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?	**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

At the comprehensive inspection dated 22 and 23 April 2015 we rated this service inadequate and took enforcement action. We conducted a focus inspection on the 27 January 2016 to check that improvements had been made. This inspection was unannounced. While we found that some improvements were embedded into consistent practice there were insufficient improvements in all areas.

Coombe End Court provides accommodation for up to 60 older people. The accommodation is arranged into three separate units over two floors. The unit on the ground floor 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 and was recently appointed. 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.

People were at risk from unsafe medicine systems. People were not always having their medicines at their prescribed times. Prescribed medicines were not always in stock which meant doses were missed for some people. Staff signed the medication administration records (MAR) charts but from the stock checks conducted it was clear that some medicines had not been administered. For other people the staff had not signed the MAR charts but had administered the medicines. Protocols were not in place for all medicines prescribed to be taken when required (PRN). This meant staff were not given guidance on when to administer these medicines which included the maximum doses that the PRN's could be administered.

People living at the service, relatives and staff said there were staff shortages. They said there was heavy reliance on agency staff. The registered manager said recruitment of staff was a priority and that consistent agency staff was used. These agency staff were included in team meetings and handovers to provide consistency. People were sympathetic about staff shortages but wanted the organisation to employ consistent staff to deliver their personal care.

While risk assessments were in place for people with a history of falls and action plans listed the preventative steps to be taken, we found that staff had not reported all falls. We also found the reports of the falls were not clearly documented.

Care plans lacked detail and were not always updated to reflect people's changing needs. Information was duplicated and at times inconsistent with each other. The people we spoke with were not aware of having a care plan or about review meetings where their needs were discussed.

Quality assurance systems were in place and while shortfalls were identified with the standards of care, actions plans were not always actioned. Internal audits were in place to assess the effectiveness of systems but there were inconsistencies in the areas assessed.

People told us they felt safe with the staff. The people who needed assistance from staff said the staff knew how to use equipment which protected them from harm. Moving and handling risk assessment gave staff guidance on how to assist people with mobility needs. The number of staff and the equipment needed to support the person was included in the risk assessment. Malnutrition Universal Screening Tool (MUST) were used to assess the potential of people to develop malnutrition. Where people were at risk of malnutrition the action plans depended on their weight which included monitoring of food and fluids intake with supplements prescribed and enriched diets served. For people at risk of pressure sores there was equipment used and regular repositioning to relieve pressure points.

People had access to GP and healthcare specialists for their ongoing health needs. People had regular check-ups with optician, dentists and chiropodists and staff organised the appointments.

People told us the staff were caring. They told us there were forums where they were able to raise issues and to make suggestions. Staff were aware of people's likes and dislikes and had insight into the needs of people living with dementia. Members of staff were eager to promote consistency to people from a stable staff team. The people we spoke with were confident to approach the registered manager with complaints. They said the registered manager investigated their complaints and acted upon the issues raised.

The specialist dementia unit and the foyer of the property were refurbished and adapted for people living with dementia. There were places of interest for people to encounter while they walked around the unit. We saw there were snacks and fresh fruit available to people in baskets to imitate fruit stands. Door entry systems into the unit were not used during the day which meant people had the freedom to walk around the ground floor. The ground floor lounge was adapted into a coffee and refreshments and movie area. Home baked cakes were available to people and their relatives at all times and we saw people enter the lounge and help themselves to cakes. We also saw relatives and people sit in this lounge make refreshments to have with cakes.

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 safe

People told us there was a heavy reliance from agency staff and they wanted the delivery of care from consistent staff who worked at the service.

People were at risk from unsafe medicine systems. People were not having their medicines administered according to the prescribed instructions.

Accidents and incidents were not reported and taken seriously by staff.

Staff knew the actions needed to minimise risks identified and risk assessment were developed but action plans were not always followed. For example, fluid intake charts were incomplete for some people.

Is the service effective?

Requires Improvement

The service was not consistently effective

People were assisted by staff to make day to day decisions. However, people's capacity to make specific decisions was not always assessed for specific decisions. For example, covert medicines and disrupt one person's sleep.

People's dietary requirements were catered for. People were offered a choice of meal at all mealtimes.

