taken place. As this had been planned their unit had not been left short. The reason for their move had been to provide leadership on another unit. One agency member of staff told us the care home staff were "very welcoming".

We spoke with the operations manager about the impact of the re-enablement beds on the unit as a whole.

They confirmed staffing numbers had been increased on this unit but also said, "It's not working". They told us they would address this. The recruitment of permenant nursing staff was an on-going challenge. We observed other units, where there were less changes happening, to be working in a relaxed and unrushed way.

We recommend that the provider seek advice from an appropriate source and review staffing levels to ensure people's nursing needs are consistently met in a timley and safe way.

We asked people if they felt safe. They told us "I can't get out of bed but yes, I feel safe in bed", "It's very quiet, there are no intrusions by other residents", "There's no atmosphere of fear" and "It's not unsafe, nobody's neglected in any way."

People lived in a care home which was kept clean. However, as we visited areas of the care home, at various times of the day, for example in the morning and then later in the day, we observed some bedrooms and one communal room in particular, continued to have debris on the floor at each visit. We asked about the cleaning arrangements and we were told priority cleaning was done first, for example, a spillage of body fluid. We were told the domestic team were currently making some adjustments to the cleaning routines in order to keep the care home sufficiently clean. The areas that required vacuuming were to be addressed later in the day. During the inspection we were informed there were two cleaners on duty, two were on sick leave and one had just left. However, a relief cleaner had just been recruited and they were due to start work in the care home after their compulsory two week induction training. We asked people if they felt they lived in a clean environment. One person said, "The rooms are cleaned at least 3 times a week" and the other person said, "If you're not careful, you'll be cleaned up as well [indicating they were happy with the level of cleaning carried out around them]." Apart from the lack of vacuuming in some areas, the environment looked and smelt clean.

People were protected from the spread of infection. To avoid potential infection and cross contamination cleaning equipment was colour coded. For example, equipment used to clean toilets was not used to clean the dining rooms. Laundry was segregated and soiled items only handled once (with gloved hands) and washed separately on an appropriate temperature. Staff also wore plastic gloves and aprons when delivering care and similar protective arrangements were in use when delivering people's food. We observed hand washing in-between different people's care. We were told equipment used by care staff, for example hoists and beds, were cleaned regularly by the care staff. The equipment we saw did not look dirty.

There were arrangements in place to protect people from those who may not be suitable to care for them. The recruitment files, as well as some additional electronic records, demonstrated that appropriate recruitment processes had taken place. Checks had been carried out before staff started work. These included clearances from the Disclosure and Barring Service (DBS). A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers. Employment histories had been requested and the reasons for any gaps explored with the applicant.

People received their medicines safely and records relating to medicines were maintained accurately. When we asked people about their medicines one person said, "They're good, the staff, they know what I need." Another person said, "My medication is assiduously [with great care and attention] delivered on time." Another person said, "I take medication twice a day, give or take [a few minutes] it's at the right time."

Although we observed some medicine administration, we did not inspect the full medicine system. This was

because there was evidence of frequent auditing and checks of medicine administration in each unit. Very few actions had needed to be addressed from the last audits. Medicines in use were regularly reviewed and monitored by the visiting GP. One person's care records recorded there had been regular reviews of the person's pain relief medicine by the GP to ensure the type and dose was effective. We spoke with one health care professional who told us staff were "very responsive" to the need for medicines to be regularly reviewed. Both staff in the care home and the health care professional were keen to avoid the unnecessary or inappropriate use of anti-psychotic medicines. The health care professional told us staff adapted their approach to people's care rather than request sedating types of medicines.

The acting manager explained that with the support of external health care professionals, a particular approach to people's behaviour had been adopted. Recent training and the implementation of this approach throughout the care home had helped staff have a better understanding of the behaviours people presented with. The Provider Information Request (PIR) had also explained this was something that was to be introduced throughout the care home in the next year. It said, "An in depth understanding of a resident's past history helps to understand possible reasons for the behaviours". In particular this approach helped staff support positive behaviours and manage more confidently and appropriately behaviour that challenged. This helped staff to keep people more safe.

People's care records contained risk assessments. These recorded risks to people's health and well-being. People at risk of developing pressure ulcers were provided with pressure reducing mattresses and cushions and were supported to reposition so as to relieve areas of the skin which were subjected to pressure. People's level of mobility, their ability to stand, transfer and their risk of falling were all assessed. Those at risk were provided with support to move themselves, use mobility equipment and develop more strength and balance. Specialised equipment was used by staff to move people safely when they were unable to do this independently.

