The Orders Of St. John Care Trust

OSJCT Coombe End Court

Inspection report

London Road
Marlborough
Wiltshire
SN8 2AP

Tel: 01672512075
Website: www.osjct.co.uk

Date of inspection visit:
09 February 2022
16 February 2022

Date of publication:
28 April 2022

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
OSJCT Coombe End Court provides care and accommodation for up to 60 people, some of whom live with dementia. Accommodation is provided on two floors accessed by stairs and a lift. People have their own rooms with en-suite facilities and access to communal areas. A garden is accessed from the ground floor. At the time of the inspection there were 50 people living at the service.

People's experience of using this service and what we found
Systems in place to monitor risks to people were not robust and staff were not recording their actions contemporaneously. Night care security arrangements had been increased to hourly, but we observed shortfalls to these arrangements which placed people at risk of harm. The provider told us they were carrying out a night care whole service review at all of their homes in the organisation. The findings would be shared across the organisations so lessons could be learned, and more effective arrangements put into place.

On our first day of inspection we observed there were areas of the home that required maintenance and needed a clean. Cleaning records had not been completed in one area of the home for four days. We observed some bins were broken and in one toilet not available. On our second day of inspection these shortfalls had been addressed and a different cleaning system had been put in place for kitchen areas.

During our inspection we received a whistleblowing concern about low staffing numbers. We reviewed staffing and found some evidence to substantiate that concern. People and staff told us there were not enough staff at all times. Agency staff were being used but at times there were none available which placed permanent staff under strain. Whilst care was being delivered, it took longer than usual. The provider was actively recruiting and trying to attract new staff to the home.

People had their medicines as prescribed and there were safe management systems in place. Staff had been trained to administer medicines and were observed to be following safe practice. We observed healthcare professionals visiting during our inspection and were told they visited people regularly where needed.

People and staff were testing for COVID-19 following the government guidance. Any visitors to the home had to complete a Lateral flow test prior to entry. All professional visitors had to demonstrate they had been vaccinated for COVID-19 and all staff had also been vaccinated.

Visiting was being supported both indoors and outdoors. Relatives spoke to us about being essential care givers which meant they could visit at any time even during outbreaks of COVID-19. Visitors had to wear personal protective equipment (PPE) which was supplied by the home. We observed staff were wearing the appropriate PPE at all times during our inspection.

Staff had been trained on working safely during COVID-19 and told us they had plenty of PPE available

throughout the pandemic. Staff told us they felt supported and had systems in place to support their well-being.

There was a registered manager in post. Feedback about them from relatives and staff was positive and appreciative of their management approach. The registered manager told us they had good support from the provider and their peers.

Quality monitoring was in place and a full range of audits were being completed for all areas. Whilst the monitoring was being carried out it had not identified all of the shortfalls we found during the inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 17 February 2020).

Why we inspected
The inspection was prompted in part by notification about a person using the service who had died. This inspection did not examine the circumstances of the incident as this was still being investigated by the provider and other agencies. This inspection reviewed the wider safety arrangements for people at night.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for OSJCT Coombe End Court on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified one breach in relation to management oversight and governance at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

OSJCT Coombe End Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
OSJCT Coombe End Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. OSJCT Coombe End Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. The first day of the inspection started at 20:00hrs.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us

to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people about their experiences of care and five members of staff. We spoke with two visiting professionals, the registered manager and two regional managers. 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 reviewed 10 people's care records, multiple medication records, cleaning schedules, health and safety records, risk management monitoring forms, three staff files in relation to recruitment, staff rotas and records of security checks.

After the inspection
We arranged to speak with a further one person about their experiences and four relatives on the telephone. We also spoke with a further four members of staff and the registered manager.

