The Orders Of St. John Care Trust

OSJCT Coombe End Court

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced inspection of Coombe End Court on the 22 and 23 April 2015. At the last inspection on 18 December 2013, we asked the provider to take action to make improvements in care planning. The provider said they would take action to address the breach of Regulation by 8 January 2014. At this inspection in April 2015 we found there had been some improvements but more were needed.

Coombe End Court provides accommodation to up to 60 older people. There is a unit on the ground floor which supports people living with dementia. The home is run by The Orders of St John Care Trust, a national provider of care.

A registered manager was in post with day to day management responsibility of the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

People told us they felt safe living at the home but raised concerns about staffing levels and having to wait for carers to come back after the initial call bell being answered.

Members of staff knew it was their duty to report any poor practice they witness from other staff. However, not all staff were able to show a good understanding of their responsibilities towards safeguarding people from abuse.

Risks to people's safety were assessed but they were not reviewed to ensure the actions taken were appropriate and reduced the potential of reoccurrence. For example, following a fall. People's needs were assessed and care plans were in place, but these did not always accurately reflect the care and support given or required. These care plans were not person centred as they did not give staff direction on how people liked their care to be delivered.

History has shown that this provider has not been able to maintain a consistent level of improvements and has breached regulations over time at this location.

Audits were in place to assess whether people received the care, appropriate to their needs. For example medicines, care plans and infection control. Incidents and accidents were not appropriately analysed to assess trends and patterns. Staff were not reporting all accidents to the manager. This meant the potential of these accidents reoccurring was not reduced.

Members of staff were not able to show a good understanding of the Mental Capacity Act (MCA) 2005. MCA assessments to establish people's capacity to make decisions were not undertaken. Staff did not show they were confident on how to gain consent from people who lacked capacity. This meant staff were not informed of the decisions people were able to make or how to support them in making such decisions.

Where people, who lacked capacity, were being deprived of their liberty by locked door with security codes, the service had made appropriate applications to the local authority authorising body. This was to ensure that people were only being deprived of their liberty so that they could get the care and support they needed in the least restrictive way.

DoLS authorisedation was also gained to provide essential care and treatment to people which included the use of restraint. Care plans showing regard for MCA 2005 were not in place. This meant staff were not given guidance on the restraint to be used which followed the Act and was proportionate and the least restrictive.

On the day of the inspection the staffing levels were consistent with the staffing rota. Staff told us the staffing levels were good and the rotas showed the staffing levels were constant throughout the week. However, we received comments that at the weekend, the staffing levels were lower. The registered manager acknowledged at weekends the number of housekeeping staff on duty was reduced. This meant not all of the staff's roles were covered at weekends.

New staff told us they had to complete an induction programme and had to be assessed on specific tasks before they were able to work unsupervised. Staff told us the training they received was good and refresher training was provided. One to one sessions with staff and their line managers were regular and ensured individual staff had an opportunity to discuss their concerns, professional development and training needs.

People said their meals were good and there was a choice at each mealtime. Staff said the quality of the meals had improved. We observed staff members give explanations to people in a way that people were able to understand. People selected their preferred meal from the choices shown to them by staff. Staff understood the need to promote people's independence and choice. A member of staff gave an example of how a person had been enabled to improve their ability to walk independently.

Staff told us the manager was approachable, the team worked well together and there was a "caring culture."

We made recommendations for the service to seek advice and guidance from a reputable source, about end of life care planning, managing difficult behaviours and on how to update emergency plans. This is to build on and develop its provision in these aspects of care.

We found breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

People living at the home felt safe although they felt anxious when other people entered their bedrooms uninvited. Not all members of staff showed a good understanding of their responsibilities towards safeguarding people from abuse. The staff knew it was their duty to report poor practice they may have witnessed from other staff.

Risks were assessed but the risk assessments were not analysed following an incident to prevent a reoccurrence of the incident.

Staff said the staffing levels were good but weekends the number of housekeeping staff was reduced. This may have an impact on the additional duties caring staff have to undertake.

Appropriate checks were undertaken before staff started work at the home. Candidates were considered for employment based on a completed application form and on an interview. Before employment at the home was confirmed the registered manager carried out checks on the staff's previous employment and on their criminal background.

