The Orders Of St. John Care Trust

OSJCT Chestnut Court

Inspection report

St James
Quedgeley
Gloucester
Gloucestershire
GL2 4WD

Tel: 01452720049
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?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected OSJCT – Chestnut Court on the 6 and 7 November 2018. OSJCT is registered to provide accommodation and nursing care to 80 older people and people living with dementia. The inspection was unannounced.

OSJCT – Chestnut Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
At the time of our inspection, 77 people were living at Chestnut Court. The care home has two floors with four separate units, each of which has their own communal spaces. Two of the units provide care for people living with dementia. The home has secure gardens which people can access as well as an internal courtyard.

We last inspected in April 2018. At the inspection in April 2018 we found the provider was not meeting a number of the regulations. We found people did not consistently receive safe care and treatment, because staff had not always assessed their risks or ensured concerns and risks were responded to appropriately. Additionally, staff did not have access to training and support. People did not have access to person centred care and stimulation which would benefit their wellbeing. The provider did not always have effective systems to monitor and improve the quality of service people received.

Following our inspection in April 2018, we issued the provider with a warning notice in relation to people's safe care and treatment. We also met with the provider during the inspection and asked them to provide us with weekly action plans regarding how they planned to improve the service people received. We rated the service as "Requires Improvement" and 'Is the service well led?' as "Inadequate" due to the inspection history of Chestnut Court that showed ongoing concerns over a period of time.

At this inspection on 6 and 7 November 2018 we found improvements had been made, however further work was still required to ensure the service was safe, effective, responsive and well led. Following this inspection, we rated the service as "Requires Improvement".

At this inspection on the 6 and 7 November 2018 there was not a registered manager in post. The manager was completing the registration process at the time of our inspection. 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.

Building and maintenance checks were completed. We found risks to people had been identified and were being managed however, care staff did not always have clear guidance regarding the needs of people whose behaviours could challenge.

There were systems and processes in place for the safe storage of medicines but people were not always receiving their medicines as prescribed. Whilst the provider was implementing systems to ensure people received their medicines as prescribed, further time and work was required to ensure this system was fully embedded and followed by care and nursing staff.

Care staff responded to people's changing needs and worked closely with healthcare professionals including people's GPs. There were enough staff deployed to ensure people's health needs were met. The provider and manager had carried out consultation work with staff to ensure they were effectively deployed to reduce agency use, ensuring people received continuity of care from familiar staff.

People's privacy and dignity was respected and protected. Visitors to the service said staff were caring. Care staff supported people in a caring and compassionate way and people's needs and choices were respected. People's care and treatment was being delivered in line with current legislation. People were supported to maintain a balanced and varied diet in accordance with their individual needs.

Staff had most of the skills they needed to meet people's needs, however staff had not always received training in relation to dementia care. Not all staff had yet received effective line management support or one to one supervision (a regular meeting with their line manager). The manager and provider were aware of these shortfalls and was taking action to address these.

People we spoke with told us the culture within the home was improving and staff said they felt able to approach the management team. People who use the service along with family members and healthcare professionals told us they felt involved with the service.

The management team and the provider were working on an action plan to address any shortfalls we found at our previous inspection and those they had identified through their own quality assurance processes. The management action plan was not always effective in driving improvements to ensure people would always receive safe and effective personalised care. Following our inspection, the area manager and registered manager provided us with a list of actions they were planning to implement to drive improvements.

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

Whilst the provider was implementing systems to ensure people received their medicines as prescribed, further time and work was required to ensure this system was fully embedded and followed by care and nursing staff.

There were enough staff deployed to meet the care needs of people.

People felt safe living at the home and staff understood their responsibilities to report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Care staff did not always have access to the training and support they needed to meet people's needs. The provider and manager were addressing these concerns.

People were supported to make day to day decisions around their care, however records regarding people's capacity to make decisions, or when decisions were made in their best interests were not always clear.

People were supported to maintain a balanced and varied diet in accordance with their individual needs and their health needs were met.

Is the service caring?

Good

The service was caring.

