The Orders Of St. John Care Trust

OSJCT Chestnut Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 16, 17 and 18 December 2015.

Chestnut Court provides nursing, residential, and respite care for up to 80 people in four separate units. Some people were living with dementia. At the time of our inspection the home was full. The home is purpose built over two floors and has secure gardens.

There was no registered manager but the home manager had already applied to become registered with us. 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 were no breaches of legal requirements at the last inspection in September 2014.

People were not always supported by sufficient staff. Two relatives, staff and a health care professional commented on the shortfall. This has required improvement.

According to the training records, which were incomplete, staff had not completed regular training updates to ensure they had sufficient knowledge to carry out their roles. Staff supervision had not been completed regularly to identify staff training needs. This has required improvement.

Staff generally lacked knowledge about the Mental Capacity Act 2005 and records were inconsistent and did not protect people with regard to consent. This has required improvement.

Quality monitoring procedures used to improve the service for people were not effective. Care plans were not always personalised and audited regularly to ensure the information was relevant. Six monthly care plan reviews usually recorded what people or their relatives said about their progress and the service but their views were unknown by the manager. This has required improvement.

The provider's area operations manager looked at various aspects of the service during the monthly review and monitored the action taken. Residents/relative meeting were held to include them in developing and improving the service. The provider also relied on comments posted on the Carehomes internet website to monitor the service

People were kept safe by staff trained to recognise signs of potential abuse and they knew what to do to safeguard people. People told us they felt safe and were very comfortable, they said, "If I stay in my room staff check if I am ok". Relatives and friends also felt that the service had a safe environment and told us, "I have been impressed by the staff and their care" and "I have only seen kindness, they [staff] are wonderful". A relative told us they felt mum was very safe in Chestnut Court.

People had access to health and social care professionals to support them when required.

People's medicines were managed safely and regular checks were made to monitor staff practice. People's medicine was reviewed by their GP or a nurse practitioner from the surgery as part of an annual review.

People were supported to have a well balanced diet that met their individual needs. We observed a variation in people's experience at mealtimes in the units. Mealtimes were relaxed but did not always engage people. There were no accessible visual menus that could be used to help people living with dementia know what meals were available.

We observed engagement between people and staff was mostly caring and kind. People appeared to be comfortable in staff presence. People indicated they were happy living in the home and with the staff that supported them. One person said, "Staff go above and beyond what their role is". Relatives were complimentary about how the staff responded to people and the relationships they had built with them. One relative described the staff as being "Kind and caring".

The new manager had been in post for just under three months when we completed the inspection visit and was well thought of by relatives and friends. They told us the new manager was very good and listened to any concerns they had. Relatives were confident their voice was heard and felt the new manager was approachable and responded well to them.

.There were good links with the local community to include the schools and the church. The service had a 'Memory Café' where people in the local community came to listen to talks about dementia and their questions were answered by the providers specialist dementia nurse. The local superstore provided refreshments for the café.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service was not consistently safe.

People's levels of care and support needs were not monitored to ensure there was sufficient staff available at all times.

People were safeguarded as staff were trained to recognise abuse and to report it.

People's medicines were managed safely and kept under review to ensure people were receiving appropriate medicines.

People were protected by thorough recruitment practices.

Is the service effective?

Requires Improvement

This service was not consistently effective.

Some staff training required updating and training records were incomplete.

There was a lack of staff knowledge of The Mental Capacity Act 2005 and the guidance with regard to consent was not consistently followed.

People had access to healthcare professionals who supported them when required.

People's dietary requirements and food preferences were generally met but there was a variation in peoples experience at mealtimes.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with compassion, dignity and respect.

Staff treated people as individuals and usually interacted with them positively.

People had advanced care plans and their end of life wishes were recorded and met.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans described how people should be supported with their daily routines but were sometimes task lead and did not reflect people's wishes.

Staff were knowledgeable about people's care needs and responded to their changing needs.

People took part in a range of activities in the home and the local community.

Relatives said they felt complaints were listened to and managed effectively.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality monitoring of the service was not always operated effectively.

The manager was accessible to staff, people and their relatives.