Is the service effective?

Requires improvement 

The service was not effective.

Members of staff were not able to show a good understanding of the Mental Capacity Act (MCA) 2005. Staff did not recognise MCA assessments had to be undertaken for people with cognitive impairments such as dementia. This meant the staff were not fully aware of the decisions people were able to make, the help they needed to make these decisions and who helped them with other complex decisions.

Deprivations of Liberty Safeguards (DoLS) applications were made to the supervisory body to restrict people's freedom to leave the property. Applications were made to the supervisory body for people who required continuous supervision and lacked the option to leave the home without staff supervision.

New staff received an induction to prepare them for the role they were employed to perform. Staff said the training was good and ensured they had the skills to meet people's needs.

People had access to social and health care professional as needed.

Is the service caring?

Good 

The service was caring.

Summary of findings

People were treated with dignity and respect. For example, we saw staff members were sensitive when they assisted people to get up from their chairs using moving and handling equipment. When staff gave assistance the person remained their primary focus. Staff worked calmly and efficiently together without talking over the person.

Staff explained and offered reassurances as necessary. At other times we saw affectionate warmth between staff and people accompanied by laughter and friendly banter.

Internal systems were in place to seek the views of people about the standards of care, the staff and the environment.

Is the service responsive?

Requires improvement

The service was not responsive.

Staff told us they knew people's likes and dislikes and how they liked their care to be provided. The care plans were not person centred as they did not give staff direction on how people liked their care to be met. Life histories were not sought on the things that were important to people.

Care plans and risk assessments were reviewed monthly but they were not updated to reflect people's current needs.

Activities were not stimulating or meaningful.

Staff were aware of the procedures for making complaints. A log of complaints was maintained and when complaints were substantiated the registered manager formally apologised.

Is the service well-led?

Requires improvement

The service was not well-led.

The audits in place were used to assess the standards of care delivered to people. for example, care plans and medicine systems. Accidents and incidents were not accurately analysed as the staff were not reporting all accidents and incidents and some people were experiencing high levels of falls.

The quality checks of the service were undertaken annually. An action plan based on the findings was developed and the area manager checked the progress of the plan on their monthly visits.

The views of people about the service were not sought since 2013. The manager said it will be taking place in 2015.

Members of staff said there was a "caring" culture. They told us the manager was approachable and the team worked well together.

OSJCT Coombe End 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 checked 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.

The inspection was unannounced and took place on 22 and 23 April 2015.

On this inspection there were two inspectors and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed 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 gathered and reviewed information before the inspection. For example notifications of accidents and incidents. We spoke with local authority safeguarding team, commissioners of the service and food safety officers.

We spoke with eight people using the service, five relatives and friends and nine staff. We observed the interaction between people and staff and we reviewed records. We looked at care records for six people which including care plans, risk assessments, intervention charts, records of visits by social and healthcare professionals and daily reports. Other records reviewed during the inspection included medicine systems, staffing rotas, handover sheets, training matrix and complaints and quality assurance systems along with their action plans.

Inadequate

Is the service safe?

Our findings

Accidents and incidents were not always appropriately reported and they were not robustly analysed to prevent a re-occurrence.

Incident reports included the immediate action such as observations to be carried following a fall. However, no robust analysis of the falls had occurred to ensure that appropriate action was taken to reduce the risk of falling and to keep people safe. For example, staff said sensor mats were used to alert the staff that some people were moving around their rooms without staff support. Some staff acknowledged that despite the sensor mats on the floor some people had continued to fall. The sensory mats on the floor were not keeping people safe in all cases. There was no evidence that other strategies had been considered to prevent these people from falling.

Care records for one person showed they had experienced five falls between 30 March 2015 and 19 April 2015. Three of these falls were not recorded on the service's accident forms and reported to the management team according to the service's accident procedure. It could not be confirmed if appropriate action was taken to prevent these people from falling again. No robust analysis of falls had occurred. Trends and patterns were therefore not identified to reduce the risk of a re-occurrence of the falls and to kept people safe.