Members of staff attended mandatory training set by the provider.

Is the service caring?

Good

The service was caring.

People told us the staff were caring and they liked the permanent staff. Permanent staff knew the likes and dislikes people.

The people living with dementia had access to the ground floor and the rear garden. There were points of interest for them to encounter on their journey.

The general downstairs lounge was converted into a coffee and movie area. We saw this area was used by relatives and people, they were able to have freshly made cake and prepare drinks.

Is the service responsive?

Requires Improvement

The service was not fully responsive

Care plans in place were not consistently person centred. People likes and dislikes and preferred routines were not always part of the care plans. Care plans were reviewed but they were not always updated as people's needs changed.

Activities were taking place and people were able to participate in group and individual activities.

People were aware of the complaints procedure and felt able to raise their concerns with the registered manager

Is the service well-led?

Requires Improvement

The service was not consistently well led

Systems were in place to gather people's views.

Members of staff worked well together but said improvements were needed mainly with the recruitment of new staff.

Quality assurance systems to monitor and assess the quality of service were in place but action plans were inconsistent with our findings and implementation was poor.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 31 January, 1 and 6 February 2017 and was unannounced on the first day of the inspection. The registered manager was aware of the two subsequent inspection days.

The inspection was completed by one inspector. The provider completed a Provider Information Return (PIR) and was received prior to the inspection visit. 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 also reviewed information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with six people, four relatives, seven staff including bank and catering staff and activities coordinator, two agency workers, the head of care, the regional manager and the registered manager.. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making. We also looked at records about the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the comprehensive inspection in 2015 this key question was rated inadequate due to breeches of the regulation in relation to the analysis of accidents and incidents. At the follow up visit dated 27 January 2016 we improved the rating from Inadequate to Requires Improvement. In January 2016 we found that reasonable steps were taken to mitigate risk to people. However, on this visit we found accidents and incidents were not always reported and acted upon as well as people were at risk from unsafe medicine administration.

Incidents were not always taken seriously and acted upon. During the inspection a member of staff described an incident where one person had approached another person and caressed them. This member staff knowing the person's history and with assistance from an agency staff diverted their attention and reported the incident to a senior staff member. The incident was not documented which meant an overview of the behaviours that this person had developed was not maintained. The registered manager was not aware of recent changes in this persons behaviour. This incident was not referred to the local safeguarding lead authority.

Action was not taken by staff to investigate the causes of injuries or bruising. On the third day of our visit one person had sustained significant bruising to their face. We asked staff about the injuries who said the cause of the bruising was not known. We saw recorded in the daily records "bruising keep an eye on her, bumped her head. No witness or cause of injury". However no further action had been taken by staff. For example, we found no evidence of the GP being contacted or observation put in place to watch for signs of head injury. When we drew the injury to the registered manager's attention, the staff were instructed to complete an accident form; request a GP visit and undertake observations to determine if a head injury was sustained. The area manager told us a safeguarding referral was to be made. The lack of action from staff may have placed the person at risk from an undetected head injury.

The handover sheet that provided staff with information about people's current needs stated that on 18 January 2017 bruising was found in the inner part of one person's thigh. The staff were told the cause was unknown and injury was documented. We found the body map for this injury indicated the locations of the injuries. A senior manager told us this may have been caused by the sling when moving the person. However, no further investigation had been undertaken.

People were at risk from unsafe medicine systems. One the first day of the inspection we found the administration of medicines in one unit was taking a significant length of time to complete. We noted that the administration of breakfast medicines was completed at 11:30am and the lunchtime medicines started at 12 noon. This meant the interval between the breakfast and lunchtime medicines was too short for some medicines to be administered safely. When we asked a member of staff about the short intervals between medicine administrations we were told this was acceptable. Another member of staff said sometimes there was one staff administering medicines in two or more units which meant medicines were missed to ensure that the correct intervals between doses was maintained.