The Provider Information Return (PIR) had given information about the actions planned for the next year to help prevent and reduce the numbers of falls people experienced. One recorded initiative was to introduce regular exercise sessions and provide additional support to those who required motivation to do this. We asked one activity organiser about this and its progress. They confirmed care and activity staff had worked together to identify individual people who were more at risk of falling. They had also identified the units that required more support to get people motivated and where people's mental ability was more challenged. At the time of the visit groups of people in two units in particular required additional support in this area. Activity staff had therefore decided to provide a regular music and movement session before lunch. This helped people wake up and get prepared to walk to the toilet and move into the dining area for lunch.

Other exercise sessions had also been organised throughout the week on all other units. Some were led by the activity staff and some by care staff. We were told it had been difficult to assess the exact impact of this action on people because of the ever changing numbers of people being admitted for short stay admissions. These numbers altered dramatically and some people had falls identified as their main problem to be addressed. There were plans to try and evaluate the impact of these initiatives in another way which would help to provide this information.

Staff had received training on how to recognise abuse and what to do if they witnessed this or received an allegation. They told us they felt able to report any concerns they may have, as did staff employed by an agency. The acting manager shared safeguarding issues appropriately with relevant agencies who also had responsibilities in safeguarding people. For example, the local authority, the police and the Care Quality Commission. Staff whistleblowing procedures were in place and any concerns raised by staff about poor practice, taken seriously and investigated. Any continuing poor practice was managed through the

provider's relevant Human Resource (HR) policies and procedures.

People lived in an environment which was kept safe and where the provider took their responsibilities seriously. We spoke with the maintenance person about what checks and tasks they carried out in relation to this. They followed a schedule of work and kept accurate records which we reviewed. They received support and guidance from the provider's estates department to do this. Checks included, those on window restrictors, wheelchairs, fire escape routes and water temperatures. Where necessary contracts were in place with specialist companies for the general servicing and maintenance of various systems. For example, this was the case for the fire safety system, heating and water system, emergency lighting and the nurse call system. Specialist companies' also serviced equipment such as the passenger lifts and hoists used to move people. We saw checks by specialists on all utilities coming into the building; gas and electric.

Good

Is the service effective?

Our findings

People received effective care. People told us they considered their needs to be well attended to. One person said, "The GP's on call all the time [implying they could see their GP whenever they needed to]". Another person confirmed all health referrals and appointments to external health care professionals such as GPs, dentists, physiotherapists, opticians were organised for them. They said, "The management organises all that, you just tell 'em what you need." Another person said, "The local GP attends regularly, opticians can be called in or they [the staff] provide transport."

We observed the main attending GP present in the care home. This health care professional confirmed most people were registered at their surgery so they provided an "enhanced service". This meant they carried out a booked surgery at the care home every week. They told us they designated half a day a week for this, starting early in the morning and completing just after lunch time. However, they and the staff told us they were often in the care home far more frequently, reviewing people and following things up. This GP confirmed there was a good working relationship in place. One member of staff said, "He is so dedicated it's like having our own private GP". Staff confirmed they were able to discuss things and get advice from the surgery whenever needed. One health care professional said, "I have recommended this care home to colleagues [for their family members]. They said, "There is at its heart an ethos of good care provision."

The staff and people's care records confirmed the care home liaised with and worked closely with many other external health care professionals. Mental health care specialists were also frequently involved with people's care. The acting manager explained their staff and the visiting professionals were "totally committed" to "driving forward" the Department of Health's Living Well with Dementia Strategy (a national strategy introduced in 2009). They said, "We want people to live well with dementia".

People's needs were met by staff who had received relevant training to be able to meet their needs. All staff during their induction training received training which helped them support the above strategy. This had recently included training on a behaviour management approach which supported positive behaviour. All senior care staff had completed more advanced training in dementia care so they could guide and advise staff accordingly. The acting manager had completed a dementia leadership course and she led a team of dementia link workers. These staff had completed a further course which gave them skills to promote and support staff to provide better care for those who live with dementia.

All staff completed the provider's basic induction training at which point they were introduced to the provider's main policies and procedures. We spoke to one new member of staff [not care staff] who had just completed this and were now in the care home to shadow staff in their designated department. Staff who were new to care were supported to complete the care certificate. This is a framework of training and support which aimed to provide new care staff with the skills and knowledge to be able to deliver safe and effective care to a recognised standard. Following induction training and the care certificate it was the provider's expectation that staff continued to gain further qualifications in their chosen area of work and they were supported to do this. It was also written into staffs' contracts that they must attend all organised on-going update training.