Where people were identified as having care and support needs relating to mobility, risk assessments had been completed. Members of staff told us risks to people's safety and well-being were assessed. For example, falling, moving and handling, behaviours staff found difficult to manage and the potential of malnutrition. Care plans were developed for people on the actions taken to reduce the level of risk to the person. However, risk assessments were not reviewed following an incident or accident such as a fall. This meant staff could not be sure the care they provided minimised risk and met people's needs..

Prior to the inspection we were informed of a number of incidents of abuse between residents. The service had not taken appropriate action following the initial incident to ensure that people were safeguarded from further repeat incidents. At the time of our inspection these incidents were being reviewed by the local authority safeguarding team. The local authority has the statutory duty to investigate safeguarding concerns.

Some members of staff were not able to show a good understanding of the safeguarding adults from abuse procedures. Two members of staff were not clear on their responsibility towards safeguarding people from abuse. One member of staff said their duty was to care for people. Another member of staff thought safeguarding was about keeping equipment working effectively.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person required support with their personal care. Their care record stated that to reduce anxiety up to four staff were needed to deliver essential care. We saw from the daily records there were occasions when staff were subjected to aggression and violence when they attempted to provide personal care to this individual. An action plan or a care plan had not been developed on the restraint or strategies to be used when personal care had to be delivered. Members of staff described the techniques used for example, giving the person time when they refused personal care. However, there was an inconsistent approach as staff used a variety of techniques. Another person told us sometimes two staff and not the four staff were needed to deliver personal care. There was no care plan to direct staff on the steps to be taken to deliver essential care. The circumstances were not described when restraint should or should not be used to ensure that any restraint would be necessary and proportionate. .

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff demonstrated a clear understanding of safeguarding. Two of the four staff we asked about safeguarding procedures showed a good understanding of safeguarding adults from abuse said they had attended safeguarding adults training. They knew the signs of abuse and the actions they needed to take. All staff knew they had a duty to report abuse they may have witnessed from other staff towards people. Staff were confident the registered manager would take appropriate action and report concerns to the lead authority for safeguarding.

Inadequate

Is the service safe?

There were people living with dementia and they were not able to tell us their experiences of living at the home. The people who were able to give feedback about the home felt safe. They said they were happy but staffing levels caused them to have to wait for care when they rang their call bell. People told us that the staff would come and answer their bell quickly but were too busy to fulfil the request at that time and said they would come back later. People said that the time that staff took to come after the initial call bell being answered varied. One person told us there were people who entered their bedrooms uninvited. Another person said agency staff were used but these "were not anywhere as good as the regular staff. We don't know them and they don't know us so we don't really talk to them."

A member of staff described the assessments undertaken to ensure staffing levels were based on people's dependency needs. Another member of staff said the staffing levels were good. This member of staff said "there are new staff starting. I've never found it a struggle." However, one member of staff and relatives said the staffing levels were not adequate. The registered manager said the staffing levels for carers did not change at weekends. We looked at the staffing rotas in place and the staffing levels were maintained throughout the week. The manager acknowledged the levels of housekeeping staff were reduced at weekends.This meant not all staff's roles were covered at weekends.

A relative told us there was a lack of continuity as there was a high reliance on agency staff. The registered manager told us there was a recruitment drive to provide continuity of care to people from regular staff. They said every effort was made to have the same agency staff to offer continuity to people.

The recruitment of staff ensured suitable staff were employed at the home. Three new staff described the recruitment process. They said an application form had to be submitted and they attended an interview. They said there were checks of their previous employment and Disclosure and Barring Services (DBS) checks. We were told DBS checks conducted were on their criminal background and they had to provide three referees.

Medicines systems were safe and people received their medicines as required. Medicines were administered from a monitored dosage system by staff that were assessed as competent with the administration of medicines. Medicine administration records (MAR) charts were used by staff to record the medicines they administered. Codes were used to describe the reason the medicines was not administered.

Medicines for some people were administered when needed and protocols were in place for these medicines. The "when required" protocols had the purpose of the medicine, the directions for administration and the maximum dose to be administered in one day.

Individual emergency plans were devised and the assessment was based on the person's ability to evacuate the property in the event of an emergency.

We recommended that the registered manager considered current guidance on emergency plans and takes action to update personal evacuation plans accordingly.