Regular resident meetings enabled some people to have their say about how the home was run.

OSJCT Chestnut Court

Detailed findings

Background to this inspection

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

This inspection took place on 16, 17 and 18 December 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors, an expert by experience and a specialist adviser in dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We received a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with 12 people, nine relatives/friends, the registered manager, the dementia lead, the area operations manager, two nursing staff, two team leaders and three care staff. We looked at 12 care records, three recruitment records and maintenance records. We completed a Short Observational Framework for inspection (SOFI) record in a dementia care unit. This is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe these themselves. We had a copy of the staff duty rosters, quality assurance information and an overview record of all staff training. We contacted a health care professional for their feedback about the service.

Requires Improvement

Is the service safe?

Our findings

People were not always supported by sufficient care staff to meet their needs during the day. There were three nursing care unit's with 20 people accommodated in each and one residential care unit for 20 people living with dementia. We found there were times on the residential unit when there was insufficient care staff to meet people's needs especially when they were anxious and restless. We completed a SOFI observation in the lounge area and seven people had no engagement with staff for a 20 minute period. Two people started to become frustrated with each other but staff were unaware. We recorded some good interaction with staff after the dementia lead staff member came into the lounge area. The staff completed 12 hour shifts and had to leave the unit for breaks during the afternoon. This meant there were less staff to engage with people. The manager told us improvements to the deployment of activity staff were planned to engage with people.

The provider's dependency tool to calculate staffing levels had not been used since June 2015 and was usually updated every three months or sooner if necessary. The manager told us agency staff were used regularly to ensure there were sufficient nurses. The manager tried to ensure people had staff they knew in the two dementia care units. Staff were busy and task driven and they told us it was due to a lack of staff to enable them to give personalised care at a level they thought was adequate and safe. Two relatives told us there was a shortage of staff. There was a concern raised when there had been only one nurse on duty to cover the three nursing units. A healthcare professional commented the home appeared to be short of staff when they visited regularly.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication administration records demonstrated people's medicines were being managed safely. There were policies and procedures in the safe handling and administration of medicines. Medicine given 'as required' had a protocol for staff to follow. A record of people's level of pain was recorded where required. People's medicine was reviewed by their GP or a nurse practitioner from the surgery as part of an annual review.

Team leader care staff were trained to administer medicine in all the units. After the inspection visit a healthcare professional raised concerns with CQC about a person unable to have their medicine as a nurse was unavailable. We contacted the manager and they told us that when care leaders need further assistance with assessing the administration of an "as required" medicine they can ask the advice of a nurse on duty as a safety precaution. The information given to us with regard to medicine training was incomplete and required updating. We were unable to check staff had completed and passed their learning with regard to medicine administration. A nurse told us their competency was checked a year ago for medicine management. The manager subsequently checked and all staff medicine competency checks were up to date.

People were protected against the risks of potential abuse. People told us they felt safe and were very comfortable. One person commented, "If I stay in my room staff check if I am ok". Relatives and friends also

felt that the service had a safe environment and told us, "I have been impressed by the staff and their care" and "I have only seen kindness, they [staff] are wonderful". A relative told us they felt mum was very safe in Chestnut Court and said "Mum has Alzheimer's which is getting worse, they keep her very safe, I am kept informed about what is happening. She is not on much medication now, just something to calm her as she becomes very anxious".

Staff were trained to recognise signs of potential abuse and they knew what to do to safeguard people. Some staff required an update to their training. There were clear policies and procedures for safeguarding people which included 'whistle blowing'. Whistle blowing is a term used when staff report an allegation of abuse by another staff member. We looked at three safeguarding records which included a 'whistle blower' and the correct action had been taken by the manager and procedures were followed. Staff had contacted the local safeguarding team and CQC. Notice boards around the home had information about safeguarding adults and what to do if anyone was concerned.

Safe recruitment practices were followed before new staff were employed. We checked three recruitment records where correct procedures were followed and suitable checks had been made to ensure people were safeguarded. The manager told us they had recently recruited six care staff and planned to recruit another nurse on day duty and a care staff member for night duty. The manager had asked the activity coordinator to ask people what they thought were important qualities for staff and people could join in with staff interviews if they wished. Nurse's registration with the Nursing and Midwifery Council was checked. The provider employed specific staff to complete the safety checks for the volunteers employed.

