The Orders Of St. John Care Trust

OSJCT Trevone House

Inspection report

22 Denmark Road
Gloucester
Gloucestershire
GL1 3HZ

Tel: 01452529072
Website: www.osjct.co.uk

Date of inspection visit:
01 June 2016
02 June 2016
03 June 2016

Date of publication:
29 September 2016

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

This inspection took place on 1, 2 and 3 June 2016 and was unannounced. One inspector carried out this inspection. At the last inspection on 3 and 4 February 2015 the provider was found not to be adequately managing people's nutritional risks. They wrote to us and told us what action they would take to address this. We followed this up during this inspection and found they had completed this action and people's nutritional risks were managed.

The service offers personal and nursing care and can accommodate to up to 47 older people. At the time of this inspection there were 27 people living at Trevone House.

The registered manager in post has managed Trevone House since 2013. 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.

During this inspection we found the provider had not ensured people's care records were accurately maintained and that they provided the information needed to ensure safe and appropriate care. We also found examples of people's health needs not being sufficiently monitored to ensure they received appropriate care when they needed it. You can see what action we told the provider to take at the back of the full version of this report.

We also found the arrangements in place for staff to receive the information they needed before they started work not to be effective and we recommended that the provider review these.

People's risks were on the whole managed in a way which kept them safe. There were some examples where these needed improvement but where it had not had a negative impact on people. We discussed these at the time with the registered manager who told us she would address these. The service had robust safeguarding procedures which staff understood and any concerns relating to any form of abuse were reported and managed correctly. There were enough staff to meet people's care/nursing needs, albeit not necessarily when people wanted these met. Robust recruitment practices helped to protect people from staff who may be unsuitable. People lived in a clean environment and were protected from avoidable infection.

People's health needs were predominantly met, although one example of not following one person's condition put this person at risk of potential and unnecessary health complications. People who were not able to make decisions independently were supported to do so. People who lacked mental capacity were protected as staff followed the principles of the relevant legislation. However, the necessary and required records of this process were not always present. Arrangements had been made to improve the delivery of people's medicines to the home and how and when people received these.

People received care from staff who were kind and genuinely interested in their well-being. We observed kind and caring interactions from staff although when they were busy these sometimes lacked compassion. People's privacy and dignity were maintained. Where people had needed to wait for support their dignity had not been compromised. People who mattered to those receiving care were appropriately involved and welcomed at all times. People's complaints and dissatisfactions had been investigated and the management team had aimed to resolve these to the person's satisfaction.

The management of the service had improved since our last inspection but it had not been effective enough to maintain full compliance with the relevant health and social care regulations. Overall the service felt more organised and people told us the management team were more approachable. The provider had provided supported and had guided the management team through a period of improvement and they continued to monitor the service's progress closely.

Some of the issues identified in this inspection had been identified through the service's quality monitoring process but had not always been effectively resolved.

People and staff had been better involved in plans to improve the services provided. Their ideas and suggestions had been sought and acted on.

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 safe.

There were enough staff to meet people's needs but not always when people preferred their needs to be addressed. Recruitment practices protected people from the employment of unsuitable staff.

People were protected against risks that may affect their health and environmental risks were also monitored, identified and managed.

People were protected from abuse because staff knew how to identify and report any concerns they may have.

Arrangements were made to ensure people received their medicines safely and on time. This had been complicated by problems with the delivery of people's medicines which had been resolved.

People lived in a home which was clean and which had systems in place to protect people from avoidable infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed however, care records did not always reflect this.

People had access to health care professionals, although a lack of monitoring people's health records potentially put people at risk of not receiving appropriate and timely care or treatment.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Staff had received training relevant to people's needs. Where staff were new to care there were arrangements in place to help them learn appropriate skills.

Is the service caring?

Good

The service was caring.

Staff provided care with kindness and a genuine desire to improve people's general well-being. When satff were busy, sometimes, compassion for the person's situation was not always shown but this was not the normal practice.

People's dignity and privacy was maintained at all times.

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Requires Improvement

The service was not always able to be responsive.

Care plans lacked the detail needed to adequately record and give guidance to staff on what people's needs were and the care they required.

Staff wanted to give personalised care but at times the demand on their time meant they could not respond to people's individual requests and preferences. People did not always receive their care when they wanted it or necessarily required it.