Requires improvement

Is the service effective?

Our findings

One person said "this is my home and I love it here. I love to make everyone laugh."

The staff understood the need to promote people's independence and how people made some choices. A member of staff gave an example of how a person had been enabled to improve their ability to walk independently. We asked staff how they ensured people had independence and made choices. One staff member said, "We check what they want by talking to them and if they can't say, we check with family."

Members of staff were not able to show a good understanding of the Mental Capacity Act (MCA) 2005. Staff were not aware that capacity assessments had to be conducted for people living with dementia. They showed a lack of understanding on how to seek consent from people who lacked capacity. One member of staff said for people who refused personal care "I would still do it" and explained this was to avoid the risk of harm to the person if care were not given. This members of staff did not refer to the provisions under the MCA 2005 which underpin lawful restraint when a person lacks capacity and there is a risk of harm to service user.

Staff did not undertake MCA assessments to establish people's capacity. The MCA is the legal framework which governs decision-making on behalf of adults with cognitive impairments such as dementia who may not be able to make particular decisions. MCA assessments must be undertaken before staff carry out best interests discussions. This meant staff were not fully aware of the decisions people were able to make, the support they needed to make these decisions or who helped them make other more complex decisions.

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

Where people, who lacked capacity, were being deprived of their liberty by locked door with security codes, the service had made appropriate applications to the local authority authorising body. This was to ensure that people were only being deprived of their liberty so that they could get the care and support they needed in the least restrictive way.

We saw DoLS authorisation was also gained to provide essential care and treatment to a person who at times refused personal care. The application form included the reasons for the request, confirmed the least restrictive action was to be used. However, a full plan which ensures this person's safety was not in place.

One person said "there is a nice choice of food and it's always hot, but I can't eat onions so I just have to choose the one without onions." We saw a carer sit and chat with one person until the focus of their anxiety was diverted.

People had an opportunity to make choices about their meals and times to rise. Staff said people were offered choices and gave us examples on how people were enabled to choose their clothing. A member of staff said "I know what people like and don't like. People were asked about their dietary needs when they first arrive. People are shown the choices if people don't respond we look at their body language and make a choice for them." Another member of staff said "people are usually shown the choices".

People's dietary requirements were catered for. For example, low sugar, high calorie and soft diets. The acting chef told us people's preferences about the menus were sought monthly. They said the menus were then adapted to meet people's preferences. Staff told us the meals had improved and people were having choices of meals at all mealtimes. At lunchtime we saw people were selecting their meals from the choices shown to them by staff. The Food Safety Officer told us the acting Chef had made improvements to the hygiene standards.

Members of staff encouraged people to eat their meals. We observed staff discuss with people their taste to tempt people to eat their meal. A member of staff said "have your tried this sauce before" and when they attempted to eat this, the member of staff said "good choice."

Staff said where people had high levels of dependency for example falls or malnutrition the GP and Occupational Therapists (OT) were involved in their care and treatment. A member of staff said some people were not able to express to staff they were in pain. We were told for these individuals GP visits were arranged when staff observed there was a deterioration of people's health which at times was established through tests and checks undertaken. For example, urine tests.

Requires improvement

Is the service effective?

Records of visits from social and health care professionals were maintained. Staff recorded the nature of the visit and the advice given. People saw their GP when needed and had access to other health care professional such as palliative nurses.

New staff received an induction to prepare them for the role they were employed to undertake. A member of staff told us during their induction they shadowed more experienced staff to gain an understanding of people's needs. Another member of staff showed us the induction programme "Back to Basics" which covered the organisation's policies and procedures, the core values of the organisation and delivering personal care. This member of staff said the induction was over 12 weeks and they had to show they were competent with each task before they worked unsupervised.

Staff told us the training provided was good and this training ensured they had the skills needed to meet people's needs. They said training they had attended included moving and handling, managing difficult behaviours, medicine administration and Mental Capacity Act (MCA) 2005. Staff told us they had to show their competency before they were able to undertake tasks such as moving and handling. They told us training was updated and there were options to progress. The training matrix in place showed the training staff had to attend and when this training was to happen. For example, staff were to attend End of Life training on the 28 April 2015.