Risks to people's personal safety had been assessed and risk assessments gave staff clear advice about how to minimise risks. We looked at examples of risk assessments for people falling, their skin integrity and when people may require bed rails for their safety. Effective action plans reduced risks for people. The care plans we looked at had clear risk assessments to minimise risk to people and meet their needs. A person living with dementia had poor eyesight and the risk of falling was high. The service had identified these risks and had put measures in place to either reduce the risk of falling or at least reduce the severity of the fall, whilst still allowing the person freedom of movement. Another person identified as a high falls risk had an action plan in place effectively minimising the risk. A sensor alarm has been ordered to use for the person and monitor their movement.

Any accidents and incidents were recorded and included any further preventative measures where applicable. The area operations manager looked at individual accident records each month. The quality manager audited them monthly and analysed where and at what times they happened. An action plan was completed. At each unit meeting staff discussed concerns regarding any incidents. Health and safety and fire risk assessments were updated every six months. The maintenance person told us urgent maintenance issues were dealt with immediately and others were planned with the provider's estates manager.

There was a contingency business plan for staff to follow and know what to do in the event of service interruption for example; adverse weather conditions, power failure and IT interruption. A local place of safety was recorded with relevant contact details.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Their compliance with training was not monitored and training records were not kept up to date. We spoke with a training coordinator for the 115 staff employed. They worked part time and had recently taken over the post. The training records we looked at were incomplete and the overall training record indicated shortfalls in most staff training. The manager was unsure what training the volunteer staff had completed. A volunteer was the only person in the dining room for 15 minutes during a meal we observed.

The training coordinator told us new staff had induction training and completed computerised training before they shadowed more experienced staff. Some training was completed face to face with staff for example, moving and handling, first aid, fire safety and food hygiene. The new Care Certificate induction training was due to start in January 2016.

One staff member told us the previous training coordinator had informed them when training was due. They said they had completed Mental Capacity Act (MCA) training many years ago and needed to complete an update to this and wound care training. They said their last supervision to discuss training had been in September 2015. Another staff member told us about a recent syringe driver medicine administration training they had completed.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were guidelines for staff with regard to the Mental Capacity Act 2005 (MCA) and 'best interest' decision's. 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.

We checked whether the service was working within the principles of the MCA and whether an application had been made to the supervisory body to deprive someone of their liberty. 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). The manager had identified 40 people who they believed were restricted. There were 12 DoLS applications made to the supervisory body and the staff continued to complete the others. There were no DoLS authorised.

The dementia lead staff member demonstrated a clear understanding of the MCA and the deprivation of Liberty Safeguards (DoLS). They explained their role was to ensure all staff had the skills to use the MCA to protect people without the mental capacity to make their own decisions.

We were unable to check people's mental capacity assessments fully as we were told the records were archived monthly and could not be located. Any Lasting Power of Attorney record which may mean the attorney had registered it for personal welfare decisions was also archived. We were unable to check whether decisions made by relatives were legal decisions on their behalf. There appeared a general lack of understanding of the MCA by staff as relatives had signed consent when a 'best interest' record was required. The mental capacity assessment records used did not have a conclusion recorded and had inconsistent terms of reference to describe capacity. Staff were unable to tell us why two different phrases were used to describe a person's mental capacity and why no conclusion was recorded.

A person diagnosed with dementia had no mental capacity assessment or best interest record for a 'flu injection' and a Do not Attempt Cardio Pulmonary Resuscitation (DNACPR), both were signed by a relative. The care plan recognised the person should be encouraged to make everyday decisions but for bigger decisions a mental capacity assessment and best interest record would be needed.

A risk assessment for bedrails had been undertaken by two staff and they had both deemed the person required them to maintain their safety. The mental capacity assessment in place for using bedrails included, 'no-one identified with authority to sign consent so decision made in the persons best Interest', however, the consent for bedrails has been signed by the person's relative. The measures in place were noted to have been effective in reducing the risk and therefore minimising falls.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who required covert medicines had a mental capacity assessment and best interest record which involved the GP, family and staff. The pharmacist had advised staff with regard to administration when medicines were given covertly.

