The Orders Of St. John Care Trust

OSJCT Hungerford House

Inspection report

Beechfield Road
Corsham
Wiltshire
SN13 9DR

Tel: 01249712107
Website: www.osjct.co.uk

Date of inspection visit:
12 September 2017
13 September 2017

Date of publication:
14 November 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

OSJCT Hungerford House provides accommodation and personal care for up to 48 older people. At the time of our inspection 46 people were living at Hungerford House, including two people who were there for a short stay. The service is a care home and does not provide nursing care.

This inspection took place on 12 September 2017 and was unannounced. We returned on 13 September 2017 to complete the inspection.

At the last inspection in August 2016, we identified the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe medicines management. Following the last inspection the provider wrote to us and said they would take action to ensure medicines were managed safely by October 2016. At this inspection we found medicines were still not managed safely. People did not always receive the medicines they had been prescribed. One person continued to receive medicines after they had been stopped by their doctor. This was a continued breach of the regulation.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The previous registered manager left their post at the service in April 2017. The area operations manager informed us a new manager had been recruited, and was in the process of working their notice period before starting work at Hungerford House. The provider had a condition of registration that a registered manager must be in post at Hungerford House and was therefore not meeting their conditions of registration at the time of the inspection. We will monitor this and will consider enforcement action if the service continues to operate without a registered manager.

People had care plans in place, however, they were not always kept up to date and some sections had not been completed. The deputy manager told us they were aware care plans needed to be reviewed and updated. The deputy manager said review of the care plans was part of the improvement plan they had in place for the service and they planned to complete the work by the end of the year.

Hungerford House has been inspected five times since it was registered under the Health and Social Care Act in 2010. Four of these inspections, including this one, have identified breaches of regulations. The provider has not demonstrated they are able to consistently meet the requirements of their registration. There were quality assurance systems in place. However, they were not effective and had not ensured improvements were made to the quality and safety of the service being provided.

People said they felt safe living at Hungerford House. We observed people interacting with staff in a confident and friendly way. People appeared relaxed in the company of staff and did not hesitate to attract their attention if they needed assistance. Staff intervened promptly if people needed assistance to stay safe, including support to move safely around the home and support with managing disputes between people.

Systems were in place to protect people from abuse and harm and staff knew how to use them.

People told us they were treated well and staff were caring. Comments included, "They're [the staff] very good to me"; "The staff are very good, they listen to me"; and "The girls are super". We observed staff interacting with people in a friendly and respectful way. Staff respected people's choices and privacy and responded to requests for support.

Staff understood the needs of the people they were providing care for. People told us staff provided care with kindness and compassion.

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

There were group and individual meetings for people to provide feedback about their care and complaints were investigated and responded to.

During our inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Please see the back of the full report for details of the actions we have taken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

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

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

Systems were in place to ensure people were protected from abuse. Risks people faced were assessed and action taken to manage the risks.

Is the service effective?

Good

The service was effective.

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

Staff had suitable skills and received training to ensure they could meet the needs of the people they cared for.

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

Is the service caring?

Good

The service was caring.

People spoke positively about staff and the care they received. This was supported by what we observed.

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

Staff provided care in a way that maintained people's dignity and upheld their rights. People's privacy was protected and they were

treated with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

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

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

Is the service well-led?

Requires Improvement

The service was not well-led.

There was no registered manager in place and the service had experienced regular changes in the management team.

Systems to identify shortfalls in the service and make improvements were not effective. Actions that had been implemented had not resulted in improvements for people using the service.

OSJCT Hungerford House

Detailed findings

Background to this inspection

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

This inspection took place on 12 September 2017 and was unannounced. We returned on 13 September 2017 to complete the inspection.

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

During the visit we spoke with the area operations manager, care and compliance manager, deputy manager, six people who use the service, and five care staff. 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 for five people. We also looked at records about the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection in August 2016 we identified that the service was not meeting Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not managed safely. The provider wrote to us to set out the action they would take to address the shortfalls following the inspection. They said they would meet the requirements of Regulation 12 by October 2016. At this inspection we found that medicines were still not being managed safely and the provider was not meeting the requirements of the regulation.

The provider submitted their Provider Information Return (PIR) to us on 11 August 2017. In the PIR the provider stated there had been 36 medicine errors in the previous 12 months.

