The Orders Of St. John Care Trust

OSJCT Coombe End Court

Inspection report

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Date of inspection visit:
11 January 2018

Date of publication:
19 February 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

At the last inspection in January 2017 the service was rated Requires Improvement. Following this inspection, the provider agreed to complete regular action plans to show what they were doing to improve the ratings in key questions of Safe, Effective, Responsive and Well Led.

OSJCT Coombe End Court is a "care home". People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At OSJCT Coombe End Court up to 60 people can be accommodated in one adapted building. There is a unit on the ground floor which supports people living with dementia.

A registered manager was 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.'

Quality Assurance processes were in place. An overarching improvement plan was in place with action plans on how shortfalls were to be met. The registered manager monitored the quality of the service and looked for continuous improvements. Healthcare professionals told us the staff made "great efforts to engage with the local community."

Care plans were person centred for some people and included their preferences regarding people's preferred first name and staff were aware of people's likes and dislikes. "This is me" profiles in bedroom were brief but informative. Life stories were in place for some people. These needed to be further developed particularly for people living with dementia as they helped in developing person centred plans.

Where people used repetitive behaviours to gain staff support we observed an inconsistent approach. Care plans were not developed on how staff were to consistently approach these situations. A professional said for people with misperceived situations some staff need to "validate how people feel" and to be accepting of this. The registered manager said some staff "need reminding, we will do some workshops and refresh the back to basics training."

There were people who expressed their anxiety and frustrations through verbal and physically aggressive behaviours. Care plans and risk assessments were in place on how to respond to triggers identified. Staff told us they used distraction techniques and where care was refused people were given time to accept support. We observed staff use different techniques to support people when difficult behaviours were

presented.

Mental capacity assessments were completed for care and treatment to live at the home. Some capacity assessments did not reflect the DoLS applications. For example a capacity assessment was not completed for people whose medicines were administered by the staff. Also staff had not recorded if the Court appointed deputy was consulted about best interest decisions such as using pressure mats in bedrooms.

People were empowered to make day to day decisions. Staff were knowledgeable about the Mental Capacity Act, people's varying levels of capacity and had an awareness of Deprivation of Liberty Safeguards (DoLS). Applications to the supervisory body were made for continuous supervision and the least restrictive options were used which meant people were able to move freely around the property.

Although we saw staff were available and spent time with people in Pearl unit, relatives and some professionals raised concerns about staffing levels. All people commented that the staff were very good, but that staff time is task focused. The registered manager told us the staffing levels were appropriate to the dependency needs of people. Staff told us that changes in staffing hours meant people benefitted from consistent staff.

People were supported to access health professionals when needed and staff worked closely with people's GP's to ensure their health and well-being was monitored. Nurse practitioners were undertaking routine visits and GP's covered more urgent treatment. Staff told us the process had become longer as nurse practitioners had to consult with the GP before prescribing or changing treatment plans.

People said they felt safe and relatives felt their family members were safe living at the home. Staff had attended training in safeguarding of adults procedures, which included the types of abuse and about reporting allegations of abuse. Staff knew how to identify the types of abuse and to report their concerns.

Systems were in place to identify and manage potential harm. Risk assessments were devised and reviewed regularly to support people to take risks safely. Some people had been identified at risk of falls, choking and malnutrition. The staff were aware of individual risks and the actions needed to minimise the risk of harm. For example, pressure mattresses for people at risk of pressure ulcers and 72 hour observations following a fall.

Accidents and incidents were reported and analysed for patterns and trends. Reflective meetings took place to ensure there was learning to reduce repeated occurrences. Robust systems of recording and auditing incidents were in place; for example, incident reports were linked to the care plan.

People received their medicines safely. Medicine administration records (MAR) sheets were signed to indicate when medicines were administered. Where people were prescribed medicines with specific instructions for administration we saw these instructions were followed.

People received effective care from staff who had the skills and knowledge to support them and meet their needs. Staff attended training set as mandatory by the provider. Staff had an opportunity to meet with their line manager as needed to discuss their performance, concerns and training needs.

People's dietary requirements were catered for. A whiteboard in the kitchen listed people's dietary needs such as intolerance, textured diets and date of birth to celebrate birthdays. The chef told us they were made aware of people's food preferences. We saw staff show people the choices of food available and to support some people to maintain their independence adapted cutlery and crockery was used.