We saw staff had recorded where pain relief was not administered because the interval between doses was not within acceptable range. However, staff had not signed the actual times medicines were administered. Members of staff were not able to confirm if after the four hour interval they had checked if people needed pain relief. A member of staff said the shift lead passed information to oncoming staff the people whose pain relief was missed. However, we found no evidence to support this. This meant people may be in pain as analgesia was not administered at four hourly intervals as prescribed. People told us the staff administered their medicines. One person told us sometimes their medicines were late particularly at weekends. Another person told us "I have blocked ears and had to wait three weeks for a prescription for ear drops".

Medicine Administration Records were not appropriately maintained by staff. The MAR charts for some people in all units were not consistently signed to show the medicine administered. We found gaps in the MAR charts for 12 days in January 2017. When we checked the medicines held against the MAR charts we found some people had their medicines administered but staff had not signed the MAR chart. For others, their medicines were not administered but the staff had signed the MAR chart as administered. . For example, for one person the medicines prescribed for heart condition and underactive thyroid were not administered. The directions for the administration of diuretic (increase the amount of water and salt expelled from the body as urine) were not followed. Members of staff failed to check if missing these doses impacted on this person's health. This meant people were at risk from deterioration in their health conditions.

For other people we found medicines had not been ordered in a timely manner which meant they were not administered. For example, one person pain relief was not administered, for other people medicines to treat high cholesterol was not administered and for one person medicines prescribed to control blood sugar levels was not administered because these medicines were out of stock. Members of staff failed to check if missing these doses impacted on this person's health. This meant people were at risk from deterioration in their health conditions.

Members of staff were not accurately recording on the MAR chart changes of medicines. For example, the MAR chart for one person stated the staff were to administer propranolol 20mg daily. However, the GP had recorded on the 25 January 2017 the medicine was to be reduced to 10 mg daily. The member of staff stated the GP had changed the directions on the MAR chart on another visit but a record of this visit which included the changes of medicines was not documented. We also noted the medicine was not administered as they were out of stock.. This meant confusion about the medicines administered was created and the risk of medicines errors increased. When we highlighted this to the head of care they arranged for a GP visit to review the medicine.

Protocols which gave staff guidance on when to administer medicines prescribed to be administered when required (PRN) were not developed. For example, the application of topical creams, pain relief and to reduce agitation. The member of staff with a lead role in medicines told us the PRN protocols had been prepared but were not filed appropriately.

A pharmacist visited to assess medicine systems on the 24 January 2017. The pharmacist identified shortfalls in the ordering of medicines, in the systems for checking received medicines and in the recording of medicines administered. The pharmacist documented that processes for ordering medicines was not robust. The registered manager told us an action plan was to be developed.

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

A significant number of staff had left the service and we were told there were 21 full time equivalent care staff vacancies. Staffing levels were maintained with agency and bank staff. One person told us they often had to wait for assistance from staff. They said "today I had to wait for a long time." Another person told us there "is not enough staff." The third person we spoke with said "not enough staff. The permanent staff have left. Sometimes the agency staff are not nice. It's not good when its strangers all the time."

A relative told us "a lot of the staff began to leave and all went downhill, the manager and head of care both left. It has been going downhill but they are trying hard to improve. Staffing levels are not good." Another relative told us an appointment was cancelled because there was insufficient staff to accompany their family member. They also stated that the staff were "better than other place". The third relative we spoke with said "80 per cent is ok, staffing is a problem. A lot of agency and bank staff which is difficult on permanent staff. Generally the care is good. They [staff] are very caring. 50 per cent of agency staff are poor but it's better than nothing." This relative also said "staff need a reason to stay and it's not always about pay. My main concern is that they care for my mum and she is safe, that she is warm, has enough to eat and she is supported with personal care which they do". A fourth relative told us "low staffing. All agency and they are not as good as permanent staff."

An agency worker told us "morale is low as the pressure is on them [staff]. People are not getting the care as there is no staff and there is a lack of management presence in the units." A member of staff told us "we are fighting a losing battle and there are some staff that have bad habits. We don't need just anybody (staff). It's not safe, even agency staff have complained." Another member of staff said although staffing levels were poor, there had been an increase in staffing levels. The third member of staff said "it's not enough, it's a struggle. Repositioning of people and assisting people with eating is the priority not making beds. Balancing getting people up, assisting people with eating and repositioning people at high risk of pressure sores when there are only staff is difficult particularly when there are agency staff who are not aware of the people's routines".