Staff assisted people in a caring and compassionate way.

The privacy and dignity of the people using the service were met.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records did not always show how their care had been planned to meet their individual needs

People enjoyed their life in the home and had access to activities which met their individual needs.

Concerns and complaints had been managed but lessons were not always learnt from complaints received.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

People, relatives and staff were complimentary about the leadership and management of the home and told us that this had improved.

The provider and manager were developing a positive culture in the home and staff morale was improving.

The management team and the provider were working on an action plan to address any shortfalls. However, their management action plan was not always effective in driving improvements to ensure people would always receive safe and effective personalised care.

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 was 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.

The inspection team consisted of four inspectors. We spoke with four people who used the service and six people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 16 staff members; including five care staff, a cook, two senior care staff, the dementia lead, a nurse, a lead nurse, the manager, the deputy manager, a clinical lead and two representatives of the provider. We reviewed 12 people's care files and associated records. We also reviewed staff training and recruitment records and records relating to the general management of the service.

We reviewed the information we held about the service, including action plans and evidence submitted by the provider on a weekly basis since our April 2018 inspection. We reviewed notifications about important events which the service is required to send us by law. We also spoke with two healthcare professionals and commissioners from the local authority and clinical commissioning group about the service. We did not request a Provider Information Return (PIR) prior to this inspection. 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 gathered this information during the inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2018, we found staff did not always follow safe medicine practices and people were not always protected from the risk of falls, developing pressure ulcers and choking. These concerns were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to these concerns we issued the provider with a warning notice stating they were required to take action to meet the relevant aspects of the regulation by 31 July 2018. At this inspection we found improvements had been made to the management of risks to people and the provider met the requirements of this regulation. However, care and nursing staff were still not always working to recognized good practice guidance, which placed people at risk of not receiving their medicines as prescribed. Therefore, the rating for this key question remained as "Requires Improvement".

The provider and manager had carried out audits and implemented systems to manage people's medicines. However, further work and time was needed to ensure care and nursing staff always followed these processes until they were comprehensively implemented. People did not always receive their medicines as prescribed. For example, we counted the stock of 16 people's prescribed medicines to check whether people had received all their medicines since the medicine cycle had started in October 2018. We found at times three people had missed dosages of their medicines. This meant that people had not always received their medicines as prescribed and were placed at risk of their health and wellbeing being negatively impacted. We discussed this concern with the provider and manager who were acting on these concerns as part of their medicine improvement plan and promoting staff responsibility.

Medicines were stored securely in temperature controlled facilities and there was access to locked fridges to ensure medicines that required refrigeration was stored effectively. Staff responsible for the administration of medication had been appropriately trained and supported. Some people were prescribed medicines that prevented blood clotting that placed them at risk of bleeding and bruising. These risks had been identified and plans were in place to monitor their risk of bleeding if they were to fall. The community pharmacist also supported people and staff to manage their blood thinning medicines safely.

Appropriate action was taken when people refused their medicines to ensure they remains safe. One person's health condition required them to take their medicines at specific times. This person had refused these medicines on repeated occasions, which had clearly been recorded by care staff. Care staff had discussed the impact this might have on the person's health with the person and their GP and other healthcare professionals.

Records showed that each person had a moving and handling, falls, nutritional and personal emergency evacuation plan in place. This identified how people should be evacuated in the case of a fire to minimise their risk of sustaining an injury.

We found people were protected from the risks associated with their care. People's skin care management had improved since our previous inspection in April 2018. Repositioning records for people cared for in bed had been completed consistently. These showed that staff had implemented the measures in place to

protect people with limited mobility from skin damage.

Care and nursing staff worked with healthcare professionals to ensure people's skin health were maintained. Where concerns or pressure ulcers had been identified the service sought the advice of tissue viability nurses regarding wound care and this guidance was incorporated in people's care plans. Staff ensured each wound had an acute care plan and documented the healing process of the wound. This enabled them to monitor if people's wounds were healing as well as ensure further guidance could be sought promptly if required.