People's consent was sought before care was provided and before for example, their care records were shared with other professionals and photography was used to record for example, the progress of a wound. Where people had been able to consent to living at the care home this was recorded on their admission.

When people had been unable to provide consent staff adhered to the principles and requirements of the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We therefore saw people being supported to make day to day decisions and their responses being respected. We also saw risks being managed in the least restrictive way. An example of this was the use of beds which lower almost to the floor and padded mats to protect people who were at risk of falling from their beds rather than the use of bed rails which can restrict people's movements.

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). We therefore saw completed mental capacity assessments and applications completed under DoLS for people who had not been able to consent to live at the care home, but who required the care and support this provided. As and when DoLS had been authorised by the local authority the care home had correctly notified the Care Quality Commission.

The management staff were aware of who held power of attorney on behalf of people and for what. For one person an application had been made to the Court of Protection so that a legal representative could be appointed to make decisions on their behalf in respect of their health and welfare. Staff had the support of the provider's Admiral Nurse (a specialist dementia care nurse) who can support people, their relatives and staff when MCA applications, assessments and best interests decisions needed to be completed.

People able to tell us about their meal time experiences and what they thought about the food, on the whole, had positive comments to make. These included, "There's a choice of two meals and pictures are used on the menu. There are alternatives, if you want them", "It's good to dine at a table", "The menu is slightly routine, I'd say", "I'm quite a fuss-pot, but there's usually something [on the menu] I want", "I eat in my room, my preference, as it's crowded in the dining room", "They say I'm putting on weight, so it must be good" and "Breakfast is excellent, full English."

People who needed it received support to maintain their nutritional well-being. People told us they had access to drinks during the day and we saw water jugs and glasses in reach of people when we visited each bedroom. People said, "They bring us a cup of tea, regularly" and "There's coffee, tea, biscuits, whenever you want." We also saw that most people had other soft drinks and snacks (fruit, biscuits, crisps) easily accessible to them. When we visited units where people did not have the mental ability to organise their own drinks we saw staff doing this for them and supporting them to drink these. Each unit had a kitchenette area where drinks and snacks could be organised by the staff or visitors. One member of staff said, "Visitors have access to the kitchenette in fact, they're encouraged to use it."

We observed the support people received at meal-times. Five people in one dining room were more able than others to communicate and socialise. The topic of conversation was the on-going inspection which they approved of. For these people staff acted more as waiters, checking that they were happy with their selection from the menu, serving their food and clearing up afterwards. Two other people required a little more help and encouragement, which was achieved quietly, unobtrusively and in a respectful manner. Throughout the meal the staff were observed in the kitchenette conversing in low voices so as not to intrude

on people's dining experience. Other people were served their meals in their bedrooms or assisted to eat their food whilst in bed.

On one of the units, where people lived with dementia, the dining experience was different. Staff sat and ate with people so people could mirror their actions, staff initiated and promoted social conversation and provided support where needed. One person was helped to the table and did not start to eat their meal. They were provided with small nuggets of encouragement as staff passed by. After no response to these a member of staff sat to the side of them and started eating their own lunch. They quietly encouraged the person to pick their fork up and try their food. Encouraging comments were made such as, "Oh, [name of person] the food is really lovely today" and "Try your pudding you will enjoy it." This person started to eat independently albeit slowly but the staff member remained supportive and patient. Any concerns relating to people's food and drink in-take were discussed with the GP. An example of this took place on the day of the inspection where concerns about one person's appetite were reported to the GP. They requested that staff monitor the person's in-take more closely for a few days and then review again with them.

Relatives were encouraged to get involved at meal-times if they wished to and could have a meal with their relative if they wanted to. One relative told us they visited each day to help their relative eat their food. They told us they liked to do this as it was now difficult to enjoy quality time with their relative. This was due to the person's degree of dementia they now lived with. Staff were fully aware of this and encouraged and supported this involvement.

Good

Is the service caring?

Our findings

People received care provided in a caring and compassionate way. People and all relatives spoken with said that they thought the staff were kind and compassionate. Specific comments about this included, "Extremely friendly and caring", "They're very kind, and yes", "They're just right. Very pleasant. I get on with all of them", "I've never heard any of them [staff] have a cross word for anyone", "They're so kind. Thumbs up. Wonderful", "I've never had experience of such caring" and "Their kindness is unbelievable".