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

The people we spoke with said that despite the staffing levels they felt safe. One person said the staff made them feel safe when they were being supported with moving around the home. Relatives said their family members were safe living at the service.

A member of staff was able to tell us about the safeguarding of vulnerable adults from abuse procedures. This member of staff was able to tell us the signs of abuse and the actions they must take to report alleged abuse. They were confident that the registered manager would report allegations of abuse to the lead local authority in safeguarding of vulnerable adults.

Risks were assessed. When risks were assessed a score was given to identify the risk level. For example, low, medium and high. One person told us the staff monitored their weight weekly. They said the staff had told them they had been losing weight. A member of staff told us the level of risk was identified and where people's needs increased the appropriate risk assessment was reviewed. They explained that where people had a history of falls, the causes were investigated which included health checks and preventative action such as sensor mats to alert staff of movement in bedrooms. Another member of staff gave us an example to explain the actions taken to minimise risks. They said where people were at increased risk of falls the staff made referrals to occupational therapists for equipment such as sensor to alert staff of movement in the person's bedroom. It was also stated that for people at risk of malnutrition snack and high calorie milkshakes were offered to people to help them gain weight.

Staff ensured people that were cared for in bed were assisted to reposition to relieve pressure from specific parts of the body. Documentation detailed the frequency people were repositioned and this was in line with the guidance available in their care plan. Where people were at risk of malnutrition staff recorded their intake of food and fluid.

A risk assessment for one person that at times refuses to take their medicines was in place. The behaviours which show to staff the person had not taken the medicines were included within the assessment. The action plan was for staff to remain with the person to ensure medicines were taken.

Requires Improvement

Is the service effective?

Our findings

At the comprehensive inspection of the 22 and 23 April 2015 we recommended that the service found out more about training for staff, in relation to managing behaviours from people living with dementia. We found some improvements had taken place but we could not improve the rating at the focus inspection dated 27 January 2016 from requires improvement because to do so requires consistent good practice over time.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications were in place for people under continuous supervision.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. It was recorded on the handover sheet for one person "needs to be woken up at least twice in the night to remain continent." The instruction on the handover sheet came from the care plan developed by the mental health team which also included that "a good night toileting programme is required". It was documented the person lacked capacity to make specific decisions and DoLS authorisation for continuous supervision were in place.

The review of the continence care plans dated 30 October 2016 stated the person was consulted and had agreed to be woken at night. However, on another review dated 18 December 2016 this person had stated they no longer required assistance. Despite the documentation which stated the person did not have capacity an MCA assessment had not been undertaken to reach decisions about the person understanding of staff waking them twice during the night. While relative's consent was sought, as they had lasting power of attorney to make decision about the person health and welfare, a best interest meetings was not conducted to ensure the decision was the least restrictive and the most appropriate action.

MCA assessments were not always completed for medicines administered covertly (hidden in food or drink). Covert medicines were administered for some people. MCA capacity assessments and best interest decision taken were recorded to administer covert medicines for one person. The reports of the best interest meeting showed the people involved with reaching the decision to administer medicines covertly. The staff had checked with the pharmacist to ensure the integrity of the medicines were not compromised when the medicines were crushed or disguised with food and fluid. It was agreed at this best interest meeting that should the person refuse the medicines they were to be disguised in food but not to be crushed. However, an action plan was not in place which included the advice gathered on how each person's medicine was to

be administered by the staff. The head of care told us a care plan was to be developed. For another person who continually refused medicines the GP had documented that "staff were able to use any method necessary including covertly." Members of staff had consulted with the pharmacist on the best method to disguise medicines. However, an MCA assessment was not completed and best interest decisions on administering medicines covertly. A member of staff told us the procedure for covert medicines was to complete an MCA assessment then involves the GP in the decision making. This meant the framework needed to reach best interest decisions was not in place.

A member of staff told us they had attended MCA training. They said most people at the service were able to make day to day decisions. For example, their clothing and what activities they wanted to complete.