Staff interact with people in a positive manner. Records showed that staff treated people cared for in bed with compassion. For example, nicotine patches were prescribe and Reike (a technique based on the principle that that energy can be channelled by means of touch, to activate the person's natural healing processes and restore physical and emotional well-being). The rights of people were respected and staff gave us examples on how they respected people's privacy and dignity.

Arrangements were in place for external entertainers to visit the home and internal activities. People were able to pursue interests and there were opportunities for them to join group activities and to have one to one time with the activities coordinators. Resident and Relatives meetings were taking place and we were told how suggestions were acted upon.

The team worked well together, they mentored and supported each other. Staff said there had been improvements since the appointment of the current registered manager.

People feel confident to approach staff irrespective of their role with complaints. They are confident their concerns will be taken seriously.

We made a recommendation about the deployment of staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was consistently safe.

Medicine systems were safe.

Risks were identified and action plans were developed on minimising the risk. Member of staff were knowledgeable on actions necessary to reduce risks.

There were sufficient staff to support people and we observed that staff were visible and available to people at different times of the day.

People said they felt safe and were able to describe what safe meant to them. Staff attended safeguarding of vulnerable adults training which meant they knew how to recognise the types of abuse and how to report their concerns.

Is the service effective?

Good

The service was effective.

Staff enabled people to make choices. People's capacity to make complex decisions wasere assessed and best interest decisions were madetaken with the person and their relatives involved.

The staff had the skills and knowledge needed to meet the changing needs of people.

People's dietary requirements were catered for.

Is the service caring?

Good

The service was caring

People were treated with kindness and with compassion. We saw positive interactions between staff and people using the service. Staff knew people's needs well and how to reassure them when they became distressed.

People's rights were respected and staff explained how these were observed.

Is the service responsive?

Requires Improvement

The service was not responsive

For some people care plans were not person centred. Some people displayed repetitive behaviours but care plans were not developed on how staff were to manage these situations. Life stories were not developed for all the people living with dementia.

People had access to in-house activities and there were visits from external entertainers. People were supported to maintain contact with relatives.

People said they felt confident to approach staff with their complaints.

Is the service well-led?

Good

The service was well led.

Quality assurance systems were in place and processes for assessing the delivery of care were in place.

There were arrangements in place for continuous improvement.

Staff were aware of the values of the organisation. They said the team worked well together and the registered manager had introduced improvements.

OSJCT Coombe End Court

Detailed findings

Background to this inspection

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

This inspection took place on 10 and 11 January 2018 and the first day of our visit was unannounced. The registered manager was aware of the visit arranged for the second day of the inspection. At the time of the inspection there were 47 people living at the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

We spoke with nine people and seven relatives. We spoke with eight staff including seniors, the registered manager and one member of staff. External trainers and social and healthcare professionals also gave us feedback about the service.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included eight care and support plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for parts of both days.

Good

Is the service safe?

Our findings

At the previous inspection we found breaches of Regulation 12 and 18 of the Health and Social Care Act Regulated Activities Regulations 2014. People were at risk from unsafe medicine systems and there were insufficient numbers of staff to deliver care and treatment in a consistent manner. Incidents and accidents were not taken seriously and acted upon. Where people sustained injuries action was not taken to mitigate the risk or to protect people from avoidable harm. We wrote to the provider telling them we proposed to impose conditions. The provider wrote to us telling us how the legislation requirements were to be met. We found improvements had taken place.

Although in Pearl unit we saw that staff were available and spent time with people, some relatives and some professionals raised concerns about staffing levels. All people commented that the staff were very good but were "task focused". Relatives raised concerns that at peak times, staff were not available to assist with personal care during or after the lunch service. Two healthcare professionals told us about their concerns in staffing levels for Ruby and Emerald units and said "we struggle to find staff in communal areas. Some altercations between people are not diffused because there is minimal staff presence in lounges. Staff are engaged in tasks instead of having social contact with people. Staff here are very busy."

The registered manager said "we are well staffed. There are 47 people [at the home] with 12 staff on duty. There is a good ratio of staffing." Additionally that a dependency tool was used to identify the staffing levels needed and the ratio was above people's levels of dependency. It was confirmed that as people's needs changed or when there were new admissions and discharges dependency levels were reviewed. The registered manager also acknowledged that "mornings are busy, but in the afternoons and evenings staff have time to speak with people".

