The Orders Of St. John Care Trust

OSJCT Seymour House

Inspection report

Monkton Park
Chippenham
Wiltshire
SN15 3PE

Tel: 01249653564
Website: www.osjct.co.uk

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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

OSJCT Seymour House is a 'care home'. 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. Seymour House accommodates up to 42 people in one adapted building.

This inspection took place on 11 October 2018 and was unannounced. We returned on 17 and 18 October 2018 to complete the inspection.

The service did not have 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. There was a manager in post who had submitted an application to be registered manager of the service. We will monitor this to ensure the provider meets the conditions of their registration.

Systems to assess and manage risks people faced were not effective. When plans were reviewed following incidents, staff did not always consider whether other actions were necessary to keep people safe. Reviews did not always include an assessment of why risk management plans had not worked or whether other measures were necessary to reduce the risks to the person.

Action had not been taken to manage the risks people faced from other people who used the service during periods of distress. Support plans for people had not been updated with information about the incidents or strategies for preventing similar incidents in the future.

People were not always supported to take the medicines they had been prescribed.

People had care plans in place, however, they were not always kept up to date as people's needs changed. One person had a plan in which some sections had not been completed and one person's plan contained contradictory information.

There were quality assurance systems in place. However, they were not effective and had not ensured improvements were made to the quality and safety of the service being provided.

The provider had not ensured they had always notified the Care Quality Commission of significant incidents in the home.

People said they felt safe living at Seymour House. We observed people interacting with staff in a confident and friendly way. People appeared relaxed in the company of staff and requested assistance when they needed it.

People told us they were treated well and staff were caring. We observed staff interacting with people in a friendly and respectful way. Staff respected people's choices and privacy and responded to requests for support.

Staff received a thorough induction when they started working at the home. They demonstrated a good understanding of their role and responsibilities. Staff had completed training relevant to their role.

There were group and individual meetings for people to provide feedback about their care. People were confident any complaints would be investigated and responded to.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 and the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Systems to assess and manage the risks people faced were not effective.

Medicines were not managed safely. People did not always receive the medicines they had been prescribed.

People who use the service said they said they felt safe when receiving support. Staff treated people well and responded promptly when they requested support.

Is the service effective?

Good

The service was effective.

Staff had a good understanding of the Mental Capacity Act (2005) and there were systems in place to make decisions when people did not have capacity to consent.

Staff received training to give them the skills to meet people's needs.

Staff supported people to stay healthy and worked well with specialist nurses and GPs to ensure people's health needs were met.

Is the service caring?

Good

The service was caring.

People felt they were treated well and staff were caring.

Care was delivered in a way that took account of people's individual needs and in ways that maximised their independence.

People's privacy was protected and they were treated with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not always up to date and did not always contain accurate information about their needs and the support staff should provide.

People told us they knew how to raise any concerns or complaints and were confident they would be taken seriously.

Is the service well-led?

Requires Improvement

The service was not well-led.

Systems to identify shortfalls in the service and make improvements were not effective.

Incidents were not managed effectively. Action was not taken to minimise the risk of similar incidents happening.

There was no registered manager in place.

OSJCT Seymour House

Detailed findings

Background to this inspection

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

This inspection took place on 11 October 2018 and was unannounced. We returned on 17 and 18 October 2018 to complete the inspection.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. The information shared with CQC about the incident indicated potential concerns about the management of the risk of falls. This inspection examined those risks in relation to people currently using the service.

The inspection was completed by one inspector. Before the inspection we reviewed previous inspection reports and all other information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us. We reviewed the Provider Information Record (PIR) before the inspection. The PIR was information given to us by the provider, setting out their assessment of the service and any improvements they were planning. This enabled us to ensure we were addressing potential areas of concern.

During the visit we spoke with the home manager, area operations manager, five people who use the service, two relatives, two volunteers and nine care staff We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for 10 people. We also looked at records about the management of the service.

Requires Improvement

Is the service safe?

Our findings

Systems to assess and manage risks people faced were not effective. On the first day of the inspection action had not been taken to manage the risks of people using stairs in the home following an incident in which a person was injured. We reviewed the care plans of seven people who were identified to be at risk of falls and resident in the home at the time of the inspection. All seven people had previously had falls in the home. Five of the seven people were assessed to be severely or moderately confused, due to living with dementia. The home had two staircases, that had locked doors at the top, but were open at the bottom. None of the risk management plans for these people covered the use of open stairs in the home or the possibility that people may access these stairs due to their levels of confusion.