A relative told us they were consulted in decisions about their relative. One person told us they made their own decisions. Another person told us they make decisions and their relative helped them with more difficult decisions. The third person we spoke with said they had support from relatives to make decisions but "it's mine [decision] at the end of the day." A member of staff told us their responsibility was to promote choices to people using the best means possible. For example, where people were not able to communicate staff gave people visual choices.

We saw that for some people Do Not Attempt Resuscitation (DNAR) orders which the GP had signed after consultation with family and the person were in place.

A member of staff on their induction gave us feedback on the support received from other staff. This member of staff said other staff including senior managers were eager to give advice from their experience. It was also stated that their induction included a tour of the premises and attending training courses set as mandatory by the provider. Another member of staff said they were registered onto the Care Certificate which covered an identified set of standards which health and social care workers are expected to adhere to. They said the training created better insight into people's needs before starting work at the service.

Staff attended mandatory training as set by the provider. A member of staff said they received reminders when they needed to attend refresher training. They said a selection of dates and the training to be attended was sent to the home for staff to choose their preferred dates. A bank member of staff told us they had access to the same training as permanent staff. The registered manager told us staff were to undertake the Care Certificate which covered the mandatory training set by the provider.

One to one meetings with a line manager were held for staff to discuss issues of concern, training needs and personal development. A senior member of staff told us although one to one meetings were more ad hoc and were not always recorded they were taking place. A member of staff told us their one to one meetings were with their line manager. They said they had gained confidence with their progression to other roles as personal development was part of their one to one meetings.

People told us the food served was good. One person said the previous evening for tea there were "hot sausage rolls. They were beautiful". Another person told us "the food is beautiful and the chef is good". A relative told us their family member enjoyed the food served and the portion served ensured they were not hungry soon after the meal ended. We observed the lunchtime meal in one unit where people living with dementia were accommodated. . We saw people were shown the choices of meals. The mealtime was relaxed which allowed for a social experience. People were seen eating at their preferred pace. Members of staff assisted people to eat their meals. For example, a member of staff comments to people included "if you use a fork it will be easier. Let's swap," "are you hungry, you have not eaten" and "try and have some lunch".

The cook on duty was knowledgeable about people's dietary requirements. They also told us that the menus were to be reviewed to reflect the changing season. They told us some people were served with soft or pureed diets and some had enriched diets which meant there were added calories to some foods. For example, cream was added to creamed potatoes. This helped support people who were at risk of losing weight.

The eating and drinking care plan for one person included the person's preference. For example, it was stated "she says she likes most foods". The action plan gave an overview of the medical condition that affects the person's diet and staff were to support the person to make decisions from the visual options shown.

People told us they had regular visits from their GP's and there was involvement from other specialists who supported them with their day to day health needs. For example district nurses and social workers. A relative told us it would be useful to know the times of GP visits. They said messages regarding GP visits were often passed to them by staff who were not present which meant some detail was missing when information was passed from one staff to another.

Staff were made aware of test results but staff were not aware on how to interpret the diagnosis. For example, one person's results had shown postural drop when standing (person may become dizzy or lightheaded, and maybe even faint when standing). A member of staff told us the person fainted easily. A care plan giving staff guidance on how to assist the person to stand safely was not developed. Handovers sheets did not provide information to staff on this person's condition. We informed the registered manager of this during our feedback.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring although, one person told us "some agency staff are rude which is not on". They told us they had reported these agency staff to the registered manager. It was stated "I tell them not to come back [to their bedroom]. This is my home they need to look after me better. The permanent staff are very good." Another person said the staff were friendly including agency staff and stated "it's a sisterhood" but that staff did not always undertake tasks when requested although some did. The third person we spoke with told us "I like it here, it's nice, I like the food and I eat it all" and the fourth person said "it's satisfactory, I get on quite well. I get the help I need. I have no complaints."

A relative told us the staff were caring towards their family member. They told us the staff kept them informed of important events. It was also stated that a relatives meeting was recently held where they were kept informed about the staffing vacancies. One person told us they had attended meetings held to discuss staff vacancies. Another person told us they attended residents meetings. They said "nothing changes but this can't happen until they get more staff."