We recommend the registered manager seek advice and guidance on the deployment of staff on duty.

The registered manager responded to staff suggestions to introduce 12 hour shifts, which the staff said they prefer. Staff told us the changes in shift patterns benefitted people as this was a better way to maintain continuity and they were also able to "pick up" vacant shifts. This meant there was less reliance on agency staff. A relative told us "The changes to the staff rotas mean that if you can't see a staff member in the morning they are still here after lunch and the staff seem to like it too."

Systems were in place to ensure people were supported to stay safe from avoidable harm and to take risk safely. Staff told us and the training matrix confirmed they had attended moving and handling training, to ensure people were supported with safe transfers. The staff we asked were aware of the risks to the individual and the actions needed to minimise the risk. They told us some people were assessed at risk of falls, choking and with mobility impairments.

The moving and handling risk assessment and mobility care plan for one person detailed the equipment used by the person and the support needed from the staff with transfers. For example, one to two staff needed to support the person with walking. The risk factors that increased the potential of falls were listed

in the falls prevention care plan which accompanied the mobility care plan. For example, some medicines may cause drowsiness and this person was also registered blind. Pressure mats to alert staff the person was moving in their bedroom and for staff to give the person clear instructions, were the actions taken to minimise the risk of falls. A member of staff's knowledge of the people at risk of falls was underpinned by reading care plans, assessments and making contact with the next of kin.

The Malnutrition Universal Screen Tool was used for people that were at risk of weight loss. For one person identified at risk of malnutrition, the plan was for their weight to be monitored and appropriate diets such as high calorie meals to be served. Staff monitored the food and fluid intake for people identified at high of malnutrition and weight charts were completed according to the care plan. For example, for people at high risk of malnutrition their weight was monitored weekly.

Where people were assessed at risk of pressure ulcers the factors that contributed to potential risk were identified. For example, continence needs and poor mobility. The tissue viability care plans for one person included a Waterlow scale used to assess the risk of them developing a pressure ulcer. The action plans included regular repositioning and specialist equipment. Body maps were attached to the care plan and illustrated the location of the ulcer on the body. Documentation indicated that community nurses were involved in the treatment of the pressure areas.

There were people that used verbal and physical aggression to express anxiety and distress. Arrangements were in place for staff to identify and respond to triggers when people became distressed or frustrated. The training matrix showed staff had attended training in "Living Well with Dementia." This meant staff had the skills needed to manage physical and aggressive situations.

There were care plans and risk assessments in place on how staff were to manage difficult behaviours. The personal care plan that accompanied the risk assessment specified the assistance the person may refuse and how this assistance was refused. For example, reluctance to rise in the morning. The action plan gave guidance for staff to give cues on the time of the day such as greeting the person, offering refreshments and opening curtains. Staff were to explain tasks and to give time for the person to accept support. A member of staff said "we ask before offering support, one staff is better as two is more threatening. We come away for five minutes and we are usually successful on the third time." Another member of staff said "some people are at risk from others. We divert people from the situation and we offer refreshments and discuss the issues."

For another person Antecedents Behaviours and Consequence (ABC) charts that provide an accurate picture of the person's emotional state were used to analyse behaviours. Staff documented behaviours and their response to the triggers presented. Requests for additional support from the mental health team were made as there were changes in behaviours. For example, Consultant Psychiatrist and one to one staff support throughout the day.

Fire risk assessments were in place on how staff were to support people to evacuate the property safely in the event of a fire. For one person with cognitive impairment the assessment was partially completed as information was missing on how staff were to give this person guidance to evacuate the property safely. For another person the guidance for safe evacuation was clear and included support from staff to "relocate two fire doors away from the point of the fire."

Staff told us there was a lack of moving and handling equipment. We observed one person waiting for 45 mins for the equipment and staff to be available. The registered manager said they were unaware that more equipment was needed and another hoist would be made available for the staff.

Accidents and incidents were reported by the staff. Recorded was a description of the accident, the name of staff where they had witnessed the incident and the injuries sustained. A member of staff said an online reporting system was used for recording accidents and incidents. Another member of staff also told us that for 72 hours following an accidents staff undertook observation for head injury. The training matrix confirmed staff were trained in "emergency first aid". The registered manager and area manager told us accidents and incidents were analysed at service level to identify patterns and trends.