People also told us they were treated with respect and dignity and were listened to. One person said, "[Names of two care staff], they're approachable and would listen [if I needed something]." Another person said, "They're attentive and thoughtful. Well-mannered." One relative said, "They treat the residents with respect, courtesy and care." Another relative said, "They are exceptionally caring staff." This relative went on to tell us how supportive the acting manager had been to them personally. They told us how they had made friends with other relatives who visited on a regular basis and they had found this helpful. They said, "The residents, staff and us [referring to the other relatives], we are like a family." Another relative who had experienced visiting other care homes explained to us that out of all the care homes they had visited, they had chosen Windsor Street for their own relative. They said, "Because they treat the residents with respect, courtesy and care."

People told us how they found the overall atmosphere. Their comments included, "Generally, we're at ease, there's a mixed social ability", "The kitchen is a hub for family visits", "Relaxed" and friendly, just right. Every day I get a good giggle." One person said, "I think I'm happier now than I ever have been."

Those who mattered to people such as relatives and friends were able to visit without restriction. One relative told us they spent many hours each day with their relative. If they [their relative] was resting they told us they talked with other people in the lounge.

We observed staff being patient, kind and giving people the time they needed. Staff recognised when people wanted to do things on their own or when they just needed to have some space. One person told us they preferred to do things themselves and at their own pace. They said, "I'm a bit of a slowcoach in the morning but they [staff] come back four or five times to make sure I'm getting up okay."

We observed people's different types of distress and confusion being responded to quickly by staff. One relative however told us this had not been their experience when they finished their visit and they advised us to watch how staff did not respond to their relative's distress. We observed the person becoming anxious and distressed as described and observed a member of staff pick up on this straightaway. They sat with them offering reassurance and remained doing so until other staff in the room were free to take over.

The Provider Information Request (PIR) told us that over the next twelve months dignity in care was to be promoted and supported further through the use of dignity champions. Staff were to sign up to dignity in care challenges and receive more training on this subject.

People's life histories, significant events and preferences were explored with people or their family members. This was done to try and personalise the support people received. To help staff have more meaningful interactions with people.

All care was delivered in private and conversations about people's care or treatment took place in private and confidentially. We observed staff being very aware of this and closing doors or moving out of hearing range of others before talking. Staff only spoke in detail about people's care and health to those who were either people's legal representatives or their nominated next of kin. Records about people were kept secure.

One member of staff told us the care home accepted people of all faiths', genders and cultural backgrounds. They told us they were not currently involved in helping to meet any diverse cultural, gender or religious needs but if this were needed they and their colleagues would do all they could to support these. All information we saw in the care home was therefore in English but could be provided in other languages if required as well as in Braille. Volunteers from a local church visited the care home every other week and provided a Church of England service for those who wished to attend. They had also brought members of their congregation to help celebrate Harvest Festival in the care home. A male voice choir had also been organised and had visited.

Requires Improvement

Is the service responsive?

Our findings

People's needs were responded to but inaccurate care records potentially put people at risk of unsafe and inappropriate care or treatment. The care plans and some associated care records on the nursing unit we visited were not accurately maintained. For example, the medication that one person took for their pain had been reviewed by their GP and altered. The relevant care plan had not been amended to reflect this change. Another care plan, for the same person, recorded they were not on any sedative type medication. Again, this had been altered and this type of medicine had been prescribed but the care plan had not been updated. Another person's wound care records were so poorly maintained we could not establish what wounds the person currently had, what had actually healed and what treatment they were still requiring. These wound care records did not appear to record care and treatment in line with the instructions given by a visiting health care professional.

Another person's care plan, relating to a specific medical condition which required daily treatment, had not been altered to accommodate a previous change in treatment and, a change that had been made on one of the inspection days. This health related care plan had not given accurate information about this treatment for some time. We spoke to staff about these records and the possible reasons for this. We were informed that it was due to a lack of poor continuity when it came to nursing staff, who were responsible for these. One visiting health care professional told us there had been a "lack of continuity in nursing care" and another said they had been concerned about "nurse's availability". One member of staff told us that on the other nursing unit a person's wounds had healed, once, their care had been managed and led by one competent and consistent nurse. We gave feedback regarding our findings, in particular the two latter health related care plans, which put people potentially at risk. Poorly maintained and inaccurate care records potentially put people at risk of receiving unsafe and inappropriate care and treatment.