We reviewed weight records for all the people living at Chestnut Court. People had been weighed regularly and risk relating to weight loss was clearly identified. Where people were at risk of weight loss, modified diets, including the use of fortified and high calories foods were in place and additional checks in place to manage their risk of becoming malnourished. However, specific details regarding the consistency of foods and fluids to prevent choking were not always clear. For example, one person's care plan only stated they required their drinks to have a soup consistency, whilst others provided clear guidance on the amount of thickening agent required for a set amount of liquid to achieve the required consistency. An observation during a mealtime demonstrated that staff knew how to prepare modified diets to meet peoples nutritional needs safely.

People's relatives and visitors told us they felt there were enough staff to meet the needs of people living in the home in a timely manner. Care staff told us there were enough staff deployed to ensure everyone received the care they needed to keep them safe. However, felt workload and the recent redeployment of staff who knew people's needs well to other areas of the building, meant sometimes they struggled to provide person scented care. One member of staff said, "I think the service is safe now. Staffing has improved, not all the way there yet, however we're covered. We're more of a team."

We spoke with a staff member from one unit who said that they had just started to work on other units and knew that this was to help reduce the need for agency staff and make best use of staff's skills across the home. They thought this was a good thing but were concerned in the short-term people might be supported by staff that were not familiar with their needs. The provider and registered manager explained that they were making these changes to the way staff were deployed to develop a consistent staff team for people in the long term. The manager told us these changes had already reduced agency usage.

People were protected from the risk of abuse. Staff had knowledge of types and signs of abuse, which included neglect. They understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to their line manager or the registered manager. One staff member said, "I would go to (registered manager)". Another staff member told us what they would do if they were unhappy with the manager's or provider's response. They said, "I am aware we can whistle blow". The registered manager had responded to any safeguarding concerns in accordance with local multi-agency safeguarding procedures.

People could be assured the premises were safe and secure. Comprehensive safety checks of the premises were regularly carried out. Fire safety checks were completed to ensure the service was safe. Fire exit routes were clear, which meant in the event of a fire people could be safely evacuated. Equipment to assist people with safe moving and handling was serviced and maintained to ensure it remained safe to use.

We observed the home was clean and cleaners were working on the different units. Infection prevention practices were followed. Care staff had a trolley with colour coded bags for laundry items so that soiled linen was kept separate from general laundry and wore personal protective equipment to prevent cross

contamination. Toilets and bathrooms looked clean and had hand-wash facilities with hand soap and paper towels. There was anti-bacterial hand gel for the use of visitors and staff throughout the home. A member of staff told us that their infection control training was up to date and a review of training records for Chestnut Court showed that 83% of staff working there had received this training with a plan in place to ensure the remaining staff would receive this training.

A review of five staff files found that the staff recruitment process was robust. Records relating to the recruitment of new staff showed relevant checks had been completed before they worked unsupervised at the service. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in April 2018, we found staff did not always receive the support they required to undertake their role effectively. While staff had received core training from the provider, their requests for additional training or professional development had not always been acted upon. These concerns were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found the provider and manager had started making improvements to ensure staff had the training and support they required. We found staff did not always have the knowledge and skills to meet the needs of people living with dementia. The manager and provider had also identified further dementia training was required and plans were in place for this to be delivered. This training and skills development in dementia care needed to be completed to ensure the service met the requirements of this regulation. We found people living with dementia did not always receive effective care and support as staff did not always have the required skills to support them appropriately. Since our last inspection the service had lost their internal dementia accreditation awarded by the provider. This was due to shortfalls we had identified at the previous inspection around staff training and person-centred care and because the dementia units were not particularly well adapted for those with dementia.

Some staff informed us they did not feel they had the skills they needed to confidently assist people living with dementia. One member of staff said, "Staff have the basic training, however they need more to work with dementia. We've got a new Head of Dementia and they are making great improvements''. Another staff member said, "I would like to do training in dementia care but I have not had chance to express this or talk about this".