People had opportunities to socialise and partake in activities and the staff were trying hard to make these activities more meaningful for people.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People had benefited from some improvements however the service had not maintained effective systems in all areas which then had an impact on people.

The management team were open to feedback from people and staff in order to improve the service going forward.

OSJCT Trevone 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 1, 2 and 3 June 2016 and was unannounced. One inspector carried out this inspection.

Prior to visiting Trevone we looked at the information we held about the service. This information included statutory notifications the provider had sent to the Care Quality Commission (CQC). A statutory notification is information about important events which the service is required to send to us by law. We reviewed information gathered from local commissioners. We also reviewed comments placed by people on a national care home marketing website.

During the inspection we spoke with six people who live at Trevone and sought their views on the services provided to them. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spoke with eight members of staff, the registered manager and a representative of the provider. We also spoke with one health care professional. We reviewed six people's care records and five people's additional care monitoring charts. These included the records of when people were repositioned and the amount of food and drink they consumed. We observed people receiving their medicines and reviewed their medicine administration records. We reviewed the recruitment records of three members of staff and the service's staff training record.

We also reviewed various records relating to the management of the service. These included the staffing rosters, complaints file, minutes of various staff meetings and a selection of quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

There were enough staff to ensure people's care needs were attended to. However, people's needs could not always be met when they wanted or preferred them to be met. The numbers of staff on duty were determined by the provider. This was done by considering the number of people living at Trevone and their individual needs. There were some people who required more support and time than others to meet their individual needs. The registered manager told us the numbers of staff deployed were "not perfect" but the home had several vacant beds (13) which had to be taken into consideration when determining staff numbers. Staffing gaps, due to sickness or annual leave were covered by staff picking up additional shifts. This was the case on one of the inspection days when two staff rang in sick. Agency staff were used to cover long-term staff vacancies but generally agency usage was avoided. Agency staff were used if the staffing numbers dropped to a number which the provider considered to be unsafe. One member of staff said, "Yes, I think there are enough staff, no-one is really poorly at the moment and there are only 27 residents". People we spoke with told us their care needs were met but they sometimes had to wait for help at busier times of the day.

Since our last inspection in February 2015 there was a noticeable improvement in how staff organised their work. For example, one member of staff during the day-time was allocated to the main lounge area to attend to people's needs, as they had been in February 2015. However, during this inspection because staffs' work elsewhere was better organised, this person could remain with these people. Meal-times were far more organised with food going out from the kitchen when it was ready. Staff told us they were very keen to respond to people's needs when they requested but at busy times the demands on the staff meant they could not always achieve this.

Busy periods of time were observed to be before and after lunch time, the same at tea time and during the evening before most people settled to bed. One person said, "I can't complain really. You do have to wait for help but you can't be selfish, they're very busy". When we asked if this wait was a long-time (over 10 minutes for example) the person said, "Yes it has been sometimes but that's all I can do, I need the help so I have to wait". We observed another person ask for help to the toilet. They were told "You'll need to wait a little while". The person said, "I know what they're 'little while' can be though". This person's call bell had been responded to in good time but they actually received help to use the toilet 25 minutes after they had asked for it. Another person located on the ground floor rang their call bell which was also answered almost immediately. This person requested some personal care and was told, "We [staff] need to attend to upstairs first". We spoke to the member of staff about this who told us they were going to start attending to people on the top floor and "work their way down". This was a task led approach to work. The registered manager told us she was trying to get staff to take a more "person centred" (personalised) approach to their work but for some staff this approach was still work in progress.

The registered manager monitored call bell response times. An audit in April 2016 showed several calls had not been responded to within 5 minutes and others within 10 minutes. This had been discussed with staff to ensure they made answering people's call bells a priority. The main reason for responding as quickly as possible to a call bell was to ensure the person was safe. For example, had not fallen or needed nursing or

medical assistance. We responded to one call bell which had been ringing for some time (just over five minutes) and found the person was anxious and saying they were in pain. We reported this to the nurse who visited the person immediately and attended to them. We requested a print out of the call bell response times for the period of the inspection and this highlighted the times of the day which we had observed to be particularly busy. Response times extended beyond 10 minutes at busy times. These findings show the staff were unable to deliver care in a personalised way which met people's preferences and needs at the time.