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

A review of the above person's wound care needs was carried out immediately by a nurse to ensure they were receiving the care they needed. Both health care related care plans were then amended immediately to ensure staff involved in delivering care had up to date guidance about people's needs.

People told us their family members had been involved in planning their care. One person said, "It was all discussed with my daughter and my son". One relative said, "Yes, I'm involved as next-of-kin with power of attorney. Changes to the care plan are discussed and agreed with me". Two other relatives told us they had been encouraged to make their views known about the care, treatment and support provided. One relative said, "Yes, we've had a few forms to fill in".

Staff were seen to understand and be aware of people's care needs despite the inaccurate information in some care records. People's abilities and their care and treatment requirements were recorded in separate care plans and on other units these were well maintained. These provided a plan of care which provided staff and visiting health professionals with up to date information on how a person's needs were to be met.

Where there had been involvement with either the person receiving the care, a relative or representative they were more personalised.

There was information about how to make a complaint in the reception area and people and their relatives were given information about this during their admission to the care home. The information told people who a complaint should be addressed to. It explained the expected time frames in which their complaint would be acknowledged and when they would receive a final response. All people able to talk with us about this said they would be comfortable raising concerns and complaints. One relative told us the acting manager was "very approachable" and they "would have no hesitation" in discussing any concerns with her. No one we spoke with had made a complaint. One person said, "I have nothing to complain about. No reservations in saying that". Records were kept of any complaints or areas of dissatisfaction and the management team aimed to address these quickly and to people's satisfaction.

People had access to activities and social opportunities which were arranged around their likes and dislikes and their physical and mental abilities. People spoke to us about the activities provided and what they took part in. Comments included, "There is a programme of activities, they [the staff] have made an effort" and "There are two co-ordinators. There's poetry, singing, quizzes, musicians and in the summer they use the quadrangle [area in the garden]." After speaking with staff we found there was a team of six activity co-ordinators in total. Further comments included, "I go to most things I want and those I can get to", "I get out once a week, if I'm lucky, if staff are free to walk with me" and "It's busy, but they're [staff] good at entertainments, some of them are very good". One member of staff said, "Cheltenham College students come and chat to residents" and another said, "Sometimes the external walks, shopping trips take second place to the essentials of personal care."

The Provider Information Request (PIR) told us the service wished to build on its "existing activity provision for residents by offering greater choice and tailoring activities to individual preferences". To do this checklists of people's activity preferences had started to be completed. We spoke with one activity co-ordinator who was knowledgeable about different people's preferences and abilities. Activities and social opportunities were therefore provided in a way that was meaningful to the individual. Some people were able to take part in group activities and others preferred or were able to engage better on a one to one basis. The garden had been used a lot in the summer as people enjoyed getting involved with simple gardening tasks, but also enjoyed the fresh air in safe surroundings. We observed equipment on one veranda leading off a main communal area which had been used in activities through the summer. The verandas gave those who felt unable to leave their unit access to fresh air and sun. Staff told us people often had their lunch or tea on the veranda in the good weather.

Exercise based activities were promoted as part of the care home's falls prevention strategy but also because people had fed back that they enjoyed them. Cycling had been a popular subject spoken about in people's feedback so the activity staff had found equipment which could be peddled whilst sitting in an armchair. The activity co-ordinator explained each activity was evaluated to ensure people were engaged in it and enjoying it. This process also helped the team ensure people's changing abilities and preferences were identified.

External entertainers were regularly used to provide singing and music sessions as well as theatre based activities and access to different animals. We were told trips out had been limited to date because the care home had not had its own transport. However, after three years of fund raising a mini bus had been purchased. At the time of the inspection the staff were waiting for wheelchair clamps to be fitted to this. One person told us about this and they said, "They have a van, which is now being adapted for wheelchair use, ready for next summer". Visits to local community venues had taken place for example, six people had

attended a Christmas Party (provided by the provider) at a local hotel. A link with parents of babies and toddlers had proven to be very popular. Regular singing and play sessions were now held at the care home and pictures showed many people engaged in these sessions.

The activity co-ordinator told us the activity team and care staff recognised that certain times of the year were more difficult for some people. Christmas had been recognised as one of those times where for some people, memories of the past would make them sad. Some people also had no family or friends to visit at this time of the year. In response to this some of the team had planned to be on duty Christmas Day and Boxing Day. They were going to focus on spending time with those who required more social and psychological support at this time of the year.

Requires Improvement

Is the service well-led?