Whilst completing our observations on the dementia care unit we saw how one persons' behaviour impacted on other people. We saw staff intervened to support people to keep safe, however their interventions were not always sufficient to manage risk. For example, on the dementia unit we observed a person in a wheelchair hit another person in his wheelchair and run over their foot. Whilst staff intervened there was no specific guidance in the person's care plan to help staff support the person effectively during incidents such as these. We discussed dementia training with the area manager and manager, they informed us they were reviewing the training needs of staff in this area. There was a Head of Dementia Care in post who was actively working to improve dementia care within the home. They said they wanted to improve care plans and care records in relation to dementia care and improve guidance to staff on managing behaviours that challenged. They told us they were working on an action plan to improve the quality of dementia care for people living at Chestnut Court, including dementia training.

All of the relatives we spoke with praised the care provided to their loved ones. However, some relatives told us they felt people were not always supported by staff who understood their needs and how to meet these effectively. One relative told us they were concerned that staff did not always have sufficient knowledge to support people living with Parkinson's disease effectively. They said, "Care is good but staff were not specialized enough to always understand how to support his individual needs or understand his diagnosis".

We asked the Manager to provide us with staff training records and we could see that training deemed as mandatory by the provider was in place. This included staff training in safeguarding, manual handling principles, infection control and staff were trained to respond in the event of a fire. Where there were shortfalls in staff not receiving training OSJCT had plans in place to arrange for these staff to access training.

Care staff had not always received the opportunity to routinely attend individual meetings with their manager to reflect on their practice and knowledge. Some staff had had individual meetings, others had not. We reviewed five staff files of these three showed that these staff had not received an individual supervision meeting in 2018. These staff had not received the opportunity to routinely discuss their development needs and concerns so that prompt action could be taken to provide them with any training and support they might need. We spoke with one member of the staff who told us that they had had one supervision meeting this year and all their training was up to date. However, we spoke with a nurse who said that they had not had supervision or training recently as nurses were needed on the floor. This demonstrated that although some training was available to staff, they did not always have the opportunity to access the training and supervision to help them develop their skills and meet the individual needs of people.

Staff did not always receive supervision and did not have the skills required to meet the needs of people living with dementia. This was an ongoing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Where people lacked capacity they were supported to make day to day decisions. For example, people were given a choice with regards to their meals and day to day activities. Care and nursing staff had understanding of the Mental Capacity Act and could explain their responsibilities to promote decision making. One member of staff said, "We do our best to ensure people have choices, that they can enjoy as much as possible. We would want to be treated that way.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorized and whether any conditions on such authorizations were being met.

At the time of this inspection a number of people were being deprived of their liberty to ensure they would remain safe within the home. The manager was aware of their responsibilities to ensure where people were being deprived of their liberties that an application should be made to the supervisory body. The head of dementia care had identified areas of improvement and had taken immediate action since they started in post to ensure MCA/DoLS paperwork were clearly completed for people living in the home's two dementia units.

The clinical lead told us that they were reviewing all care plans to make it clear to what extend people had been involved in developing their care plans. The new plans contained a statement at the beginning of each

plan about how the person had been involved in developing their plan. For example, where a person had been assessed as lacking the capacity to be involved in making specific decisions about care there was clear information to guide staff on the best interest decision making process.

People had access to a range of health and social care professionals to ensure they received the treatment and equipment needed to promote their health and well-being. One healthcare professional told us, "The staff are very caring here." Records confirmed people had been referred to GPs, tissue viability nurses, occupational therapists and physiotherapists. For example, one person was living with type two diabetes, which was well controlled. The person was supported with a range of medical appointments, including a diabetic review and eye screening to manage their condition. Feedback from these appointments were recorded to ensure care and nursing staff had the information they needed to meet people's health need and demonstrated that staff were able to follow the guidance given by relevant professionals.

Staff supported people to have access to food and drinks throughout the day. Staff were aware of people who had been assessed at risk of dehydration or malnutrition and the support they required to maintain their wellbeing. People were given a choice of meals that reflected their preferences.