We spoke with four staff about training relevant to managing aggressive and violent behaviours which people may at times exhibit. One member of staff said "Distress Reaction training, not useful" to manage people who exhibit difficult behaviours. Another member of staff said they were undertaking the induction but had not attended Distress Reaction training. The third member of staff said the Distress Reaction training gave "advice on managing aggressive behaviours, I was disappointed." The four members of staff did not comment on this training.

One to one meetings with staff were taking place with their line manager. A member of staff said all staff had a minimum of six one to one meetings with their line manager in a year. We were told at these meetings staff discussed their performance, concerns and professional development.

Staff said there were annual appraisals where they reviewed their past performance with the registered manager and developed a personal plan for the year ahead.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to managing behaviours from people living with dementia.

Good

Is the service caring?

Our findings

Staff members approach to people was warm, caring and promoted dignity and respect. Choices were offered to people and communication from staff members was calm and respectful. We saw staff explain to people and offer reassurances as necessary. Our conversations with staff members showed that they endeavoured to make positive and caring relationships with people who used the service.

Staff members said they knew the people who used the service very well. Another member of staff said they understood some people may wish to be reserved, and others may want to laugh and joke. Staff members were aware that people sometimes needed time to respond to communication. We observed that staff spoke respectfully and in a manner that suited people's individual needs. This approach encouraged people to join in the conversation and make their views known. We noted how the members of staff smiled and responded to people which also encouraged conversation.

We observed staff members give explanations in a way that people were able to understand. We saw staff give people prompts using objects of reference when necessary. For example, to help a person who had difficulties with spoken communication choose a dessert; the different options were brought to the dining table so that the person could see them all and make their choice.

We asked staff members for examples of people being helped to make choices. We were told staff had supported a person to have a motorised wheelchair for them to increase their independence. Staff said people made choices on a daily basis such as: what and when to eat, what activities to do and which clothes to wear. One staff member commented, "Little day to day wishes are key and can make a difference." An example given was stopping night time checks for a person who did not want to have them. A further example was meeting a person's wish to move quickly to their armchair as soon as they had finished eating a meal.

We observed that people were treated with dignity and respect. For example, we saw staff members assist people to get up out of their chairs using moving and handling equipment. Staff gently and discreetly explained what they intended to do. We noted that staff knelt down to ensure eye contact was made in order to aid communication with people who had sensory and cognitive impairment. We noted that when two members off staff gave assistance that the person remained their primary focus; they worked calmly and efficiently together without talking over the person.

Staff explained how they ensured they promoted people's privacy and dignity. Staff members said they maintained people's confidentiality and ensured that care was provided in the way the person would like. Staff members said they ensured that doors were shut and curtains closed before care was given. We were told how care was given in a dignified manner; for example when giving personal care. We were given examples of how people were assisted to maintain their dignity when for example they may inadvertently have been inappropriately dressed. We observed that staff members knocked on doors and waited before entering people's rooms.

The registered manager said various systems were used in order to promote privacy, dignity and care. Checks were made by observing staff and giving on the spot feedback on practice matters. This included positive as well as negative feedback.

We asked how people were enabled to express their views on the care they received. Staff members and the manager said that they spoke to people informally on a daily basis in order to find out their views; "To keep checking their preferences" as one member of staff said. In addition, the care plans were reviewed on a monthly basis. Staff informed us that they gave feedback on any issues to their care leader so that care plans could be adjusted as necessary. This feedback was given through systems such as daily handover meetings and staff meetings. One senior member of staff said, "The carers are very good at coming straight to us and telling us of any issues." When asked for an example of this, one carer told us that they had raised concerns about using a 'stand aid' for a person which was quickly reviewed and replaced with a hoist.

As well as informal communication, the manager said that formal residents' and carers/family meetings took place. Residents and Relatives meetings were held three times per year and the most recent meeting took place in March 2015. We saw at this meeting there were discussions about staff recruitment and refurbishment strategies."The manager said that they also operated an 'open door' approach in order to actively encourage people and their

Good

Is the service caring?

families to raise any concerns. In addition residents' surveys were normally used although such a survey did not take place last year. However, the manager said a residents' survey was planned for this year.