This is a breach of regulation 9 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

The print out also showed that the majority of other call bells, over the three day inspection period, had been answered in less than two minutes. This showed that at less busy times of the day staff were able to meet people's needs when they wanted them met without too much delay

Appropriate recruitment procedures were in place to protect people from staff who may not be suitable. Recruitment files showed checks had been carried out before the staff member started work. These had included clearance from the Disclosure and Barring Service (DBS). A DBS request enables employers to check the UK criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. The records of one member of staff from overseas also showed that a police check had been completed in their own country. References had been sought from previous employers and unexplained gaps in employment explored. During our last inspection the recruitment of nurses had been a priority. This situation had improved with new nurses recruited. Two further staff members were waiting to register as nurses in the UK. This successful recruitment had enabled Trevone House to have more senior staff with the appropriate skills and knowledge to meet people's needs. This had resulted in the reduction of agency staff usage.

People were protected from the risk of abuse. The service had a safeguarding policy with procedures in place. All staff read this when they first started work for the provider. The provider's procedures worked in conjunction with Gloucestershire County Council's multi-agency policy and protocols. Staff adhered to the provider's policy as well as the county's wider safeguarding protocols. The service therefore appropriately shared safeguarding concerns with external agencies that also had a responsibility to safeguard people. This for example included, the local county council's safeguarding team, the police and the Care Quality Commission. The service always fully investigated safeguarding concerns and took action to protect people. When requested they appropriately shared the outcome of these investigations with us and any actions they took. Staff told us they had received relevant training and they knew who to report their concerns to.

Risks to people's health and well-being were identified and action taken to manage these risks. For example, risk assessments stated what the problem was, for example, the development of pressure ulcers and then provided an assessment of the level of risk. Once assessed a care plan outlined what action would be taken to manage the risk. The same process was in place for other health related risks such as poor appetite, falls and problems with swallowing and the risk of choking. Additional monitoring records were used when staff needed to record their actions or monitor someone more closely. For example, for people who were at risk of developing pressure ulcers these records showed when staff repositioned a person in order to alleviate pressure from their skin.

Arrangements were also in place to keep the environment and equipment safe. This included a well-managed cycle of maintenance checks and servicing by appropriate contractors. The maintenance person had maintained comprehensive records of what checks and work they had completed since their employment in April 2016. This included such tasks as monitoring water temperatures as part of the overall

arrangements in place to reduce the risk of Legionella. We were shown information (dated May 2016) generated by a specialist contractor which showed there were procedures and actions being taken to maintain a healthy water system. We saw electrical and gas safety certificates which showed these systems and any relevant equipment was safe. Equipment used as part of personal care such as hoists, bath hoists, electrical beds and hoist slings were all serviced and checked on a regular basis. All fire safety precautions were in place. The fire detections systems and firefighting equipment were checked regularly by the maintenance person and by a specialist contractor. Staff received appropriate fire safety training which included evacuation processes.

People's medicines were administered safely, stored appropriately and the whole medicine system was regularly monitored. We observed staff following appropriate procedures when administering people's medicines. They made sure the right medicine was given to the right person at the right time. There had been several medicine errors since our last inspection which had been investigated. These had involved medicines not being given when prescribed and people's medicine administration records (MARs) not being signed by nurses. Members of staff administering medicines have to sign people's MARs once they have administered medicines so that an accurate record was kept of what medicines had been given. Inaccurate records can put people at risk of errors being made with their medicines.

Audits had been increased when this shortfall had been identified and these had shown they were predominantly down to agency nurses who did not regularly work at the home. The result of the investigations carried out had been; the agency staff who had made these errors had not been used again and the agency had been responsible for providing additional training and support to improve their staffs' competencies. Trevone's own staff received relevant training to be able to administer medicines and had their competency checked. If there were any concerns with a staff member's practice they were provided with additional support and had their competency monitored more closely. Additional complications had also been experienced with the supplying pharmacy who had not always managed to deliver people's medicines in time for them to be administered. This had been predominantly during the monthly changeover of stock. This had been managed by the senior management team and new arrangements were due to start soon.

People lived in a clean environment where precautions were in place to prevent the spread of infection and reduce potential cross contamination. In April 2016 a comment on a website for care home reviews had been made by a relative. They had said their relative's bedroom "is always spotlessly clean". We observed cleaning staff carrying out their tasks and storing their cleaning products securely when they were not attended. Care staff also took appropriate precautions to prevent the spread of potential infection. They were observed to wear plastic gloves and aprons when delivering care which they changed between visiting different people. In the laundry arrangements were in place to segregate various items of laundry and to ensure it was washed adequately and correctly. The kitchen had obtained a rating of "five" by the Food Standards Agency. This is the top rating awarded and means the kitchen was found to have 'very good' hygiene standards (www.food.gov.uk).