People had detailed falls risk assessments and action plans to help minimise the risk of falling. A person had fallen twice recently. The person's falls action plan described how the risk was reduced with the use of a sensory mat and bed alarm to alert staff they were beginning to mobilise. Staff we spoke with knew about the persons falls action plan. The person's eyesight was tested regularly and they needed to wear glasses, but staff told us the person often mislaid them.

People had access to health and social care professionals. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. A GP had been consulted for a person who was unsettled at night and medicine for pain and anxiety was given to help them rest.

There was a variation in people's experience at mealtimes in the units we observed. Not all units had a menu displayed. Mealtimes were relaxed but did not engage people. There were no accessible visual menus in the dementia units. A picture menu could be used to help people living with dementia know what meals were available. Staff were not deployed to sit with people and join them eating lunch which can be beneficial with a group of people. It was evident that people who were disengaged and restless would have benefitted from staff joining them for lunch.

There was a lack of visual food clues for people to choose their meal in the dementia unit we observed. People were not offered any choice of either the main meal or dessert. Meals were served on white plates which can prove difficult for people with poor eyesight and dementia. One person did not eat and staff told us they would ensure they had something later. We saw the person had sandwiches and cake during the

afternoon.

A volunteer and a staff member assisted people to eat at a pace to suit the people. Conversation between people and staff was minimal and limited to the task of assisting the person to eat in a dementia care unit. Three people on one table were independent but ate very little and one person ate nothing at all. They were only prompted to eat twice, once when staff filled up beakers of juice and again when staff came to assist the fourth person at the table to eat. The fourth person had been sat at the table for 20 minutes while other people had their meals 10 minutes earlier. A person told us they liked the roast dinner but only ate a third, their relative told us the portion size was too large.

A relative said, "Food is generally ok although there could be more variety. My only observation is that they serve up too much and there is so much waste. They monitor her food intake, she loves smoothies". A person told us "I like roast meals, traditional food".

Through discussion with staff and observations in one nursing unit it was evident staff had built a good rapport with the people. People were able to choose their meals and staff offered them choice from the menu displayed. One person had difficulty expressing their wishes so staff showed them both choices of drinks available to enable them to decide.

The chef described the procedures in place to ensure people who had special dietary needs received appropriate types of food. Meat and fish products were prepared in separate fryers and ovens. The chef also told us that in addition to the special dietary requirements detailed in the person's care plan, the kitchen also had records of individual dietary requirements to ensure people were provided with meals to meet their needs.

The dementia units were designed so that people were able to walk around without restriction. However the environment was not designed to engage people. There was no orientation to place, time, wellbeing and state of purpose for improved understanding. The date and time was incorrect at the time of our visit but was changed at lunchtime after we prompted staff.

Requires Improvement

Is the service caring?

Our findings

People told us about the staff, "X is wonderful, she is so kind and will do anything for me", "I Look forward to seeing X [staff] she is like a friend" and "They are all so nice and friendly". Staff were seen speaking to people respectfully with care and compassion. A good example seen was a member of the care staff giving compassionate support to a person who was concerned and distressed about their personal appearance and body shape following a mastectomy. The staff knew people well and demonstrated they knew their individual preferences and choices.

Staff felt they could not always be as supportive and engaged with people due to staffing numbers. Staff told us, "I know the residents well", "I take time to chat whenever I can but sometimes we haven't time" and "I wish we had more time to chat sometimes". Staff communicated effectively and used age appropriate language and demonstrated empathy by using open questions and waiting for answers and understanding. Senior staff were seen prompting junior staff if they were not communicating effectively.

When staff assisted people with their meal we observed them talking to two visitors sat in the dining room and discussing people as if they were not there which showed a lack of dignity and respect for people. Staff were not sitting with people prompting them to eat. We observed lunchtime in a dementia care unit dining room. Staff were not focused on people but were task led. For example a person held two empty beakers in the air asking for another drink. Two staff passed them by while taking trays to bedrooms and the person was ignored.