Lounges were social areas for people and for visitors. Visitors were welcome by staff and refreshments were offered. Some visitors used the small kitchen areas in the lounges to prepare snack and make refreshments for their family members. There were points of interest in Pearl unit for example there was themed quite lounge. We saw people had access to the garden and some people went out into the garden. There was a central lounge converted into a coffee and cinema area. We saw people helping themselves to freshly made cakes and staff or visitors prepared refreshments.

We saw staff interact well with people. We saw staff use a variety of approaches to engage with the individual which depended on their level of understanding. We saw when people showed signs of anxiety staff offered drinks and snacks to help distract them.

A member of staff told us that a calm, polite and welcoming approach was used. They said people living with dementia "remembered faces, they know who is nice to them, they remember". This member of staff said that to make people living with dementia feel they mattered staff spent time with people "reminiscing and building relationships with relatives and involving people." Another member of staff said speaking at eye level gave people a sense that they mattered to the staff. They also stated "I hold their hands, listen to what people want to say, I ask what they need me to do. I pass on information it they are concerns".

People told us staff were respected their rights. One person told us they were able to take small pieces of furniture and have personal belonging in their bedroom. This person said their bedroom was home. A member of staff gave us examples on how people's rights were respected. For example, before delivering personal care doors were closed and curtains were shut. Another member of staff stated "I explain what I am doing and I do one half at a time the other half is covered [when delivering personal care]. I keep the information stored safely. I don't share their information or their secrets [where appropriate]."

End of Life care was delivered to people on this pathway. We saw the families of one person thank the staff

for the dignified care provided to their family member on their end of life journey.

Requires Improvement

Is the service responsive?

Our findings

At the comprehensive inspection of the 22 and 23 April 2015 we found a breach of Regulation 9. We found 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. We improved the rating from Requires Improvement to Good on the focus inspection dated 27 January 2016. However, we found on this inspection that the improvements had not been sustained.

Life stories were gathered for some people. For one person there was information about them which included how they made choices. A relative had also documented that the person was likely to make choices from visual options shown. A member of staff told us families were asked to provide background history which staff used to develop life stories. One person told us they were able to manage their care and staff "helped where assistance was needed." This person was not aware of a care plan and about reviews meetings of their needs. Another person told us the staff delivered personal care in their preferred manner. However this person was also unaware of having a care plan in place.

Systems to make sure that each person received appropriate person-centred care and treatment that was based on their preferences were not effective. A member of staff told us care plans were developed by the care leaders. They told us developing care plans for people living with dementia was more difficult. It was stated that staff where possible made efforts to capture what people told the staff about the delivery of care. The communication care plan dated 11 November 2015 for one person stated the person was able to communicate with staff. The action plan was for the staff to ask "closed questions and staff were to use distraction methods instead to saying no". Also included was that this person responded well to staff who smiled. The personal care for this person stated they needed prompting and supervision from staff. The aspects of care the person was able to manage was described was included within the care plan and it may be necessary to complete tasks in stages which the staff reviewed on 10 January 2017. However, a member of staff providing one to one care told us the person needed full support in all areas of care. They described how staff must position themselves for the person to accept personal care from staff.

Staff lacked the guidance needed to manage incidents. It was documented in the daily notes for one person "XX too agitated to sleep in his room. Slept in XX [another person's] bed and had a settled night". We asked the registered manager to investigate this incident. The registered manager said the person whose bed was used by another person had an unsettled night and this person slept in the lounge. It was stated that both people were not disturbed as they settled well during the night. We also saw recorded in the antecedents, behaviour and consequences (ABC) chart where this person had shown behaviours towards staff when they were delivering personal care to another person. The description of the event showed the member of staff had difficulties getting the person to release their hold on them. However these incidents were not reported to the manager. This meant the registered manager was not aware of people's current behaviours; there was no indication that staff had followed a behaviour plan and where appropriate referrals to the lead authority for safeguarding were not made.