By the second day of the inspection the provider had taken action to assess the risk of the stairs for everyone who lived at Seymour House. A sensor alarm had been placed at the bottom of both sets of stairs, which alerted staff through a pager linked to the alarm call system. During the second and third days of the inspection we observed staff responding promptly to the alarm when it was activated. The management team informed us they had ordered a gate to be made to be fitted to the bottom of both staircases. It was expected the gate would take three weeks to be manufactured and fitted, during which time the alarm system would remain in place.

Risk assessments were in place and included actions to manage the identified risks people faced. However, when plans were reviewed following incidents, staff did not always consider whether other actions were necessary to keep people safe. Examples included reviews of falls in which staff recorded the measures that were in place to prevent falls. However, no assessment was completed of why those measures had not worked or whether other measures were necessary to reduce the risks to the person.

Action had not been taken to manage to risks people faced from other people who were experiencing periods of distress and anger. The incident recording system contained reference to four incidents involving a physical altercation between people. The incident reports refer to people being hit with walking sticks and being punched. Some actions had been taken to report these incident to the local safeguarding team. However, the support plans for people had not been updated with information about the incidents or strategies for preventing a similar incident in the future.

The management team had identified a high number of errors in the management of medicines. Following this staff had received additional training and there were daily checks of the medicines records to ensure any recording errors were identified quickly. Although these actions had resulted in improvements to the medicines management systems, there were two incidents in October 2018 which resulted in people not receiving the medicines they had been prescribed. One incident occurred when staff thought a person's medicine was not in stock. The medicine was subsequently found, but the person had missed one of their prescribed doses by that point. In the other incident the balance check of a person's medicine demonstrated they had missed a dose over a seven-day period. It was not clear which dose had been missed, as the medicine administration record had been signed on each day to say the person received it. On both occasions senior staff had reported the incident to the person's GP and the person was not harmed.

Medicines held by the home were securely stored. There was a record of all medicines received into the home and disposed of. Where people were prescribed 'as required' medicines, there were protocols in place detailing when they should be administered. We discussed one issue with the manager regarding an 'as required' protocol that did not contain information about how to decide what dose of a medicine they should support a person to take. The manager said they would gain further information from the person's GP and amend the guidance, which they had completed by the end of the inspection.

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

People said they felt safe living at Seymour House. Comments included, "I'm very happy with the care provided. All the staff are lovely" and "Yes, they treat me very well. I have no concerns." People appeared relaxed in the company of staff and did not hesitate to attract their attention if they needed assistance. Staff intervened promptly when people needed assistance to stay safe, including support to move safely around the home.

Sufficient staff were available to support people. People told us there were enough staff available to provide support for them when they needed it. We observed staff responding promptly to requests for assistance and the call bells. Staff told us they were able to provide the care and support people needed. Comments included, "Staffing levels have been difficult, but they are much better now. I feel we are able to meet people's needs with the levels as they are now." The manager reported they had recruited new staff and were in the process to reviewing the way staff were deployed in the home, to increase the time staff had to provide care to people.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. They had access to information and guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. Staff told us they had received safeguarding training and we confirmed this from training records. Staff were aware of different types of abuse people may experience and the action to take if they suspected abuse was happening. They said they would report any concerns and were confident the management team would listen to them and act on their concerns. Staff were aware of the option to take concerns to agencies outside the service if they felt they were not being dealt with.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. We checked the records of two recently recruited staff, which demonstrated they had been thoroughly checked before starting work in the home.

Good

Is the service effective?

Our findings

People told us staff provided the care and support they needed. Comments included, "I am very happy with the care provided" and "Staff know what they're doing." A relative told us staff had a good understanding of people's needs.

Staff demonstrated a good understanding of people's conditions and how these affected them. This included specific information about people's dementia and periods of distress, skin care and use of specialist equipment such as hoists. Staff had worked with specialist health professionals where necessary to develop care plans, for example, community nurses and the care home liaison team.

Staff told us they received regular training to give them the skills to meet people's needs. This included an induction and a comprehensive training programme. New staff spent time shadowing experienced staff members, learning how the home's systems operated and completing the care certificate. The care certificate is a nationally agreed set of standards that sets out the knowledge, skills and behaviours expected of care staff.

Training was provided in a variety of formats, including computer based, group sessions and observations of practice. Where staff completed computer based training, they needed to pass an assessment to demonstrate their understanding of the course. Staff said the training they attended was useful and relevant to their role in the service. None of the staff identified any training they felt they needed but was not available.