Medicine systems ensured proper and safe use of medicines. Medicines were stored securely, including those with additional security requirements. Medicines were stored at the correct temperature, which was recorded appropriately within the medicines room; the refrigerator temperature was also recorded daily.

Two staff were assigned with medicine lead roles. The staff were trained in administration of medicines and were able to describe the protocols for errors including missed or late administration and were familiar with the duty of candour. This meant being open and honest with relatives when there were mistakes.

The medicine rounds we observed were conducted in a timely manner. Some people were having their medicines disguised and the staff understood why they were doing this. Individual Medicine Administration Record (MAR) charts included a front sheet with a photograph of the person to help staff identify the person. MAR charts were signed by staff to indicate the medicines administered. When people were prescribed additional medicines on an 'as required' (PRN) basis there were protocols to guide staff when people might require them.

People told us they felt safe living at the home what feeling staff meant to them. Comments made by people included "You feel Safe with someone around all the time," "I do feel safe – it's just the way its run that makes me feel [safe]" and "Oh yes the carers have a lot of compassion. They are great". Relative's comments included "Staff are staying – it's a happy home and I feel she is safe and happy here and I don't have to worry when I go home at night" and "he is safe definitely – he has one to one twenty four hours a day."

Systems were in place to monitor safeguarding referrals. The registered manager told us there were no outstanding safeguarding referrals made to the lead Local Authority. Staff told us and the training matrix showed that staff had attended training in safeguarding of vulnerable adults from abuse. Members of staff explained the procedures for safeguarding adults, which included how to identify the types of abuse and to report their concerns.

People were protected by the prevention and control of infection. A relative told us "it is nice and clean and there are never any odours. The room is cleaned daily but not today and when the cleaner has a day off." The head housekeeper was recently appointed and told us there was one housekeeping vacancy. They said the registered manager was to look at the rota once they were fully staffed to ensure there was cover from 6:30 am until 6:30 pm. This was to ensure there are staff available to maintain the home as clean and free from lingering odours.

All housekeeping staff were provided with individual cleaning schedules. A housekeeper told us that training had been provided on the use cleaning substances. We found the home clean and free from unpleasant smells.

Good

Is the service effective?

Our findings

New staff received an induction to prepare them for their role. Staff told us they completed the Care Certificate (set of standards that health and social care workers adhere to in their daily working life) and they attended mandatory training set by the provider. For example, confidentiality and safeguarding of vulnerable adults. A member of staff said basic training was also provided and this included tasks such as making a bed. Another member of staff told us their induction also included shadowing more experienced staff. They said six shadow shifts took place before they felt confident, as this was their first experience of the care environment.

Systems were in place to support staff and to ensure they had the skills and knowledge to meet the needs of people. Staff told us they had attended mandatory training and there were opportunities for vocational qualifications up to NVQ level five. The training matrix confirmed the comments of the staff and showed all staff attended the Care Certificate and "Living Well with Dementia".

All the staff we spoke with said they had regular one to one sessions. The registered manager and area manager told us one to one meetings were known as "Trust in Conversation" and were ad hoc. They said these conversations were "an informal way of knowing staff." Appraisals were annual and the registered manager said these were in progress.

People were supported to maintain a balanced diet. People told us the food was good and chalk boards in dining rooms listed the day's menus. The chef told us the menus were annual and were adapted to meet people's preferences. They said on admission people's preferences were gained and reviewed three monthly. This was to ensure people were served with their preferred meals.

A white board in the kitchen detailed the specific diets that were catered for and included textured, food intolerance and diets for people on specific medicines; for example, anticoagulants.

The temperatures of the hot trolleys were checked by catering staff when they arrived on the units. People in the upstairs dining rooms were served their meals once a visual choice was made and then the people their bedrooms were served.

We observed that on two consecutive days people were supported into the dining area for meals half an hour before the mealtime. However, on these days the meals were delayed which meant people in the upstairs units were sitting at the table for extended periods of time. There were insufficient staff in the dining area as staff attention was needed to assist people in bedrooms. This meant the lunch service happened with only the hostess. We saw the hostess had to help each person make visual choices of meals, serve and wait on tables before going back to the hot trolley to get the sample dinners again. The registered manager said while staff were needed in bedrooms they were supporting the meal service.

People were helped to eat their meals and where appropriate adapted cutlery was used. One person told us "large grip cutlery" was used and "I have a deep plate/bowl with a guard so I can eat better on my own, but

learning to do it all with my left hand has been a challenge."