During the inspection we looked at the home's incident recording system. This identified there had been nine errors in the administration of people's medicines between 1 August 2017 and 13 September 2017. Six of these incidents resulted in people not receiving the medicine their doctor had prescribed for them. Three of the incidents resulted in people being given medicines that they were not currently prescribed by their doctor. On one occasion a person continued to receive their medicine for four days after their GP had stopped it. On another occasion a person did not receive a medicine their GP had prescribed for them for four days. Each of the incident reports stated staff had reported the error to the person's GP or out of hours on call doctor for medical advice. Staff recorded the advice they received and took the action that the doctor said was necessary.

We discussed the errors in medicine administration with the area operations manager, care and compliance manager and the home's deputy manager. The deputy manager told us action to resolve the number of medicine errors had been their key priority since coming to work in the home. Each error had resulted in a disciplinary investigation to find the causes of the incident and hold staff to account for their actions. As a result of the investigations a number of staff had been subject to disciplinary action by the provider, including the issuing of formal warnings, removal of staff from administering medicines and demotion. The deputy manager said they had introduced different systems to minimise disruption to staff responsible for administering medicines and clearer recording systems for medicines that had been administered to people. Despite the actions that had been taken, staff continued to make errors when administering medicines to people. The most recent error had taken place five days before the inspection.

During the inspection we observed a member of staff administering medicines. The staff member followed safe practice and only completed the medicines administration record when they had observed the person taking the medicine. The member of staff wore a tabard which asked other staff not to disturb them during the medicines round. However, we observed other staff disturbing the member of staff administering medicines on several occasions. The interruptions from other staff increased the risk that the staff administering medicines would make mistakes.

Medicines held by the home were securely stored. There was a record of all medicines received into the home and disposed of. Where people were prescribed 'as required' medicines, there were protocols in place

detailing when they should be administered.

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

People told us there were sufficient staff available to meet their needs. During our observations we saw staff responding promptly to people's requests for assistance and staff anticipating the support that people may need. Staff were unhurried and took their time to chat with people whilst they provided support.

Care assistants told us the staffing levels were generally sufficient, but raised concerns about the level of staffing in the afternoon, particularly if the care staff needed to support people with their medicines. Staff told us in one area of the home there was only one member of care staff allocated to support people in the afternoon / early evening. If that person was needed to support people with medicines it left no other staff available to provide other support people needed.

We discussed the concerns raised by staff with the management team. The care and compliance manager told us they were in the process of reviewing the way staff were allocated, to ensure there were deploying staff in the most effective way. We were told the service was in the process of recruiting new staff to fill vacancies. Two new care staff had been recruited and were in the process of having pre-employment checks completed before they could start work. The management team were also in the process of reviewing shift patterns for all staff, to ensure they were being used in the best way to meet people's needs.

People said they felt safe living at Hungerford House. When asked whether they felt safe, one person replied, "Oh yes, they're very good to me". We observed people interacting with staff in a confident and friendly way. People appeared relaxed in the company of staff and did not hesitate to attract their attention if they needed assistance. Staff intervened promptly if people needed assistance to stay safe, including support to move safely around the home and support with managing disputes between people.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. They had access to information and guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. Staff told us they had received safeguarding training and we confirmed this from training records. Staff were aware of different types of abuse people may experience and the action they needed to take if they suspected abuse was happening. They said they would report any concerns and were confident the management team would listen to them and act on their concerns. Staff were aware of the option to take concerns to agencies outside the service if they felt they were not being dealt with. We saw the home had reported issues and worked openly with the safeguarding team where any concerns had been raised. The management team had records of issues addressed through the safeguarding procedures and tracked them to ensure any actions were completed in a timely way.

Risk assessments were in place to support people to be as independent as possible, balancing protecting people with supporting them to maintain their freedom. Assessments included details about how to support people to minimise the risk of falls, maintain suitable nutrition and support needed in the event of distress which was demonstrated through challenging behaviours. People and their representatives had been involved throughout the process where possible to assess and plan the support needed to manage the risks. Staff demonstrated a good understanding of people's need and the actions they needed to take to keep them safe.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting

previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. We checked the records of three recently recruited staff. For one of the staff, the management team had not obtained a full employment history. The deputy manager looked at the records and felt this had been an oversight on the part of the recruiting managers as this was normally checked at the interview stage. The other two records we checked demonstrated employment history was checked during the interview. The deputy manager said she would take action to address the missing information as a matter of urgency.

Good

Is the service effective?

Our findings

At the last inspection in August 2016 we found that people received support in an effective way. We found these standards had been maintained during this inspection.

Staff demonstrated a good understanding of the principles of the Mental Capacity Act 2005 (MCA). The 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 legally authorised under the MCA.