Requires Improvement

Is the service effective?

Our findings

During our last inspection in February 2015 the provider had failed to ensure people's nutritional risks were suitably assessed, identified and met. The provider wrote to us to tell us how they would address this shortfall. During this inspection we checked to see if this area of care had improved. People's nutritional risks were identified and recorded correctly. We observed people receiving individual and appropriate support with their food and drink. People's dining experience overall had greatly improved. One member of staff told us proudly they thought there had been "real improvements" with this. Where people needed their food cut up to help them manage it this was done for them. One person requested that their food be cut up at one particular meal and a member of staff said, "Of course I can" and did this immediately. This person was then able to enjoy their meal whilst it was still hot. We observed the needs of one group of people at mealtimes being consistently met by one designated member of staff. In this inspection the member of staff allocated to do this remained with this group; this had not been the case in 2015. Pictorial table menus had been printed again since our last inspection and now resembled what was being served and the writing was easier for people to read. People who needed additional support to make food choices were now shown the food options presented on a plate. We observed two people making independent choices by using this method.

We reviewed the food and fluid intake monitoring charts for two people. These monitoring charts gave a clear indication of what people had consumed. Another person had been reviewed by external health care professionals and they had requested that the person's food and fluid intake be closely monitored over three days. This was so they could determine the best course of treatment for the person which could include a referral to a dietician. A monitoring chart had been put in place for staff to complete. We reviewed this chart which had been completed for the first day at five different times between 8am and 10pm. The next two days consisted of one entry on each day. One entry at 10am on the first day and an entry at 10pm on the second day. It provided no indication as to whether the person had been offered any food or drink in between these entries or if they had refused it. We spoke with this person and they told us what they had to eat at each meal. We also spoke to the cook who confirmed what they prepared for this person. We were therefore reassured they were eating and drinking, however staff had not consistently recorded this. We fed this back to the registered manager. They told us it was the team leader's responsibility to ensure these records were completed and they would address this with them.

This person was not in any immediate risk with their nutrition because they were eating and drinking and what they were eating had been fortified (extra cream added to their soup and porridge to increase their calorie intake). In this case, poor record keeping had delayed the gathering of important information which had been requested by health care professionals. This shortfall in staffs' record keeping practice could potentially put people at risk of not receiving appropriate treatment when it is needed.

This was a breach of regulation 17 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

People's consent and agreement was asked for by staff before they delivered their care. We observed on

many occasions staff asking people if they were happy for them to do whatever it was they were about to do. For example, help someone to the toilet, help them to bed or help them to eat. Staff were aware of the Mental Capacity Act 2005 and the principles that underpin this. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Therefore, in practice, we observed people being supported to make decisions and if they were unable to do so we did not observe, at any time, care being forced on a person. If needed staff returned a little later and tried again when the person was more able to receive their care.

Where people had been suspected of lacking mental capacity, mental capacity assessments were sometimes in place and sometimes they were not. For one person who was "resistive to care" a mental capacity assessment had been completed in relation to this. The assessment recorded the person had no understanding of why they required care and why it needed to be delivered. This person's care records explained they lived with dementia and recorded many episodes of behaviour which had been challenging for staff to manage during care delivery. An appropriate referral had been completed to the local authority for deprivation of liberty safeguards (DoLS) as the person was deprived of their liberty in order for the care they needed to be delivered. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). This had not yet been formally authorised by the local authority. The care records and care plans did not explain that the person's care was delivered in their best interests. Decisions about this person's care and treatment were being made on their behalf and for this to be lawful needed to be delivered and recorded under best interests processes.

Another person who lived with dementia was also resistive to care and exhibiting behaviour which was challenging for staff to manage. Several entries in the persons care records stated staff were delivering personal care to this person despite the person's physically challenging behaviour. There was no record of staff using restraint and some entries stated that staff had returned a little later to deliver care successfully without resistance. In a professionals' meeting it had been agreed that an application must be completed for authorisation under DoLS. We could not establish from the records or by talking with the staff present if this had been done. Appropriate paperwork to explain that this person's care was delivered in their best interests was not seen and neither was a mental capacity assessment. This person's care plans also did not refer to the care being delivered in the person's best interests. The provider had developed a MCA/DoLS booklet which contained all necessary documents and care plans but this was not seen for these two people. The registered manager told us they would discuss this with their team. These shortfalls again were around a lack of proper recording of these processes rather than the principles of the MCA not being understood.