The behaviour management plan for one person included preventative strategies. The signs of distress and

how staff were to approach the person. For example, the staff were to introduce themselves, use topics of interest as distraction and where appropriate administer medicines to reduce anxiety. Also two male staff were to deliver personal care. Staff were to complete antecedents; behaviours and consequence (ABC) charts following incidents. However, ABC charts were not analysed and care plans were not reviewed following incidents. This meant ABC charts were not used to identify triggers to prevent incidents of aggression. The registered manager said Admiral Nurses [specialist dementia nurses who give expert practical, clinical and emotional support to staff] that visit the service twice weekly were to support staff to develop positive behaviour management plans and analysing ABC charts.

A member of staff said where people presented with aggressive behaviours antecedents; behaviours and consequence (ABC) charts were completed. They also told us there was also support from the Care Liaison team on how to manage these behaviours. Another member of staff said distraction techniques were used when people became angry or resisted support from staff. Helping people move away from the source of their distress was a technique used by staff and people were given time when offers of personal care were offered.

While people had access to healthcare professionals care plans were not always updated to include their advice. The Eating and Drinking action care plan dated 12 June 2016 and reviewed on 13 December 2016 for one person advised staff to monitor the person's weight monthly and to serve soft diet. However, guidance provided from the Speech and Language Therapist (SaLT) was not used to update the care plan. For example, SaLT assessors had recommended for staff to prompt the person to swallow following each mouthful to prevent choking. This advice was not reflected in the care plan. On the second SaLT visit which took place on 17 January 2017 the staff were advised to ensure the person was sitting upright when eating meals and to avoid high risk foods such as nuts and biscuits. Again this was not reflected in the care plan. The tissue viability care plan for this person was not reviewed following a visit by the district nurse. This meant staff were not provided with the information to ensure people's safety.

Care plans did not always include the information known by the staff on how to care for people. While the staff we spoke with were knowledgeable about the assistance needed to support one person's with their mobility, the guidance from healthcare professional to encourage the person to take big steps when walking was not included in the care plan. The area and registered manager told us a member of staff was be designated the role of reviewing care plans.

The handover sheet that included information to staff on people's current needs instructed staff to ensure the person did not remain in their bedroom and was guided to the lounge. A member of staff told us this person became angry at times which caused them to be "muddled". They said the person "likes to eat in the bedroom and had trashed the [their] room. Staff get him ready and bring him to the lounge where he enjoys the company of others." The Eating and Drinking care plan was reviewed on 25 January 2017 and stated the person "tends to eat better when sat in the dining room and at the table, if left in the bedroom tends to drop food on the floor and over himself". There was no evidence that there was a discussion with the person about their preference not to eat their meal with others. This meant people preferences were not considered in the development of the care plan.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Member of staff had a handover when there were shift changes. Events of the day were recorded. We saw staff had recorded the checks undertaken during the night, the behaviours some people presented and the tasks staff completed. A bank worker told us that at handovers they were updated on people's current

needs. They told us care plans were accessible to them and read them when people are admitted and when there were changes but "we don't always have the time to read them [care plans]".

There was a programme of group activities which included "in house" activities, visits to places of interest and entertainers coming into the home. One to one activities were also organised for people who preferred not to participate in the group activities. We saw the programme of activities on display and boards decorated to help people remember upcoming events. For example, Valentine 's Day. Photographs were on display of previous activities where visits from a petting farm had been organised. People were seen petting a miniature donkey that went into the home and into some bedrooms.

An activities coordinator was employed to work four days per week not including weekends. The activities coordinator told us there were boxes of activities to help staff initiate activities at weekend. For example, quizzes. One person told us the new activities coordinator was good but they missed not having Bingo on Saturdays. Another person told us "I rest as much as possible" [during the day] when we asked about activities.

The activities coordinator also told us the "in house" activities people enjoyed which included baking. they told us that having small kitchens integrated into lounges helped to organise baking activities. This meant people were able to enjoy the smell and be present when their baking was taken from the ovens. The third person we asked told us they joined in all group activities. They said baking was their favourite activity.

We observed people and some relatives enjoying and joining in with the singing from an outside entertainer. Members of staff ensured where people wanted assistance was provided for them to join in the activity. Relatives told us there was regular entertainment from external entertainers. The activities coordinator told us following all activities people's feedback was sought to ensure the activities organised were suitable to people.