Peoples relatives spoke positively about the food they received and felt improvements were being made to the quality and variety at mealtimes. One relative told us "Meals are varied; I am happy with the quality". The management team and the chef told us about "high tea". This was a new initiative within the home and had been received well by people who use the service and their relatives. They felt the high tea improved socialisation within the home and led to a more enjoyable experience for the people living there. Our observations of mealtimes were positive and we saw people's food were modified when needed to prevent them from choking. Where people received pureed diets, the food was attractively presented so people could see the individual components of their meal. People were given a choice of meals that reflected their preferences.

The premises were suitable to people's needs. There were areas both inside and outside of the home where people could walk to maintain their mobility. The dementia units were colourful and had a number of adaptations to help people find their way around the home and back to their bedrooms. The Head of Dementia Care had plans to develop the environment for people living with dementia further to ensure it kept them engaged and provided sufficient stimulation.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the caring nature of staff at Chestnut Court. One person said, "Care is great. I have no complaints at all about the staff" and another person told us "The staff are very good". Relatives' comments included "The carers are very good. I get involved through residents' meetings. and "There is an even-handed approach. I am happy with the level of care within the home". The atmosphere in the home was friendly, inviting and relaxed.

Staff understood what was important to people. For example, one person enjoyed a beer with their lunch time meal. The person enjoyed this drink from a special mug. We observed one member of staff, ensured their drink was prepared as they wished while they got ready for their meal. The person was grateful for this support. Care staff spoke confidently and positively about how they supported people. For example, one person was cared for in bed. Staff explained how they ensured this person did not become isolated and focused on what was important to them. One member of staff said, "We make sure we spend time with her, we hold her hand, we sing and we put on music. The local vicar also comes and visits."

We saw people's privacy and dignity being respected. Each person had their own room and en-suite toilet to promote their privacy and dignity when receiving care. We observed care staff engaging with people in a respectful way for example, we observed one member of staff assisting a person to eat their meal. The member of staff had a caring approach; explained what the food was and supported the person to eat at their own pace. We spoke with this member of staff later. They said that they thought it was "important to be caring and to work with people in a respectful way."

People enjoyed positive relationships with care staff. Throughout our inspection we observed many positive interactions between care staff and people. On one day, care staff engaged with people as they prepared for lunch. People enjoyed friendly conversation about their lunch options with staff, as well as random bouts of singing which people and staff enjoyed. We also observed staff engaging with people in a caring manner, taking time to address them with respect and to ensure transfers between wheelchair and seating were conducted with respect and dignity.

We observed people enjoying time with their relatives within the home and using the home's garden. One relative who visits daily said they always felt welcomed by staff and said, "When I want to take my wife out she will be up and ready for when I come in".

People were supported to make decisions around their care and treatment. For example, one person's care plan clearly documented their views and also their wants and wishes for daily living. We also saw that people had statements in their care plans that they had been involved in developing their plans and agree to the proposed care. Where appropriate there was information regarding people's end of life care wishes.

Where possible, staff promoted choice and respected people's wishes. For example we saw one member of staff asking people in their rooms what they wanted for lunch, provide a choice of two dishes and asking whether they wanted to eat in their room or in the dining room.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in April 2018, we found people did not always receive care which was personalised to their needs and promoted their wellbeing. These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found some improvements had been made, however further action was required to enable the provider to meet the regulations.

People's care plans provided staff with basic guidance on their dietary preferences and how they should be supported with their day to day needs. People's care plans reflected their diversity and protected characteristics under the Equality Act. Each person had a key worker who was responsible for updating and reviewing their care and risk documentation. A number of the files we looked at had not been reviewed or updated in accordance with the provider's policies. We spoke with the clinical lead who said that they were working through all the care plans and were reviewing them and this was a work in progress. This meant that all the care plans were not yet written to a consistent standard and still did not provide staff with all the information they needed to support people's needs.

We found people's care plans still did not always contain personalised information about them. For example, some of the files we looked at contained specific and detailed information about a person's life history and had "all about me" sheets whereas other files we looked at contained no such documentation. This meant there was limited information for staff about some people's background which would be important if they lived with dementia and could not independently provide this information to staff.