This was a breach of regulation 17 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

People had good access to local GPs who visited the home on a regular basis. We spoke with one visiting GP who expressed surprise and concern that several issues had been stored up for their end of week visit (Friday). One issue had been added to the list because we had asked staff about what had been done about one aspect of one person's health. This person, according to a care monitoring record, had some health concerns. We checked other care related records and there was no indication of the person having these health concerns acknowledged or investigated. This was therefore referred to the GP during the inspection. Whilst the GP did not have any concerns at that time, staff were asked to closely monitor the person's

condition. When talking with staff after the GP visit they reflected on the situation and told us the person had not presented with other relevant symptoms that would have indicated the person had a health problem. They listed symptoms that if presented they said would have alerted them to a potential health issue and they would have referred it to the GP. With regard to the health care monitoring record, staff told us they suspected this had either not been correctly maintained or the person had failed to update staff on their condition and the record completed accordingly. Our concern was the lack of staffs' reference to an on-going health care monitoring record; the purpose of which was to help staff monitor a particular area of a person's health. If appropriate care records are not going to be checked this puts people at risk of not receiving appropriate and timely care or treatment to meet their individual need.

This was a breach of regulation 9 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

People also had access to other health care specialist who could be referred to via the GP and who would also come and assess people if needed. These professionals included occupational therapists, speech and language therapists, mental health specialist and community nurses. A chiropodist (foot care) visited regularly. Optical and hearing appointments could be organised for people who could not attend external appointments. These were also accessed on the NHS for people who could not pay privately.

People were cared for by staff who had received training and support relevant to their needs. Staff training was on-going and a record held by the registered manager kept them aware of who had completed what training and who needed update training. The registered manager told us there were some gaps in staffs' knowledge for example relating to the Mental Capacity Act (MCA) 2005 which were being addressed through training. We saw notices for several training sessions, which included MCA training, due to take place soon. Staff had signed up for training they had to complete or additional training they were interested in.

All new staff employed by the provider underwent induction training which consisted of training the provider considered necessary for staff to be able to carry out their work safely. This included an introduction to the provider's policies and procedures and a period of shadowing more experienced staff. Staff completed training on subjects such as first aid, safe moving and handling, safeguarding people, health and safety and the Mental Capacity Act. Staff new to care completed modules from the care certificate. The care certificate is a nationally recognised framework of training and support which new care staff can receive. Its aim is that new care staff will be able to deliver safe and effective care to a recognised standard once completed.

Training needs were identified during one to one support meetings and by senior staff when working alongside staff. A nurse meeting in May 2016 had discussed the fact that staffs' one to one support sessions needed to be completed. There had been work done by senior staff to complete these and the registered manager told us they were almost all done. We saw a record which confirmed this. One member of staff confirmed they and other colleagues had received their one to one session.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. Comments included: "They [staff] are all very helpful and nice", "They are all polite and kind and the night staff are very good", "They look after me", "They're very sociable here, too good really" and "Yes, they look after me okay". Comments placed on a website for care home reviews in October 2015 and April 2016 included, "I cannot speak highly enough of the care and treatment [name] receives, each and every one of the staff treat [name] with kindness and dignity", "While [name] was there [name] was always treated with the utmost respect and dignity" and "A relaxed and caring atmosphere for residents and visitors".

We observed very kind and caring interactions from staff. We did not always like the way people were told they needed to wait for help. When this happened staff were not rude or nasty but the interactions did not always show compassion for the person's situation. If staff had offered an apology when they could not attend to a person this would have helped. This was the only time we felt compassion was not shown.

When staff delivered people's care they were totally focused on the needs of that person at that time. They knew the people well and gave them the time they needed when they were with them. People were not rushed through their care and staff chatted and laughed with them. One interaction from a nurse who had stopped the medicine round to come and offer reassure to one person was done with great compassion. They took their time with the person and showed genuine concern and empathy. This person relaxed and told them they felt much better. There were several interactions throughout the inspection along these lines.

People's dignity was maintained at all times, for example staff knocked on people's doors before entering and covered people before using a hoist so they were not inappropriately exposed. Conversations about people's care took place in private or out of hearing reach of others. Some staff were signed up dignity champions and they were committed to maintaining a person's dignity whilst they were in care. These fundamental values were promoted throughout the home and staff learnt about these in their induction training.