The manager and area manager agreed that the end of life care plans may benefit from further development to make them more person-centred and holistic. However it must also be noted that Coombe End Court had, from the beginning of January 2015, received over 25 letter and cards of compliments and thanks from the families of people who have used the service. These included thanks and recognition from the families of people who received end of life care at Coombe End Court.

We recommend that the service seek advice and guidance, about end of life care planning in order to build on and develop its provision.

Requires improvement

Is the service responsive?

Our findings

We observed some individualised, person-centred approaches to giving care. Staff described how they developed caring relationships with the people who used the service. They said they read people's care plans and life histories, and made time to talk to them. One member of staff said, "I chat to people, introduce myself, give a smile and let them lead the conversation." Another member of staff said, "I find out how they are feeling" and "see what we can do to help them."

Care plans were not person centred as they did not say how the person wanted their care to be delivered. Care Plans for people living with dementia did not tell staff about their background and the things that were important to the person. People and relatives were not invited to meetings to review their care. One relative told us there was no six month review and this was now well overdue since the arrival of their family member.

Care plans did not always accurately reflect the care and support given or required by people. All aspects of a person's health and wellbeing needs were assessed and care plans were devised to give guidance to staff on meeting the assessed needs. Care plans were reviewed monthly but they were not updated according to the evaluation. For example, an evaluation said the person was not maintaining a healthy weight and were at risk of malnutrition. The care plan in place did not correspond with the evaluation of the person. Members of staff gave us examples on the care delivered to people but this information was not recorded in the care plans.

Staff said there were people who refused personal care. They said some people expressed their emotions and frustrations using aggression and violence. The care plans directed staff to keep calm but the distraction and diversion techniques were not included. A care plans evaluation we looked at directed staff to provide reassurance but the guidance on how this was to be achieved was not included. This meant staff were not given clear direction on how they must respond to violent and aggressive behaviours.

Staff told us they were informed of people's changing needs. The four members of staff we asked said senior carers evaluated the care plans monthly and care staff read the care plans. However, care plans were not updated to show the current needs of people. A member of staff said it was the responsibility of the care and shift leaders to ensure the staff were informed of the changes in service user's needs. For example, leading handovers when shift changes occurred. A member of staff said the quality of the handovers were variable, they lacked details and "can be rushed and non-specific". For example X had a "restless night" an explanation on what this meant to the service use was not given to staff. This meant staff were not always given sufficient detailed guidance on the delivery of appropriate care and treatment to people.

People were not experiencing meaningful activities or stimulation. One person told us most days they watched TV as most of the entertainment was down stairs and only upstairs very occasionally. A relative told us there was a lack of activities. Staff told us there was an activities coordinator who developed the programme of activities and the staff supported the activities coordinator. A member of staff described the types of activities which took place on Pearl Unit. For example, the arts and crafts taking place for St George's day. Another member of staff said more activities could be organised. A third member of staff said there were few people participating in activities. We observed an activity taking place in Pearl Unit. We saw one member of staff helping two people prepare for St. George's day by making flags for the dining tables. However, the five other people in the lounge were not participating in any activity. The only other interaction in this room was a CD playing the same music throughout the day. The registered manager was aware the activities provided were not suitable for all the people.

One relative said "there is a lack of activities. Activities happen upstairs and not down here [Pearl Unit]. Another relative said monthly church services took place which their relative attended. They also said "they had a school volunteer who was coming in to help but she hadn't seen them for a while." The third relative we spoke with said activities were varied and sometimes there were games like scrabble. They also said their relative used the garden in the warm weather but not many people used it."

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Care plans were in place for people assessed at risk of developing pressure ulceration, malnutrition and for

Requires improvement

Is the service responsive?

people who required support with moving and handling from staff. We saw appropriate equipment such as pressure relief mattresses was used to minimise the risk of pressure ulceration. Malnutrition Universal Screening Tool (MUST) were used to assess people who were at risk of malnutrition. Staff recorded intervention checks undertaken to reduce the levels of risk. For example, repositioning to reduce the risk of pressure sores and monitoring food and fluid intake.