Relatives were very positive about the staff and told us, "They are lovely, they always look happy", "Great bunch, who seem to care ", "Always happy to help", and "Majority of staff are lovely". The relative was not willing to expand on the term 'majority' but said, "I have not witnessed anything of concern, but some [staff] are better than others ". A healthcare professional told us the staff were caring and had a good awareness of people's needs on a dementia unit.

We observed engagement between people and staff which was caring and kind. People appeared to be comfortable in staff presence. We saw a care assistant get down on her knees to talk to a person who said they felt really tired. The staff member told the person, "Don't worry; I'll help you to go and have a lie down on your bed". We observed another person asking for the toilet, they were told, "I'll just go and get the hoist". The staff member came back almost immediately with another member of staff and the hoist. The manoeuvre was carried out calmly and in a dignified way. One person liked to say a prayer before eating and staff supported them with this and also took part in the prayer.

Advanced care plans included people's end of life wishes. There was input from the person and their family where possible to ensure the person's personal preferences were taken into account. A person receiving end of life care had a clear care pathway where every aspect was discussed with their family and the GP to ensure the person had no pain and was comfortable. The relative was provided with a daybed and all their meals. They told us the care was marvellous and the service had kept the promise of not sending the person to hospital.

When staff engaged with people they used age appropriate language and the person's preferred term of address. Staff told us this was recorded within their care plans. Ancillary staff were also engaged with people and involved with what people were doing. We saw the housekeeping staff engaged with people supporting their activities.

Staff were observed supporting and responding to people's needs throughout the day. People were observed spending time with staff. Three people indicated they were happy living in the home and with the staff that supported them. One person stated, "Staff go above and beyond what their role is". Relatives were complimentary about how the staff responded to people and the relationships they had built with them. One relative described the staff as being "Kind and caring". The relative told us that they had seen an improvement in both their relative's health and their quality of life. They told us their relative was happy living at Chestnut Court.

Staff had received recognition for the quality of care and support they provided for people. A nurse was awarded Nurse of The Year and a member of the care staff was awarded Unsung Hero of The Year both within Order of St John Care Trust. The dementia lead member of staff had been named Inspiring Dementia Leader of the year for 2015 in a National Dementia Care Award and was Dementia Carer of the Year at the South West Great Britain Care Awards 2015. They had developed the services to involve people in the community to learn about mental health and dementia.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not always personalised. On the dementia units staff were more reliant on a perceived need and medical care rather than identifying what each person said or demonstrated as their needs. The care plans were focused on tasks not the person. Six monthly care plan reviews usually recorded what people or their relatives said about their progress and the service.

A person's care plan was contradictory as in one area the person ate and drank well and in another area they had a poor diet. The person had lost 4.1Kg in three months. The malnutrition screening tool told us the person was a medium risk for malnutrition. Without consistency people may be at a greater risk. We recommended that the service seek advice and guidance from a reputable source with regard to writing a personalised care plan.

There was a robust risk assessment in place for a person with changing mental health needs which demonstrated the service was responsive to them. However, their care plan did not reflect the persons changing needs and had not been updated since their admission. This was acknowledged by staff on the day of the inspection as an omission. The person's daily records contained a lot of information but their condition had not been monitored sufficiently to ensure the GP was informed when required.

Generally people's changing care needs were identified promptly and were reviewed with the involvement of other health and social care professionals when required. Staff confirmed any changes to people's care was discussed regularly at the shift handover process to ensure they responded to people's care and support needs consistently. Relatives we spoke with told us that they were kept informed of any changes and were given regular updates in respect of general well-being and activities their relative had taken part in.

There were care plans for specialist equipment used for people, for example specialist bathing equipment or walking aids to reduce the risks of falls. Staff confirmed they had received training on moving and handling to enable them to support people and respond to medical emergencies such as falls. This included first aid training.

People had effective care plans to maintain skin integrity and prevent pressure ulcers. Some people had acute care plans for example wound care, chest or urinary infections. We looked at a wound care plan where regular photographs had been taken to record the progress and a tissue viability specialist had supported the staff to use the correct dressings. Clear records were maintained.