People's records showed evidence of relatives' involvement and discussions held with people's representatives when there were any changes in people's care or health. People were supported to maintain links with the people who mattered to them. People's family and friends were welcomed at any time.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to their admission so staff could make a decision as to whether they could meet the person's individual needs. It also helped staff get to know what was important to the person, how they liked their care delivered and if they required additional equipment. For example, pressure relief equipment, specific hoist and sling requirements, specific arrangements around feeding and medicines. This information went towards the formulation of care plans and risk assessments. These documents were designed to inform staff on how to manage particular risks and how to meet the person's care and nursing needs. Care plans were also a point of reference for visiting health care professionals such as agency staff and professionals carrying out assessments.

When we reviewed people's care records we saw a regular review process in place. People's risks assessment and care plans were reviewed monthly and more often if their health or needs had altered. This process was completed either by a nurse or care leader depending on the person's type of care. The standard of these reviews also varied. For example, if a person's nutritional assessment and recorded weight had shown they had lost weight in a month, sometimes this important piece of information was added to the review of the relevant care plan and sometimes it was not. However, in most cases if the review had recorded information which had ultimately led to a change in care this did not always result in the actual care plan being amended. To find out what had altered and to get a better picture of what care was currently needed it was often necessary to read through the monthly reviews. The care plans did not always document what people's current needs were and how these were to be met.

Staff were therefore also dependent on comprehensive verbal hand-overs to keep up to date with people's care and nursing needs. A lack of correctly maintained care plans for staff to reference, in particular by health care professionals who were unfamiliar with people's needs potentially puts people at risk of receiving inappropriate or unsafe care. Examples, included: one person had been provided with a piece of equipment which altered significantly how staff could communicate with them. As this person tended to get distressed and anxious good communication was integral to how successfully the person could be reassured or distracted. We saw staff using this equipment with good effect. The relevant care plan made no reference to the introduction and use of this piece of equipment. Another person had their night time medication reviewed. The care plan reviews did not record what had led to this person's night sedation being doubled and the care plan itself had remained unaltered. A lack of up to date care planning can put people at risk of not receiving care that is appropriate or safe for their individual needs.

This was a breach of regulation 17 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

There were two examples where the directions in a care plan/ review section had not been followed. For example, one person's care plan related to the risk of the person developing pressure ulcers. It stated they had to be repositioned every two hours. Their repositioning record on one day recorded two hourly repositioning up until 3pm and then again at 8pm; a five hour gap. Another person's record stated the same

intervals for their repositioning. They had been, according to the repositioning record repositioned at 11am and again at 2pm; a three hour gap. Staff did confirm there had been no deterioration in the condition of these people's skin and in fact one person's skin had improved. These people were also cared for on specialised pressure relief mattresses, so the risk to them if they were not repositioned was lowered. However, the care stipulated in the care plan had not always been delivered. As this potentially put people at risk we reported our findings to the registered manager. They said they would make sure the care leaders were monitoring these records and addressing any gaps in care.

Care plans tended to vary in levels of personalisation. People's particular choices, preferences and wishes relating to their care did not always come through in the text. We spoke with one person who was fully able to tell us about, the little things that if staff consistently did in practice, would make a big difference to their comfort. This important detail had not been explored with them and therefore it was not in the care plans.

Since our last inspection in February 2015 there had been a positive improvement in the provision of social events and activities. One member of staff described the difference they had observed in one person since they had been better supported to join in various activities. They spoke about the time this person returned from a trip out. They said, "[name] was totally animated telling us what a lovely day they had". They described this person as being withdrawn and disengaged from any social activity before they had been encouraged to get involved. They said, "What a difference that time spent with [name] and others has made to them". The activity coordinator worked 30 hours during the week. They had just been on annual leave and there had been no additional hours designated to cover their absence. We were told care staff could organise some activities during these times but our observations told us this would be limited as they were so busy.