One person said "I have not had to make a complaint but I think I would be listened too if I had too." Staff told us when people complained they passed these concerns to the manager for investigations. A member of staff said "One person complained yesterday. I recorded the information and passed it to the care leader." We saw five complaints were received from January 2015 which the registered manager investigated and resolved. We saw where complaints were substantiated the registered manager formally apologised.

Requires improvement

Is the service well-led?

Our findings

CQC has conducted five inspections of this service between 2011 and December 2013. In four out of five inspections breaches of regulations were found. The service has not had effective systems in place to assess monitor and improve the quality and safety of the service to ensure that it consistently meets the expected standards.

There was a lack of reporting of incidents for people who experienced a high number of falls and a safeguarding matter that was not monitored appropriately. This meant people may not be safe. In addition, the provider did not use mental capacity assessments in line with legislation.

A range of audits were used to assess that people received care and treatment appropriate to their needs. For example medicine, care plans and infection control. The registered manager had anticipated improvements in care planning with the appointment of a Head of Care. The registered manager told us accidents and incidents were analysed to assess trends and patterns. The manager described the analysis of incidents for example, the staff on duty, the times of the incidents and the location of the incidents. However, the analysis was not accurate as staff were not following the accident procedures by reporting all incidents. This meant effective methods of monitoring the service was not in place to ensure people received safe care that met their needs.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since transitional registration in 2010 to the present date there have been two registered managers in post. It is a condition of registration to have a registered manager in post. However, there were significant periods when a registered manager was not in post. The lack of a registered manager and changes in managers has created instability to people and staff. However, it should be noted a registered manager has now been in post since 2014."

A registered manager was appointed to this post in April 2014. A member of staff told us there was a culture of improvements. We were told the environment was to be improved and staff were well supported. Another member of staff said the staff provide "all around good care and put people first." The registered manager told us there was an open and honest culture. We were told "the staff know where I am. They see me and I lead by example."

Staff told us the registered manager was supportive. A member of staff said "the manager is okay. Efficient [the manager] things are done properly." Another member of staff said "we are all brilliant. There are agency staff but it's okay." A third member of staff said "the manager walks around. We are not left out. The team is good. We have a good laugh and they [people] laugh with us." The registered manager told us the aim was to have a stable staff team to provide continuity to people but there had been challenges with the recruitment and retention of staff. Care planning was another challenge for the registered manager and progress was anticipated in this area with the appointment of a Head of Care.

The views of people, their relatives and other professionals were not sought as part of the quality assurance system. The registered manager said surveys to capture people's views had not happened since 2013 but were to take place this year. Residents and Relatives meetings were held three times per year and the most recent meeting took place in March 2015. We saw at this meetings there were discussions about staff recruitment and refurbishment strategies.

Annual checks on the standards of care were conducted by the organisation's quality team and the frequency of their follow up visits depended on the findings of the visit. The area manager then visits monthly to assess quality standards and action plans were developed where these standards were not fully met. The 2015 home action plan was devised to enhance the service provision. It included the steps needed to meet the aim of the plan along with the progress made to achieve the plan. Area manager's signed the action plan when each action point was met. For example, the refurbishment of the property.

Other checks included a "daily debrief" meeting with staff, regular staff and senior meetings, and staff supervision meetings. In addition staff training was provided and "reflective meetings" were used in order to build on good practice and to make improvements where needed. The manager said that they and care leaders also participated in giving care in order to have direct contact with, and

Requires improvement

Is the service well-led?

feedback from, people who used the service. The manager said that when necessary, formal disciplinary proceedings were implemented in order to ensure good standards of care were promoted.

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This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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's capacity to make decisions was not assessed to establish if their impairments prevented them from making decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not involved in the preparation of their care plans. Their care plans did not reflect their needs and preferences on how this care was to be delivered by the staff. Regulation 9 (1) (2)

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reasonable steps were not taken to mitigate risk to people. Regulation 12 (1) (2) (b)

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected against inappropriate use of restraint. Staff were not given guidance on the restraint to be used which was proportionate and least restrictive. Regulation 13 (4) (b)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems to drive improvements and ensure people were safe and their needs met were not effective. Regulation 17 (1) (2) (a) (b)