On Pearl unit we observed that although the mealtime was delayed, there were staff available in the dining room. We saw people being offered visual choices of the meals and the meal explained before placing the meal in front of the person. Where people needed assistance with eating we saw staff take their time to support and encourage people to eat.

Social and healthcare professionals worked together with the staff to deliver consistent, timely, and coordinated care to people with changing needs. Two professionals told us the staff had made referrals to support one person with End of Life care needs in a timely manner. They said the staff were "open to advice and followed guidance." The registered manager had accepted training that was to be delivered on the five principles of care for people on End of Life pathways; for example, pain and physical symptom management.

Two other healthcare professionals said "there is good will, they [staff] ring us and want to work with us. They [staff] are accepting of advice. They [staff] are good at identifying pain and looking at physical reasons. They [staff] fight for people and are person centred. They [staff] want the best outcome for people but we can't find staff" available to support people.

Generally people's needs were fully assessed prior to moving to the service. Personal assessment forms were detailed for all areas of need, which included physical, emotional and medical history. However, the assessment was brief for one person admitted under winter pressure agreements. The registered manager explained the admission had occurred at short notice and during the weekend when staff experienced in assessments were not on duty. A member of staff agreed that more information would be gained if the person had been asked about their needs.

People received support with their ongoing healthcare needs. People were registered with a GP and they had access to specialists such as the mental health team and district nurses. Staff told us routine weekly visits were by nurse practitioner instead of the GP. They said the process of gaining appropriate treatment became longer because the nurse practitioner had to consult the GP before changing medicines or making referrals for specialist support.

Reports on outcome of healthcare visits were documented in people's care folders. Records also showed people had regular check-ups with opticians and dentists. Staff told us they were informed about healthcare professional's visits during handover meetings and the information was also recorded in handover sheets.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People were empowered to make decisions. One person told us "We can choose what time we get up and go to bed but I can do most things for myself, so don't need help." Members of staff were knowledgeable about the principles of MCA, that there were varying levels of capacity and recognised that people were able to make day to day decisions. We saw people make decisions and we observed staff ask people before offering support or delivering treatment. Where people had cognitive impairments staff completed mental capacity assessments and these were in place for living at the home and for continuous supervision. For example, 24 hour staffing and keypads on exit doors which alerted staff to people leaving without support.

Best interest decisions were made before capacity assessments were undertaken. For example, capacity assessments were not completed where people lacked capacity to make decisions about the administration of their medicines. For one person, staff had not recorded if it was appropriate to consult the court appointed deputy about best interest decisions, such as using a pressure mat in the bedroom.

Where Do Not Attempt Resuscitation (DNAR) notices were in place, the GP completed the mental capacity assessment in consultation with the person and their family where appropriate. The notices detailed the person's capacity to make the decisions, the family members consulted and the rationale for allowing natural death. For example, one person lacked capacity to make the decision about having a DNAR notice and the decision was reached with the person and their family to allow for natural death but can be treated with oral antibiotics.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw applications for continuous supervision were made to the supervisory body which the registered manager reviewed. .

The decor of the home was clean and bright and the ground floor had interesting things and scenes fixed or painted on to it. On the ground floor there was a large lounge/cinema with refreshments making facilities. There was a smoker's room for those that needed it and a "shop' with a small stock of toiletries which could be purchased by relatives and people. There was a Living well with Dementia notice board opposite the lift entrance on the ground floor with useful information which signposted people and relatives to where help was available.

We found dementia friendly features in Pearl Unit. We saw notice boards with photos of the recent activities and outings. Memory boxes were fitted to all bedroom doors with a photo identifying the person which helped them find their bedrooms. We observed people mainly congregated in the lounge/dining room area, although there were two other quiet lounges and one was decorated in a sea side theme. There was a clock on a notice board in the main communal space which also showed the date, day, season and weather which helped people with their orientation to time and place.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. Comments from people included "Everybody is so nice to us – they ask us what we want for dessert and we all shout 'Eton Mess', it's our favourite so we get it quite a lot," "I am just very forgetful – that's why I live here" and "you [staff] look after us so well – we are very lucky. I feel I'm treated just like family." A relative commented "they [people] are treated just like family – It's lovely to see them all treated the same".