People were not able to tell us about what activities they took part in so we reviewed records from January 2016 which told us what activities and social events had taken place and who had been involved. The records showed there had been various group outings involving between two and four people at a time. Places visited had included Bristol Zoo and Cadbury World. Activities in the home had included regular quizzes, bingo sessions, nail care and hand massage and visits from a dog. Other regular social gatherings in the home included singing sessions led by an external group, a regular exercise group also led by an external person, music groups and film groups. A food tasting session had been organised as part of the provider's week which focused on nutrition and hydration. Other external entertainers included an Irish band on St Patrick's Day and a drama theatre group. Another regular gathering was the 'memory club' where specific and carefully chosen topics of conversation or pictures were designed to evoke people's memories and promote discussion. One discussion had been on "The Power of Women" through the years and their role in society.

Local community involvement had included a visit to Gloucester Cathedral, a local vintage tea dance, an invitation by a local senior school for tea and an invitation to join in with the local church and their coffee mornings. During April 2016 there had been visits by local representatives of all the main political parties. The records stated that groups of up to 12 people had enjoyed the discussions and debates. A visit by the local police and a discussion on community policing and crime prevention was also enjoyed. The activity records stated how engaged each individual person had been. The activities coordinator and registered manager then assessed and evaluated how well each activity had gone. The registered manager told us they were working on trying to make activities more meaningful to individual people.

There were processes in place for people, their representatives and visitors to make a complaint. Local commissioners informed us there had been a reduction over the last year of concerns and dissatisfaction expressed to them about the service. Complaints whether verbal or in writing were investigated by the

registered manager with input from their deputy manager if it involved issues around nursing care. One person had raised a concern about a specific area of their care. The registered manager had investigated this and also shared the concern with relevant health care professionals who also reviewed the person's care. Their involvement was to ensure the service were meeting this person's needs correctly and to offer advice if needed. In this case, the issues raised could not be substantiated and all professional assessed the person's needs as being met correctly.

Another complaint had involved a change in a person's curtains. These had been replaced with curtains that did not meet in the middle and were too short. The registered manager investigated this and followed this up with a member of staff. This complaint was used to remind all staff that it was everyone's responsibility, whatever their role, to maintain people's privacy and dignity. The registered manager also used the heads of department meetings to discuss areas of dissatisfaction. Collective problem solving was used to drive improvement so future complaints and areas of dissatisfaction would be avoided. Any complaints and concerns received by the home were also monitored by the provider. The provider's representative visited regularly and the management of any complaints or concerns were closely monitored.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led. Quality assurance systems and other systems and processes were not operating effectively in all areas to identify shortfalls and ensure compliance with relevant health and social care regulations.

Where there had been areas of positive improvement, other areas had faltered. For example, a lack of correct and appropriate maintenance of people's care records, a lack of appropriate reference to these records to ensure people's well-being and health and staff not being able to meet people's needs as and when they wished them to be met. The registered manager had held a meeting with nursing staff in May 2016 telling them care plans still needed to become more personalised and where needed care plan reviews must result in appropriate amendments to people's care plans. A meeting in March 2016 had been held with care staff who had been reminded to read people's care plans. One member of staff during this inspection had told us they and their colleagues rarely had time to read people's care plans. They also told us they were still not involved in reviewing people's care plans even though they predominantly delivered people's basic care. The registered manager had also held meetings with team leaders to clarify their roles and responsibilities. One member of staff told us they had found the team leaders to be very supportive. One of the team leaders' roles however had been to ensure care monitoring records were accurately maintained. Therefore, the action taken so far had not been fully effective. Other areas were simply not effectively managed such as how staff received information about people before they started their shift and the deployment of staff during this time. When we fed back our findings to the registered manager they told us they needed to be "tougher" and make their expectations clearer and, if these remained unmet they would need to take further action.

On two evenings we joined the staff hand-over meeting, held between the day nurse and the night team coming on duty. There was no designated hand-over time to do this in so the day care staff left as the night staff came on duty. One nurse told us it was helpful if the night staff came on duty a little earlier so hand-over could take place whilst the day staff were still able to respond to call bells and monitor people. However, they also told us this did not always happen as it was down to "the goodwill of the staff" to do this. On both evenings the night staff made it a priority to answer people's call bells; as had been previously directed by the registered manager, however they then struggled to be present in order to receive pertinent information about people before they started their work. We observed the night care staff constantly leaving the hand-over meeting to answer call bells. Both day nurses told us the arrangement did not work. As one day nurse waited for two out of the three care staff on duty to return to the hand-over meeting they said, "It's hopeless". On one evening an agency nurse had not worked in the home for two years so needed to be orientated to various safety systems and other processes before the day nurse could go off duty. This resulted in the day nurse eventually going off duty at 9:45pm instead of at 8pm. On the second night the night care staff could not physically attend the hand-over until 8:20pm because, as they had arrived at work they had needed to immediately attend to people's call bells.