During the inspection we observed staff supporting people to make day to day choices. Staff supported people to choose which meal they would like by showing them the different plated meals that were available. This enabled people who found it difficult to communicate their preference verbally to make a choice. We also observed staff explaining activities that were available on the days of the inspection, using objects of reference to help people understand what choices they had.

Mental capacity assessments had been carried out to determine whether people had the capacity to make certain decisions. For example, there were assessments in relation to people's capacity to make decisions relating to management of health conditions and whether to live at Hungerford House. Where people did not have capacity to make decisions, best interest decisions had been made following involvement of the person and others involved in their care, including their family, advocates, staff at the service, social workers and health professionals.

The service had records of people who had appointed a Lasting Power of Attorney (LPA), which gave another person legal rights to make certain decisions on their behalf. Key staff were aware what powers the LPA had and records reflected their involvement in decision making.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made where the service had identified that restrictions were in place for people who were unable to consent to them. Examples included locks to prevent people leaving the building or being constantly supervised by staff. There was a record of all DoLS applications that had been made, which were kept under regular review to ensure they were supporting people in the least restrictive way possible.

Staff told us they received regular training to give them the skills to meet people's needs. Staff told us most of the training they attended was useful and was relevant to their role in the home. However, two staff did report they would like more in-depth training on supporting people living with dementia. The care and compliance manager told us the provider was in the process of developing their training on dementia, with the new course planned to be delivered before the end of the year. The provider also employed an Admiral Nurse to provide specialist dementia support. The area operations manager said the Admiral Nurse was

used to provide bespoke training and development to help staff develop strategies to meet people's specific needs. The deputy manager had a record of all training staff had completed and when refresher training was due, which was used to plan the training programme. Staff were supported to undertake formal national qualifications in health and social care.

Staff had regular meetings with their line manager to receive support and guidance about their work and to discuss training and development needs. We saw these supervision sessions were recorded and the deputy manager had a schedule of meetings that had been planned. The deputy manager monitored this to ensure all staff had regular meetings. Some staff said they received good support, but said this had not always been the case until the deputy manager came to work in the service. Staff told us the changes in management had led to changes in the support and direction they received and were looking forward to a new manager starting work in the home.

People told us they enjoyed the food provided by the home and were able to choose meals they liked. Comments included, "The food is ok - quite good really" and "I like the meals, there's a good choice". People were offered a choice of meals, which were well presented. During the meal people chatted and staff joined in with discussions that were taking place. People were able to choose where they had their meal, with some eating in the dining room, some on trays and some in their rooms. Staff provided support to those who needed it, taking their time and explaining what food they were offering people. Snacks were available throughout the day and staff were observed supporting people to have regular drinks and snacks.

People said they were able to see health professionals where necessary, such as their GP or specialist nurse. There were records of regular meetings between the service and different health and social care professionals when people's needs were changing. Staff contacted health professionals promptly when people's needs changed and made appropriate referrals.

Good

Is the service caring?

Our findings

At the last inspection in August 2016 we found that people received support in a caring way. We found these standards had been maintained during this inspection.

People told us they were treated well and staff were caring. Comments included, "They're [the staff] very good to me"; "The staff are very good, they listen to me"; and "The girls are super". We observed staff interacting with people in a friendly and respectful way. Staff respected people's choices and privacy and responded to requests for support. We observed staff responding to people in a caring and respectful way. For example, staff took time to help people understand where they needed to go in the building when they were confused and regularly checked with people whether they needed any assistance. Staff responded promptly when people became distressed and provided reassurance and comfort to people. Staff were friendly and spoke about people in a respectful way.

Although the majority of our observations were of positive interactions, we did see one occasion when staff did not support a person in a caring way. One member of staff did not respond to a person who was confused in a way that was caring or demonstrated an awareness of communicating with people living with dementia. We raised this with the management team who said they would address this through their revised training courses.

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

Staff demonstrated a good understanding of what was important to people and how they liked their support to be provided, for example people's preferences for the way staff supported them with their personal care needs.

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

Staff received training to ensure they understood the values of the organisation and how to respect people's privacy, dignity and rights. This formed part of the core skills expected from staff and was mandatory training for everyone working in the service.

Requires Improvement

Is the service responsive?

Our findings

People had care plans in place, however, they were not always kept up to date and some sections had not been completed.