The manager had a record of all training staff had attended and when refresher training was due. This was used to plan the training programme. A management review had identified a number of gaps in refresher training for staff, which they were in the process of catching up with. The manager had identified all staff who had gaps in their training record and they had been booked on courses over the following two months. Staff were supported to complete formal national qualifications in social care.

Staff told us they had regular meetings with their line manager to receive support and guidance about their work and to discuss training and development needs. Actions from these supervision sessions were recorded. The registered manager kept a record of the supervision and support sessions staff had attended, to ensure all staff received the support they needed. Staff said they received good support, which they felt had improved since the manager returned to the service. They said they were able to raise concerns at any time and the manager was open to receiving and acting on people's feedback.

People were supported to eat meals they enjoyed. Staff had consulted people and their representatives about their likes, dislikes and any specific dietary needs. Comments from people included, "The food is very good." Most people chose to eat their meals in the dining room, with others having meals in their room. During the meal there was a relaxed atmosphere, with people chatting and laughing together. People were offered a choice of plated meals. There were two main meals available, although some people chose alternatives, such as a baked potato.

People were able to see health professionals where necessary, such as their GP, specialist nurse or to attend hospital appointments. People's care plans described the support they needed to manage their health needs.

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. Staff checked with people before providing any care or support. They asked people questions in different ways to help ensure they understood the decisions they were making.

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 are called the Deprivation of Liberty Safeguards (DoLS). Applications to authorise restrictions for people had been made by the manager where necessary. Cases were kept under review and if people's capacity to make decisions changed then decisions were amended. Staff understood the importance of assessing whether a person had capacity to make a specific decision and the process they would follow if the person lacked capacity.

Good

Is the service caring?

Our findings

People told us they were treated well and staff were caring. Comments included, "Staff treat me very well. I'm very happy"; "The staff are very nice" and "All the staff are lovely." We observed staff interacting with people in a friendly and respectful way. Staff respected people's choices and privacy and responded to requests for support. We observed staff responding to people in a caring and respectful way. Staff responded promptly when people became distressed and provided reassurance and comfort to people. Staff were friendly and spoke about people in a respectful way.

In addition to responding to people's requests for support, staff spent time chatting with people and interacting socially. People appeared comfortable in the company of staff and had developed positive relationships with them. Staff ensured they spoke with people who chose to stay in their room or sit alone in one of the quieter areas of the home. This helped to ensure that people did not become socially isolated.

Staff had recorded important information about people; for example, personal history, plans for the future and important relationships. People's preferences regarding their daily support were recorded. Where people were not able to express their preferences, staff had consulted with family members to gain an understanding of what they thought their preferences would be. Staff demonstrated a good understanding of what was important to people and how they liked their care to be provided. This information was used to ensure people received support in their preferred way.

Staff communicated with people in accessible ways, which took into account any sensory impairment that affected their communication. There was clear information in people's care plans about any specific communication needs they had and support they needed from staff to ensure they understood. Examples included details of how people used verbal and non-verbal communication and how people's distress could affect their communication. Plans also contained information about aids people used, such as hearing aids and glasses.

People were supported to contribute to decisions about their care and were involved wherever possible. People and their representatives had individual meetings with staff to review how their care was going and whether any changes were needed. People told us staff consulted them about the care they needed and their preferences. There were also regular residents' and relatives' meetings, which were used to receive feedback about the service and make decisions about activities in the home.

Staff received training to ensure they understood the values of the service and how to respect people's privacy, dignity and rights. In addition, the management team completed observations of staff practice to ensure these values were being reflected in the care provided.

Requires Improvement

Is the service responsive?

Our findings

People had care plans in place, however, they were not always kept up to date and for one person some sections had been left blank. The management team had identified the need for care plans to be reviewed and updated before the inspection started. Examples included plans that had not been updated following changes to people's mobility needs or to reflect the result of consultations with their GP. One of the plans we inspected contained contradictory information, stating in one section that a person needed support from staff when they were walking, and in another section that they 'sometimes' needed staff support when walking. The management team had also identified that six monthly reviews of the care plans were not happening consistently.

Some of the plans included a one-page profile, in which people and those who know them well had set out details of what is important to them and how they want care to be provided. Where these were in place they gave staff access to information which enabled them to provide support in line with people's individual wishes and preferences. The management team had identified that work was needed to ensure these were in place for everyone.