We continued to validate evidence found and reviewed staff meeting minutes, risk management plans, training records, policies and procedures and quality monitoring records. We also met with the provider.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Following a serious incident which occurred overnight, the provider had increased night security checks on external doors and every person at the home. Staff were required to check people hourly and record their checks on night care security forms.
- We found shortfalls with the recording on the forms. For example, we observed one check had not been recorded on the form when it was due, or staff had not carried out the check. The provider could not be assured checks were being carried out as required. We also observed checks had been recorded for one person who was not in the home. We raised this with the provider who told us they would investigate our findings.
- One external door was being used for a person to go outside during the night. Staff were de-activating the alarm to enable the door to be opened. We observed whilst the door was locked, it was left un-alarmed following its use. We raised this with the provider who told us they would investigate the incident.
- We found two people's risk monitoring records had not been completed contemporaneously. This meant the provider could not be assured the necessary actions had been completed at the time they were needed which placed people at risk of harm. The provider told us they would review their systems.
- People had risk management plans in place for a range of risks such as falls, moving and handing and development of pressure ulcers. Staff reviewed them regularly and made changes when people's needs changed.

Staffing and recruitment

- During the inspection we received a whistleblowing concern regarding the service being short of staff. We found whilst the service was at times lower on numbers than planned, this was usually due to short notice sickness or absence. The registered manager told us it was difficult at times to get agency cover for the shift as it was such short notice.
- People told us staffing numbers was at times a "struggle". Comments from people included, "Sometimes they [staff] are short, but I could not wish for better staff" and, "They do struggle with staff, they [staff] just look busy all the time."
- All the people we spoke with told us whilst they were aware the staff were short of numbers on some days, this did not impact on them significantly. They told us they did not have to wait for long periods of time for help and staff always responded to their call bells in a timely way.
- However, one person did tell us they felt opportunity for social interaction was stretched when the numbers of staff were low. They told us, "There is not enough time for the human side of things. You get washed and dressed but there is no time for a talk". We shared this feedback with the registered manager.

● The registered manager told us they were actively recruiting for more staff, but this had been a challenge. The provider told us this reflected a national picture in the social care sector. To cover gaps in staff rotas the service used agency staff. These were block booked in advance to help with continuity of care, although there had been times when the agency had let the home down at short notice.
● Staff were recruited following the required pre-employment checks being carried out. This included obtaining a full employment history and a check with the disclosure and barring service (DBS).

Systems and processes to safeguard people from the risk of abuse
● People and relatives told us people were safe at the service. One relative told us, "Yes, I think [relative] is safe, I feel confident about them [staff]."
● Staff received training on safeguarding and felt able to report any concerns they had. Staff told us they felt their concerns would be addressed responsively. One member of staff said, "If I saw staff not treating someone well, or not speaking to someone nicely I would report this to the [registered manager]. I am confident she would deal with it."
● We saw the registered manager reported concerns to the local authority safeguarding teams and notified CQC when needed to inform us of any allegations of abuse.

Using medicines safely
● People had their medicines as prescribed. Systems were in place to make sure medicines were checked into the home safely and stock checks were carried out regularly.
● People had their own medicines administration record (MAR), those seen had no gaps in recording. People had a separate MAR for any topical creams they were prescribed. Care staff had undertaken training and competency checks regarding application of topical medicines.
● Two people had been prescribed thickeners for their drinks. Thickeners can help people who are at risk of choking. Information in their care plans detailed the amount of thickener required and two staff members were able to confirm the correct amounts to be used.
● We observed during our first day of inspection thickeners had been left on a worktop in an area accessible to people. We raised this with the provider who took immediate steps to address this shortfall and share learning across the organisation about the risks involved. Thickeners should be stored securely as they can cause harm when ingested without the correct preparation.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. During our first site visit we observed one area of the home that was dirty and in need of a clean. We also observed handrails with flaked paint and rust in toilets and bathrooms. Some pedal bins were broken, and a lid was partly missing from one bin. When we returned on the second day of inspection, we observed the provider had addressed all of the concerns shared and bought new pedal bins where needed.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● People could have visitors indoors. During our inspection we observed families visiting their relatives in people's rooms. All visitors were required to carry out a Lateral Flow Test prior to entering the home.