One of the care plans we looked at had several sections that had not been completed. The sections left blank included the support the person needed to manage their medicines, support to take part in activities and interests they enjoyed, support around resting and sleeping and support in relation to religious, spiritual or cultural needs. The daily care records for this person referred to several incidents in which they had been 'unsettled', 'tearful' and 'distressed'. There were communication and emotional well-being / mental state care plans in place, but these did not include any information about any possible reasons for the person's distress or support that staff should provide. The assessment for this person stated they had diabetes. The eating, drinking and nutrition care plan did not mention the person's diabetes and there was not a specific diabetes care plan in place.

The care plan for another person had not been kept up to date to reflect their changing needs. The care plan stated the person did not take any medicines after they were stopped by their GP in May 2017. However, the person's medicines had subsequently been re-started and they were prescribed several medicines, including sedatives to help manage their distress. There was no information in the plan about the support the person needed to manage these medicines.

The service had not planned with these people to meet their specific needs, which increased the risk of them receiving inappropriate care. The deputy manager told us they were aware care plans needed to be reviewed and updated. The deputy manager said review of the care plans was part of the improvement plan they had in place for the service and they planned to complete the work by the end of the year.

Some of the plans included a one page profile, in which people and those who know them well had set out details of what is important to them and how they wanted care to be provided. Where these were in place they gave staff access to information which enabled them to provide support in line with people's individual wishes and preferences. Despite the lack of information in some of the plans, staff demonstrated a good understanding of people's needs and how they should be met.

The home did not have an activities co-ordinator in post at the time of the inspection. The management team said they were in the process of recruiting to the vacancies and were offering care staff overtime shifts to provide support with activities until the posts were filled. People told us they could take part in activities they enjoyed. Planned events included, movies in the cinema room, visits by animal groups including zoo lab and bird of prey and a tea party. Holy communion took place each month. We observed staff providing company and interaction with people in their rooms and quiet areas of the home throughout the visit.

People were confident any concerns or complaints they raised would be responded to and action would be taken to address their issue. People told us they knew how to complain and would speak to staff if there was anything they were not happy about. People also told us they could speak to their social worker if they

needed help to raise concerns. The service had a complaints procedure, which was provided to people when they moved in.

Staff were aware of the complaints procedure and how they would address any issues people raised in line with it. Complaints received had been investigated and a response provided to the complainant. The area operations manager said that in addition to formal complaints, they would like to establish clearer procedures to deal with lower level concerns that people had. They felt this would be a good opportunity to learn more from people's experiences and ensure the learning was applied to benefit everyone who used the service.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The previous registered manager left their post at the service in April 2017. The area operations manager informed us a new manager had been recruited, and was in the process of working their notice period before starting work at Hungerford House. The provider had a condition of registration that a registered manager must be in post at Hungerford House and was therefore in breach of their conditions of registration at the time of the inspection. We will monitor this and will consider enforcement action if the service continues to operate without a registered manager.

Following the last inspection in August 2016 the provider wrote to us to set out the action they would take to meet the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe management of medicines. The provider said they would meet the requirements of this Regulation by October 2016. Despite the actions the provider said they would take, improvements had not been made to the way medicines were being managed and the provider was not meeting the requirements of Regulation 12.

There were quality assurance systems in place. However, they were not effective and had not ensured improvements were made to the quality and safety of the service being provided. A medicine compliance tool had been completed on 22 August 2017 and identified concerns in relation to medicine errors, records not being correctly completed and medicines not always being dated and labelled when opened. However, a weekly medicine audit completed before this on 11 August 2017 had not identified any of these concerns.

Hungerford House has been inspected five times since it was registered under the Health and Social Care Act in 2010. Four of these inspections, including this one, have identified breaches of regulations. The provider has not demonstrated they are able to consistently meet the requirements of their registration.

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

Other quality assurance systems that were in place had led to improvements in the service provided. Audits of call bell response times had led to actions to ensure people received quicker assistance when they needed it. Falls were monitored to identify trends and action taken to provide additional support to people at high risk times. Catering audits had identified the need to improve kitchen procedures, which had been implemented. The service had a development plan in place, which included actions to improve the quality of care plans, medication practice and to ensure staffing vacancies were filled.

Staff had clearly defined roles and understood their responsibilities in ensuring the service met people's needs. However, staff we spoke with felt the frequent changes in management had made it more difficult to provide a consistent service to people. Comments from staff included, "The only downside is we don't have

a stable manager. We get used to a new manager and then they go. There is a constant change in the routine" and "Different managers have a different focus and it is difficult to keep up with the [changes]".

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

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

This section is primarily information for the provider

Action we have told the provider to take

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

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

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were managed safely. Regulation 12 (2) (g).

The enforcement action we took:

We served a warning notice.