When we discussed our observations with the management team they suggested the care staff could have been initially informed of any major changes or issues and been given a more detailed hand-over later by

the night nurse. They said a printed hand-over form had been introduced with basic information on it about people to help with this. However, on the night when the agency nurse was not familiar with the people, their conditions and needs and the home's systems, having the regular night care staff present enabled them to give this nurse further information and clarification about what happened with people during the night.

On both evenings people in the lounge were not monitored during the time of the hand-over meeting as night staff were prioritising the answering of people's call bells. In the lounge were five people who were either watching the television or sleeping. However, one of these people had been assessed as a high risk of falls. During the day this was managed by the staff member allocated to the lounge area making sure they were near to hand to be able to support this person immediately when required. The accident records did not record any particular pattern to this person's falls although there were two recorded incidents of the person being found on the floor. Once at 8:30pm and once at 10:30pm. As we were aware of this person's risk and staff were otherwise engaged we left the hand-over meetings intermittently to reassure ourselves that the person was settled and seated, which they were. This person's care plan stated they needed alarmed equipment to help alert staff to when the person needed appropriate support to prevent a fall. One entry also said, "none [equipment] in working order in the home" so "care staff to do 30 minute observations". A later review of the care plan referred to the alarmed equipment being in place but it was unclear when this had taken place. The care plan also stated the person required a walking frame. One member of staff said, "If you can spend the time with [name] they are settled". During the inspection we saw the alarmed equipment in place by the person's armchair in the lounge. We also witnessed on one occasion staff becoming aware that the equipment was disconnected because staff had failed to previously reconnect it after presumably they had helped the person move, for example to the toilet or the dining room table.

Quality monitoring processes showed the provider had continued to support and guide the registered manager through various performance targets and improvements since the last inspection. The service had been assessed against the provider's core expectations and performance indicators and an improvement on the previous assessment had been achieved. An improvement plan had been developed to address the identified shortfalls and areas for improvement from this assessment. The provider's representative had monitored and supported the registered manager in addressing these actions. Some of these actions had been completed and others were still work in progress. The registered manager had completed their own in-house auditing which had identified some of the issues identified during this inspection. They had also set actions to address these although as discussed above some of these had not resulted in a positive outcome. Systems and processes were not operating effectively to ensure the service could remain compliant with the necessary requirements.

This is a breach of regulation 17 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

People's views about the services provided were sought informally for example, by the activities coordinator during small group gatherings. They had done this when they had wanted to know what social activities and events people wanted to get involved in. They had used this feedback to develop the activities programme. Feedback had also been sought from people when staff were improving the dining experience. Relatives and visitors could feedback their comments about the services provided on a national care homes website which the registered manager monitored. They told us their score on this website had increased from 7.2 to 9.4 following more positive comments. Comments from this website in October 2015 and February 2016 said, "From the management to kitchen staff I have found all to be approachable" and "All the management and staff were always very helpful". The provider informed us that a new questionnaire had been developed

for people and their relatives and was due to be introduced soon.

Staff had also been asked in meetings for their views and suggestions. They had requested more safe moving and handling equipment (stand-aid hoists) so they did not have to waste time looking for the equipment in another part of the home. They had requested that there be one hoist on each floor. The registered manager told us they had ordered these and were waiting delivery. The registered manager said, "It was nice to get staffs' views and feedback". They told us they had worked hard on "taking on and listening to the team".

During this inspection there was also evidence to show the service was also running in a more structured way and that staff were more organised in the way they were worked, albeit at times in a task led manner. Factors influencing this was less dependency on different agency nurses, because there was a more stable team of nursing staff and care leaders had become more confident in directing care staff. The successful employment of nurses from overseas; some working as senior care staff whilst they waited for their UK nurse registration, had also improved the skills of the care team overall. There had also been improvements in how social activities were provided.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always appropriate and was not always delivered in a way which met people's individual preferences and choices. Regulation 9 (1) (a)(b)(c) and (3)(b)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and relevant care records were not always maintained. This related to people's care monitoring records, records relating to process under the Mental Capacity Act 2005 and people's care plans. Effective systems and processes for ensuring compliance with relevant requirements and for maintaining improvement had not been effective. Regulation 17 (1) and (2) (c).