People's care assessments were not always current and did not always provide sufficient information for staff to know how to support people when they moved to Chestnut Court. For example, there was not detailed information about one person's known history of anxiety and associated behaviours. It was not noted how these behaviours might impact on the person, staff or others living in the home, particularly during a period of significant change for the person. Only once the person had moved in and had been living in the home for several days did staff seek information from other professionals in relation to their behaviour. This meant this person might not have received the support they needed during this unsettled time.

We found staff had identified people's needs and health concerns however, when we looked at peoples care plans where behaviours that challenge were a factor, behaviour management plans were not evident. Behaviour management plans can be used to help staff to understand and reduce behaviours that challenge thus lessening the impact on the person and other people.

People's care was not always planned holistically to ensure all factors that might impact on, for example their skin health, would be considered and supported. One person had a pressure ulcer which was recorded on a body map and they had a corresponding pressure area care plan which was monitored regularly to keep their skin healthy. The person also had a nutrition care plan but this plan did not provide staff with

guidance on how to ensure they continued to be appropriately nourished to prevent their skin from deteriorating further. This is important because the nutritional needs of people with pressure ulcers are very high and they may need extra protein, calories and vitamins and minerals, to help their wounds heal.

People did not always receive support promptly when they requested assistance to meet their individual needs. Some staff raised concerns about the system people used to call for support. Building and equipment audits identified that handsets used by staff to respond to people who had pressed their call bell and needed assistance were frequently lost or broken and often needed replacing. On one occasion we saw that staff did not attend to a person promptly. At 4.05pm on the second day of our inspection a person was in their room saying, 'help me please' repeatedly. A staff member came to see what they wanted at 4.20pm and they said that they needed the toilet. On another occasion we heard a call bell ringing for more than ten minutes. When we addressed this with a member of staff we were told that there were not enough handsets for every member of staff and staff may not have been aware that the person was calling for support. This meant that the way in which people needed to request support was not always effective in ensuring staff could provide assistance when needed. We discussed these concerns with the manager and operational support team for Chestnut Court who informed us a review of the call system was already underway and an alternative call system was being considered.

This demonstrated an ongoing breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regular activities took place within the home. Activities are important for people living in care to promote mobility, social interaction and personal well-being. The activities co-coordinators offered regular programmes of activities and these were clearly displayed throughout the home. Activities often involved the local community. On the first day of our inspection the local school was visiting for a session of singing and dancing. We also saw people planning for an event to recognise "Remembrance Day" and we heard about plans to involve the local supermarket in a carol concert planned for December. One person's relative told us ''Activities are good, we went on a day trip in the minibus recently".

We also observed examples of personalised care. We observed one member of staff assist someone to enjoy a biscuit at tea time. They told us the person enjoyed a biscuit, however due to their dietary needs they needed the biscuit to be soft. They said, "Everyone gets to enjoy a biscuit and so should they, they enjoy having a biscuit with their tea". We discussed complaints management with the manager, operations manager and the operations director.

Chestnut Court had good working relationships with a number of external agencies. There was a particularly good relationship with one of the GP surgeries and we saw evidence of the involvement of Tissue Viability nurses, Occupational Therapists, Pharmacists, Eye Care Specialists, Physiotherapists and an Admiral nurse. Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia. Chestnut Court was working closely with all of these professionals to meet the needs of the people living there. Chestnut Court had also worked closely with the Local Commissioning Team and Care Home Support Team to develop an action plan to address areas of concern.

We found that Chestnut Court were regularly reviewing complaints from people and their families. Correspondence sent to complainants showed they had received feedback about intended actions to be taken by Chestnut Court in response to their complaint. It also showed people who had made complaints had been treated fairly and with respect. One recent complaint was being investigated by the operations director. The complaints procedure was on display throughout the home and relatives knew how to make a complaint if they were unhappy with the service being provided.