Despite the lack of information in some of the plans, staff demonstrated a good understanding of people's needs and how they should be met. The management team had a plan of action to address the shortfalls in the care planning systems, which they expected to be completed by the end of November 2018.

People told us they could take part in activities they enjoyed. Planned events included, visiting entertainers, coffee mornings, arts and craft activities. The home had activities co-ordinators and volunteers, who spent time with people on a one to one basis. This helped to ensure people who did not want to take part in group activities did not become socially isolated. We observed staff providing company and interaction with people in their rooms and quiet areas of the home at times during the inspection.

People were confident any concerns or complaints they raised would be responded to and action would be taken to address their issue. People told us they knew how to complain and would speak to staff if there was anything they were not happy about. The service had a complaints procedure, which was provided to people when they moved in. The procedure was available in a large print and easy read versions to help ensure it was accessible to people. A relative told us they had raised concerns in the past, which had been resolved quickly.

Staff were aware of the complaints procedure and how they would address any issues people raised in line with it. Complaints received had been investigated and a response provided to the complainant.

Requires Improvement

Is the service well-led?

Our findings

The service did not have 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. The manager had submitted an application to be registered manager of the service in August 2018, which was in the process of being assessed. We will monitor this to ensure the provider meets the conditions of their registration.

The provider's quality assurance systems had not identified all the shortfalls in the service or planned how improvements would be made.

A quality improvement tool completed in October 2018 assessed that the service had met the standards it measured itself against in relation to risk management. The document stated 'Risk assessments are in place, completed and reviewed monthly and / or as needs change'. The assessment did not identify that risk management plans had not been effectively reviewed after incidents in which people were injured. The plans did not assess what further measures were needed to reduce the risk of a similar incident happening. The quality assessment tool did not identify that plans had not been updated following incidents of physical aggression between people and did not contain strategies to manage these risks.

The service had an electronic system to records accidents and incidents that happened in the home. The system required action to be taken by the management team before incidents could be closed. On the third day of the inspection the system had 25 incident that were listed as being 'open' and were awaiting management review and action before they could be closed. The incidents that remained open went back to January 2018 and related to falls, incidents of physical aggression between people and medicine errors. The failure to review these incidents and take action to manage them demonstrated a lack of management oversight of the service. Action was not being taken to assess, monitor and improve the quality of the service being provided.

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

The provider had failed to notify the Care Quality Commission of incidents they were legally required to. We saw records of four incidents between November 2017 and September 2018 that should have been reported to us, but had not been. The incidents included two occasions where staff witnessed people hitting each other and two incidents in which people alleged that another person had hit them. These incidents had been reported to the safeguarding team at Wiltshire Council. Each record stated the provider had not reported the incident to us. The manager said some of the senior staff that completed the incidents reports had not been aware that they needed to be reported to us. The provider's quality assurance systems had also failed to identify that the legal requirement to notify us of these incidents had not been met.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Although quality assurance systems had not always been effective, the management team had identified that improvements were needed. A service improvement plan had been developed and there was additional input from the area operations manager to plan how the improvements would be made.

Staff told us the service had experienced significant problems during a period of change in the management of the home. Staff said they welcomed the return of the current manager, who had previously worked at the home as the registered manager. Comments from staff included, "We are currently moving in the right direction. I am confident the improvements will be made"; "Since [the manager] has returned there has been a significant improvement"; and "She is a good manager, fair and supportive. She has a good understanding of the issues in the home."

There was a brief daily heads of department meeting, which was used to ensure everyone knew what was happening that day and make sure there was a plan to deal with any issues that had arisen. This helped to ensure there was clear communication about any changes in people's needs and the support they needed.

Personal confidential information was securely stored in locked offices and cabinets. Staff were aware of the need to ensure information remained secure. We observed staff following the home's procedures and ensuring confidential information was not left unattended or unsecured.

There were regular staff meetings, which were used to keep staff up to date and to reinforce the values of the organisation and how they expected staff to work. Staff said the manager encouraged them to raise any difficulties, was open and worked with them to solve problems.

People's views were sought through group and individual meetings. These had been used to plan social events and activities in the home. There were also meetings held for relatives, to receive feedback and let them know what was happening in the service.

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 registered person had not ensured incidents of abuse or allegations of abuse were notified to the Care Quality Commission. Regulation 18 (2) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured risks people faced were effectively assessed and managed or that people received the medicines they were prescribed. Regulation 12 (2) (a) (b) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured there were effective systems to assess, monitor and improve the quality and safety of services provided. Regulation 17 (2) (a).