Communication was prompted using the addition of 'Memory life boxes' adjacent to each person's bedroom. Staff knew peoples life stories and used the information in the memory boxes to engage with them. Staff were aware of how knowledge of peoples life histories was integral to their wellbeing, but weren't confident on their involvement. Staff said, "I think the activities organisers sort that". Another staff member told us, "I know my resident well and plan his days around his choices".

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

Activities were planned and the new manager had introduced a more defined and recordable activity schedule. This information was unavailable when we visited as Christmas activities were taking place. The activity plans were usually available on the notice boards and delivered to each person. People had opportunities to engage in activities. Activities included exercise clubs, flower arranging and chocolate tasting sessions. People were given the opportunity to make suggestions about the activities they would like to take part in. During the inspection some people attended a Christmas party one afternoon. A family member told us their relative led an active life with regular activities taking place both in the home and the local community. A relative said, "They [staff] do what they can to keep her interested, excellent activities".

Activities and staff support for people were not consistent across all units. We observed that four people on Willow dementia care unit were in the activities room without any staff support. This was raised with the team leader who responded appropriately. The staff told us the DVD's for people to watch were locked in the activity room from 3pm every day and all weekend as there were no activity staff. We were informed after the inspection that all staff could access the activity room at any time. The provider should ensure that all staff are aware of this.

A staff member told us three staff were employed as activity co-ordinators and although three units were provided with sufficient activities, more activities could be arranged for people on Willow unit. The manager told us there was a total of sixty hours of activity staff during week days only. Care staff told us they felt excluded from activities and their involvement was not welcomed. The said "Some days something happens, sometimes it doesn't" and "We don't know what activities we are having until it happens". The staff had discussed activities with the new manager and expected positive changes to increase the level of activities.

A newsletter for October 2015 had been produced to inform people and their relatives about activities completed and included photographs of people on trips in the community. People had been to Slimbridge Wildfowl Trust, a garden centre and Gloucester Cathedral. A tea dance had taken place in the home.

Relatives confirmed they knew how to complain. They had confidence in the manager to respond promptly to any concerns or suggestions made. The manager held relative meetings every three months to enable family members to make suggestions to improve the quality of the care within the home. For example, at a previous meeting, relatives had requested 'suggestion boxes' to be placed at various points throughout the home. These had been implemented by the time of the inspection. To ensure all relatives and supporters had the opportunity to express their views, the manager informed us she provided monthly drop in sessions at the weekend.

We looked at how complaints were managed. There was a clear procedure for staff to follow should a concern be raised. The manager responds to the complaints. It was evident from the complaints file the manager handled complaints effectively. The manager informed us if complainants felt their complaint was not resolved appropriately by them, they could raise the complaint with a more senior manager within the organisation. A relative told us the manager had taken their complaint seriously and it was being investigated.

We recommend that the service seek advice and guidance from a reputable source with regard to writing a

personalised care plan.

Requires Improvement

Is the service well-led?

Our findings

The systems in place to monitor the quality of care and support that people received were not fully effective. People were asked at a six monthly review about their care and any improvements they wanted and this was recorded in their care plan. However there was no collation of the information from the 80 people accommodated or an action plan for any improvements. Not all people had a record of a six monthly review completed.

Training records were incomplete and the new coordinator was unable to identify where all the shortfalls in training were. Some staff on the training record were no longer employed and some had completed training at another service. We were told the overall training records were not a valid picture of what staff had completed but all training was behind and staff required support and time to use the computer based training.

Care plans were not always personalised, there was contradictory information in some records. Care plans were not audited as planned. The care plans audited had an action plan but no date for completion. The service planned to audit eight care plans each month. We looked at two care plans audited in December 2015 and the other audits were missing.

The service although specialised in dementia care had not embedded best dementia practice into the environment of the home. There were opportunities where the environment could be enhanced. The manager was planning changes to enhance the dementia unit environment and the well-being of people.

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

The monthly review visits by the provider's area operations manager looked at various aspects of the service. They included health and safety, accidents and care plans. A July 2015 monthly review recorded the infection control audit scores for three units were between 90% and 92% and there were time scales for completion of identified actions.