One relative said "The management team are very supportive, I feel I can approach them and have my say, although I don't always get feedback on what I have said". We found Chestnut Court did not always learn lesson when things went wrong for example, where a complaint had been received regarding records being passed onto hospital staff in the event of a hospital admission we were told there had been improvements made to this process, however, one nurse and one member of staff told us there was not a clear process in place for records to be transferred to the hospital with a person. These staff also told us it was not clear who should take the lead in ensuring care records are sent to the hospital with a person. This meant that Chestnut Court did not always learn when things went wrong. We discussed this with the manager and operational lead who confirmed they were working to ensure a new system was implemented to prevent a repeat occurrence.

When people needed end of life care this was provided with dignity and respect. Care plans provided information in relation to people's end of life plans and wishes. This included information regarding their next of kin, funeral plans and Power of Attorney documentation to show who people's legal representatives were. One person had decided not to continue with further scans or treatment in relation to illness and this decision had been clearly documented and respected.

Requires Improvement

Is the service well-led?

Our findings

Chestnut Court did not have a registered manager at the time of our inspection. 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 was in the process of registering with CQC to ensure the provider met their regulatory registration requirements.

At our previous inspection in April 2018 the provider had not demonstrated that they were able to consistently meet the requirements of their registration and operate effective systems to ensure that OSJCT Chestnut Court met the requirements of the Health and Social Care Regulations. Effective actions had not always been taken to improve the quality of service people received over a period of time. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Therefore we rated this question as 'Inadequate' at the April 2018 inspection.

At this inspection we found improvements had been made and the provider met the requirements of this Regulation. The management team and the provider were working on a lengthy action plan to address the shortfalls we found at our previous inspection and those they had identified through their own quality assurance processes. However, we found this action plan was not always effective in driving improvements to ensure people would always receive safe and effective personalised care. It was not clear from the action plan what areas were to be prioritised, who was responsible for completing the improvement tasks and the timescale for completion. We found some of the improvements, for example, in relation to medicine management, training, supervision, learning from complaints, care planning and dementia care still needed to be completed before people would consistently receive good care.

Following our inspection in April 2018 changes had been made to the management team at Chestnut Court and a new manager had now been in post for a number of months. A new Deputy Manager, Clinical Lead, Bursar and Operational Manager had also been appointed. We found this new management team was having a positive impact on the culture in the home.

Staff told us the culture in the home was improving and we could see that there was a strong sense of team work (some significant improvements were being made). One staff member told us "Things have definitely improved since last time, there is now a steady management team. Staffing has improved and recent changes have led to us having more staff". A nurse we spoke with told us, "there have been some improvements in leadership, the management come and work alongside people and they go to meetings so staff know them and know what is expected of them". Staff said that the management team worked alongside staff and helped out when they are short staffed. During our inspection we saw the clinical lead helping with lunch by supporting one person to eat their lunch.

The manager had implemented daily "flash" meetings involving key personal from across the home to focus

on issues arising daily. We spoke with a care assistant who told us that since the new manager was in post and there was a clinical lead that there had been improvements, particularly with the paper work. They said that they felt clearer about what was expected of them and the direction the home was going. They thought that if all the staff worked together they could make all the improvements needed. The management team were reviewing staff deployment and the use of agency staff had reduced to ensure people were supported by staff that knew them.

Records demonstrated that the provider was open and transparent with staff, regardless of their roles, through a range of regular meetings although, some staff told us access to meetings and how minutes of these meetings are distributed could be improved.

The provider demonstrated their awareness of the Duty of Candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. The provider had been open and transparent, recognising and explaining the shortfalls that had been found at the previous CQC inspection and that the ratings from the last inspection were displayed on both the OSJCT website and within the home.

Records we reviewed showed that people and their relatives or representatives, if appropriate, were informed if peoples' health needs or condition had changed. The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. Peoples' right to privacy was respected and information held about people, within both manual and electronic records, were stored and passed to other professionals appropriately.

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 9 HSCA RA Regulations 2014 Person-centred care We found people did not always receive care which was personalised to their needs and wellbeing. Regulation 9 (3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found people living with dementia did not always receive effective care and support as staff did not always have the required skills to support them appropriately. Regulation 18 (2) (a)