Care homes (Vaccinations as Condition of Deployment)
From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.
● The provider had systems in place to check that staff are vaccinated against COVID-19 prior to employment. For existing staff, the provider obtained evidence of vaccination dates via the COVID pass.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Checks carried out by the night staff were recorded on forms and given to management following each night shift. However, we found forms were stored in envelopes without a full and thorough check being carried out. Shortfalls in recording we observed on some of the forms had not been identified by the management so that action could be taken. The registered manager informed us the forms had been reviewed and updated following our visit.
- Systems in place to make sure all external doors were alarmed overnight were not robust. We observed a person using an external door which was left locked but un-alarmed. This was not in line with revised night security measures put in place by the provider. The provider told us they would investigate this incident and review the system.
- Systems were not in place to ensure records were maintained contemporaneously. In addition to the shortfalls with night security records, we observed one re-positioning record and falls observation record that were not completed to record actions taken in a timely way. We discussed this with the provider who told us they would review systems to make sure actions were recorded when they were taken.
- During our inspection we asked to see a copy of the home's legionella risk assessment. This was not available for us to review. Following our inspection, the provider sent us a copy and informed us an error had occurred in giving staff access to the document. The provider told us this error had been corrected.
- We also asked for evidence of action taken in response to a service report identifying hot water valves were faulty. The provider told us action had been taken but were not able to provide us evidence. Following our inspection, the provider gave us evidence of action taken.
- Quality monitoring checks were being carried out but had not identified the shortfalls we found at this inspection. We met with the provider during the inspection who told us they would investigate some of our findings.

Systems were not effective in assessing, monitoring and mitigating risks to the health, safety and welfare of people using the service and monitoring and improving the quality and safety of the service, and to ensure a contemporaneous record was completed for people. This placed people at risk of harm. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider told us they were carrying out a whole service review for all of their homes following the serious incident at the home. The review was being completed by a range of staff across the organisation

including night care workers and covered night care security arrangements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People told us they enjoyed living at the home and the staff were kind. All the relatives we spoke with were happy with the care provided. One person told us, "The girls [staff] here are so kind." One relative told us, "They [staff] have been very welcoming, [relative] is happy, we are very pleased, things have worked out well for us all."

● Feedback we heard from relatives and staff about the registered manager was positive. Staff told us they could approach her at any time and that she was a visible presence in the home. Comments included, "I can talk to her about anything she is approachable" and "[Registered manager] is just awesome. Because she has come up through the ranks, she knows the home, she knows the staff. I can't speak highly enough about her."

● People were being cared for by staff who enjoyed their jobs. Comments from staff included, "I love working with the residents" and, "It is a good place to work, the management are very understanding."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were able to attend meetings to give their feedback on the care and support provided. The home had a 'residents committee' who took an active role in providing feedback on managing the home.

● Relatives told us communication with the provider had been good. They had been kept up to date with news on visiting and outbreaks via email.

● The registered manager told us the home had links with local schools and community initiatives. For example, a local dance school had been visiting the home prior to COVID-19 to perform for people. During the pandemic the children had filmed their performances so people could still watch them dance. The home had linked up with a racehorse charity which brought horses to visit people at the home. The registered manager told us this had been a real success and they hoped to build on the visit with further involvement.

● Staff had meetings where they could share ideas for improvement. Staff told us they felt listened to and valued by the management. One member of staff told us, "When you raise a complaint, they listen to you, they support you and guide you."

● Following a serious incident at the home the provider had organised for staff to have counselling if they wished. Staff told us they had taken this opportunity to talk with someone and found it to be helpful.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had a duty of candour policy in place which outlined how they would meet their responsibility to be open and transparent with people.

Working in partnership with others

● Feedback from professionals was that staff were busy and at times they had noticed a lack of attention to small details. For example, they had observed people without a drink in their reach or people who were diabetic had been given sugary foods. In response to observations management told professionals they would instigate a back to basics programme with care staff. This would remind staff of the importance of good basic care.

● Staff worked with various health care professionals to make sure people's health needs were met. We saw evidence in people's records of visits from GP's, community nurses and therapists.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to have robust systems in place to assess, monitor and improve the quality and safety of the service and assess, monitor and mitigate the risks relating to health, safety and welfare of service users. The provider had also failed to have systems in place to make sure there were accurate and complete contemporaneous records at all times. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

We served the provider a Warning Notice.