The November 2015 review noted shortfalls in several care plans with regard to falls, nutrition and a pressure ulcer. Some items identified had been completed since the review, for example cleaning records were updated and there was a new carpet where a malodour was identified. The manager completed visits at night and the weekend to monitor the service. There was an on call system where staff could contact a manager at any time.

A Dining Experience meeting was held in May 2015 where the majority of the 13 people were satisfied with the food provided. Comments included. "Can we have jam tarts instead of sponge?" and "Seems the same every time [teatime] can we change"? The catering staff present said people can be offered specifics like poached egg instead at tea time and they will make jam tarts too. Caribbean food had also been provided since the meeting.

The new manager planned to complete a dining experience compliance tool where all aspects of dining would be audited. Resident /relative meetings were held and the November 2015 meeting, where 20 people attended, recorded people wanted different activities and more individual engagement. The manager told us improvements in recruitment and deployment of staff would help to address these issues.

The provider relied on some quality feedback information from an internet website. A relative told us they had completed a feedback form on the internet and went to meetings at the service when they could. Information on the Carehome internet website told us 28 people had added a review about the service in the last two years and had rated the service an average of 9.4 out of 10.

People and relatives had commented the care was excellent and said, 'My father-in-law enjoys gardening and there are many troughs for plants, so we spend time outside enjoying the outdoors and helping to plant different vegetables', 'The staff are very friendly and helpful. The food is very good and If I wanted something that wasn't on the menu I only need ask' and 'I am extremely happy with the care I receive'. There were no negative comments on the website. There were eight positive comments on NHS Choices website in the last year where a five star rating was added and relatives commented on the excellent care and support provided to people and themselves particularly where end of life care was provided.

Medicine audits were completed for all units twice in 2015 and actions identified were completed. The last audit by the supplying pharmacy was in 2012. A different pharmacy had been supplying medicines for less than 12 months. Medicine errors were recorded and the appropriate action was taken.

A staff meetings for each unit was held in November 2015 and the main issues identified were for additional staff and more activities. The manager was recruiting more staff and was looking into the improved deployment of activity staff to cover weekends and afternoons. Care planning training was mentioned and more training for staff in moving and handling. A staff member identified that meals in the dementia unit would look better on different coloured palates. Most staff were positive about their role and felt they worked as a team. The manager aimed to have a staff meeting every six weeks. Staff told us they were able to discuss their concerns at staff meetings particularly around staffing levels.

The new manager had been in post for a few months when we completed the inspection visit and was well thought of by relatives and friends. They told us the new manager was very good and listened to any concerns they had. Relatives were confident their voice was heard and felt the new manager was approachable and responded well to them.

Links had been made with the local community. The dementia lead staff member told us the dementia care vision was to promote peoples independence to make their own decisions and provide meaningful occupation. They told us the values and vision for dementia care was embedded through staff training and supervision and this was not always reflected in the care plans.

The services 'Memory Café' used volunteers to involve people in the local community. A local superstore supported the involvement of the community and provided refreshments for the café meetings. The café was a room where people from the community came to listen to guest speakers about dementia and provided an 'Ask us anything' service. The Admiral dementia specialist nurse within OSJCT responded to peoples questions. We were told this provided a local service and promoted the home. There were links with the schools who visited the home and the church where regular holy communion was offered at the home.

The providers Care and Quality Compliance Tool was completed in September 2015 and looked at all areas of the service and identified shortfalls. The servicing of equipment was up to date and completed. The

Provider information return (PIR) told us about improvements planned. For example the recruitment and development of a deputy manager and a rota co-coordinator. Further development of the senior management team and care staff roles and responsibilities was planned.

Regular managers meetings were held. The providers Care Quality Department provides knowledge of The National Institute for Health and Care Excellence (NICE) guidelines and Serious learning alerts.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who use services were not protected by the Mental Capacity Act 2005. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to monitor the service were not operated effectively. Regulation 17 (1) and (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services were not protected against the risks associated with inadequate staffing levels. Regulation 18 (1) and People who use services were not protected against the risks associated with insufficient training for staff. Regulation 18 (2) (a).