Our findings

Some improvements were needed to how the care home had been managed. At the time of the inspection the registered manager for Windsor Street Care Centre was temporarily managing another of the provider's care homes. They were still registered with the Care Quality Commission as the registered manager for Windsor Street and were in regular contact with the current acting manager. The deputy manager of the care home had become the temporary acting manager. They had been in this position for 10 days. The provider had ensured they were well supported to do this. For example, one of the provider's support managers was acting as the acting manager's mentor and providing management guidance. This member of staff was working in the care home during the inspection visit. The operations manager was also providing additional support and was present for part of the inspection. Support was also provided by the care home's administrator who was also a member of the care home's senior management team. Therefore, although there had been recent changes to the leadership of the care home, there was a senior management structure in place which had access to appropriate support.

Management staff used meetings to communicate with people and their relatives and staff. Management updates and expectations could be communicated and feedback received back. Not all staff spoken with told us they had felt able to communicate and give feedback. In particular this was around their concerns about staffing numbers and people's dependency levels on the nursing units. One member of staff explained why they had not raised their concerns about this. They told us this was because other staff before them had and there had been "no change". Another member of staff told us comments about this were not well received. Another member of staff told us staff morale was low because of how staff were responded to. Another member of staff told us when they had voiced their concerns, the response had been "unhelpful". We had also identified a breach of regulation and other issues relating to the nursing units. We discussed some of the above feedback with the operations manager who told us they would look into these.

There were quality monitoring arrangements in place although their effectiveness needed some improvement. There was an extensive action plan which was clearly a working document. It addressed actions and their progress, identified in various audits carried out by the staff, the provider's previous quality monitoring assessment (September 2016) and the local authorities last contract monitoring review. The acting manager had already been part of the working group who met to plan and co-ordinate actions from this action plan so they were aware of what improvements needed to be made. This showed there were organised processes in place to address shortfalls and make improvements to the service. However audits of care plans that had been completed were not as effective as they should be as they had not led to improvements in the shortfalls we identified around record keeping. Regular visits by the operations manager helped the provider be aware of what progress the service was making and what support it required.

The acting manager was known to people who lived in the care home, known to their relatives and the staff. All who knew her made positive comments. For example, "very friendly", "very helpful" and "I think she is worth her weight in gold". One relative explained how supportive they had been to them personally during

their relative's time at the care home. They were pleased they had been "made up" to acting manager and said, "She deserves it", but they also told us they had missed seeing them on the unit when they visited. They felt there was now "a gap" on their unit. One person told us, "I've had no contact with management at all. I have no means of judging". The acting manager told us they completed a daily walk around the care home so as to meet people and staff and to "get a feel" for what was happening in each area.

The acting manager had particular areas of practice they really wanted to still promote and see further embedded whilst in their current role. One was a recently piloted care approach to behaviours that could be perceived as challenging. They told us their vision was for staff to be "automatically proactive" in situations where the behaviour being exhibited could potentially become more challenging.

Meetings were held on a regular basis with people and their relatives in order to communicate with them and to receive their feedback and ideas for improvement. One of the subjects discussed had been staffing. There had been some concern in one of the meetings about the numbers of staff on duty, staff retention and how the staffing requirements were worked out. An explanation had been given, the care dependency tool had been shown and explained to them and the usage of agency staff had been discussed. This showed that the management team were prepared to answer questions directed at them and help people and their relatives to have a better understanding of some of the decisions made.

Other subjects discussed had been for example, the menus; previously discussed with people and their relatives. Now there was a new chef in position we were told there would be another meeting to introduce the chef and review the menus again. One relative said, "Focus groups have addressed food and other issues, they're not just swept aside". A new activity co-ordinator had been introduced to people and relatives and their suggestions relating to activities had been asked for. The purchase of the mini-bus had been discussed. A volunteer had offered to chair some of the meetings held for people and their relatives.

People and their relatives were also actively encouraged to give their feedback on the service in other ways. The provider had sent out satisfaction questionnaires in September 2016. We were told the information received back had not yet been collated by the provider's head-office. We were told this would be shared with people and relatives and areas for improvement and suggestions would be discussed and acted on. People and their relatives could also place their feedback comments on a website designed for this purpose which the management team then monitored. The activity team also dedicated time to talk with people and ascertain their feedback and ideas on things in a less formal manner.

Statutory Notifications of significant events taking place in the care home were correctly forwarded by the management staff to the Care Quality Commission.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Records relating to some people's care and treatment were not always accurate and up dated. These records did not always give a relevant account of the care required by the person or a clear account of what care and treatment had been provided. Regulation 17 (2) (c).