Members of staff welcome visitors. An agency worker who delivered one to one for one person told us this person had regular visits from relatives which were important to them. This agency worker told us "he doesn't remember her (relative) name or the relationship but the love is still there. He knows her and that she means something to him."

A relative told us they would approach the head of care or registered manager with complaints. People told us they approached the registered manager with complaints. Three complaints were received which related to staffing levels and about the time taken to repair the lift. A relatives meeting was organised to discuss staff vacancies. The registered manager said the lift was not operating effectively but remedial action was being taken.

Requires Improvement

Is the service well-led?

Our findings

On the comprehensive inspection of the 22 and 23 April 2015 we found a breach of Regulation 17. We said systems to drive improvements and ensure people were safe and their needs met were not effective. We improved the rating from Requires Improvement to Good on the focus inspection dated 27 January 2016. However, on this inspection we found that the improvements had not been consistent and had not been sustained over time.

A home action plan dated January 2017 was in place. The area manager reviewed the action plan on their monthly visits to the service. The action plans included the shortfalls and how they were to be met and the progress made on the visit. The date when the actions were completed was to included. For example, medicine systems needed to be improved and a meeting was to take place with the registered manager to discuss the arrangements for medicines.

Medicine audits were undertaken from the feedback given during our visit and an action plan was to be developed on how medicines system. While a pharmacist visit was undertaken and recommendations were made an action plan on meeting the recommendations were developed but as yet had not been actioned.

The registered manager told us staff were to be allocated specific lead roles and were to complete audits to ensure systems were effective. For example, the registered manager was to have lead role in care planning and a senior was to have the lead role in medicine systems.

Risk management systems to identify trends and patterns were in place. The registered manager said people were currently at risk of falls and from malnutrition. They said the information was gathered for example where people had lost weight and analysed which included organising GP visits and planning on how to support the person to gain weight. However, we identified that not all incidents and accidents had been reported to the registered manager

The staff said the team worked well together. A bank member of staff said the team was good including agency staff and stated "we work closely". They also stated "it's easier to work as a team and on Pearl unit it was important". A member of staff told us there was good team working between care assistants and stated there was a lack of management presence in the units. A member of staff said the registered manager "listened". Another member of staff said the registered manager had a lot of "good ideas and processes "and these needed to be implemented. The third member of staff said the manager was approachable and "happy to listen" but there were times when support was needed from senior staff particularly during medicine administration. The registered manager said suggestion boxes were to be installed for staff to give anonymous feedback and make suggestions. They said this was to support team building of staff. It was stated that the team was supportive and that "I want the best for the service. If I have to help I will and expect the same from all staff." Staff told us the registered manager was approachable.

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

A registered manager was in post and were in post since November 2016. The registered manager told us the key challenges in the delivery of the service people receive. They said the recruitment of suitable staff and the retention of staff was a challenge. It was stated that more staff "will make a difference" and good practice will increase and be built on as staff complete the Care Certificate.

Infection control systems were last audited in September 2016. Where shortfalls were identified an action plan was devised on how standards were to be met. For example training of staff and cleaning. Care plans were audited in October 2016 and shortfalls were identified. The home action plan stated that care plans needed improving to reflect people's current needs. This was to be achieved by February 2017.

A member of staff said the organisation's values included providing excellent care, promoting good quality care to people. The staff were complimented by some people and relatives for the care delivery.

The Head of Care told us staff meetings were organised for specific roles. For example, care leaders, cares, night staff, catering staff meetings. General staff meetings were also organised. The schedule of these meetings was displayed in unit offices. The Head of Care said a general meeting was organised to introduced new staff and to discuss recruitment to staff vacancies

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 Care plan were not fully person centered and lacked guidance on how staff were to deliver care and treatment. Assessment tools were not analysed to ensure strategies and management plans gave staff information on managing incidents where people became distressed. Advise from professional were not included within care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Incidents and accidents were not taken seriously and acted upon. Where people sustained injuries action was not taken to mitigate the risk or to protect people from avoidable harm. People were at risk from unsafe medicine systems

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Shortfalls were not always identified and action plans were not always developed. Where action plans were in place improvements were not embedded into consistent practice

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

There were insufficient numbers of staff to deliver care and treatment in a consistent manner