Staff were aware that building relationships with people was important. Staff knew people's preferences, how to address them, who the next of kin were, and about their earlier lives. When one person was no longer able to move out of the room for a cigarette a member of staff arranged for nicotine patches to be prescribed. Staff explained how they showed kindness to people in the day to day support they provided. Their comments included "consistency of care ensured people recognised staff, smiling at people and engaging with them by holding hands," "Speaking to people at eye level," "Presenting a good mood to people as it's about the way you speak [to people]" and "Consoling people when they become upset or distressed."

"What was important and how best to support me" information was in-front of most people's care files. A member of staff told us reading care plans and profiles helped gain an understanding. This member of staff said "something clicks if people know you [staff], know about them." A relative told us about the benefits of having a keyworker system (specific staff assigned to work with people). They said "There are good communications between the home and the family and the key worker is working well. The [registered] manager is very approachable and will listen and get things done."

People's rights were respected. We saw people's dignity and privacy was respected when staff were observed knocking on doors before entering. A member of staff gave us examples on how people's privacy and dignity was respected. For example, "ensuring doors were shut and locked when personal care was being delivered, offering personal care in a discreet manner and ensuring confidentiality of information."

The registered manager told us they promoted companionate and respectful care within the staff team. They told us that staff practice was observed and there were one to one conversations with staff about their performance. Staff attended internal "back to basics" training based on respecting people's rights, gaining consent to care and treatment and caring for people at end of life.

The minutes of Resident and Relative meetings showed people and their relatives felt able to raise issues about living at the home. Heads of departments attend these meetings so questions could be answered on the spot avoiding lengthy fact finding. The registered manager had attended at the beginning of her post and expressed "the need to not wait for the next meeting as I have an open door policy and we can deal with things at any time not just in the meetings".

People and relatives were not always made aware of the actions taken to resolve issues identified at Residents and Relatives meetings. The activities coordinator who chaired the meetings told us of some of

the changes. One of these was "the purchase of a label printer and staff now sew in labels to all clothing reducing lost or misplaced items." This activities coordinator said the agenda for future meetings will include "they said – we did" item to inform people how their comments and suggestions made a difference.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we found a breach of Regulations 9 of Health and Social Care Act Regulated Activities Regulations 2014. On this inspection we found that care plans were not fully person cantered and lacked guidance on how staff were to deliver care and treatment. Assessment tools were not analysed to ensure strategies and management plans gave staff information on managing incidents where people became distressed. Advice from professionals was not included within care plans. The provider kept us informed on the improvements made and where shortfalls were identified the action plan listed the date for completion. We found some improvements had taken place.

People's accessible information needs were identified. For some people, communication care plans were in place on how to meet their accessible needs. We saw for one person, the care plan detailed the level of vision impairment and the guidance for staff to ensure the person wore sunglasses in bright daylight. For another person, the care plan stated "able to lip read", but we observed a member of staff using sign language to communicate. The registered manager acted promptly and purchased white boards and flash cards to enable staff to communicate with the person.

Care plans were mostly reflective of people's physical needs and for some people were person centred in relation to people's physical, mental and social needs. For example, the personal care plan for one person detailed the preferences with their appearance, the tasks the person was able to manage for themselves and the assistance needed from staff.

For two people, guidance was lacking on how staff were to address repetitive behaviours. We saw two people display repetitive behaviour to gain staff attention. However, the staff's approach was inconsistent at times. A social and healthcare professional said when misperceived situations arose the staff were not always acknowledging the person's feelings, which at the time inflamed the situation instead of diffusing it. The registered manager told us refresher training was to be delivered.

The mission statement on display for people living well with dementia stated "Every resident has the right to work with team that has good dementia knowledge base and focuses on life stories and my home life." Life stories were not in place for all the people living with dementia and for some people one page profiles on "what was important and how best to care for me" were brief. The activities coordinator acknowledged not all life stories were in place. They told us relatives were consulted about their family member's background histories, but said "sometimes people don't want to say and I have to respect people for this. I value the residents they have led interesting lives and had interesting jobs. I want to respect them." Quality assurance improvement plans showed life stories were an area for improvement.

Eating and drinking care plans detailed people's ability to make menu choices, if adapted utensils were needed and the assistance needed from the staff. Where people were identified at high risk of weight loss, the action plan gave staff guidance on the high calorie diets to be served. In the care plan for one person at risk of choking, the action plan gave staff guidance on the textured diets to be served.

People were supported to have a comfortable, dignified and pain-free end of life. Advanced care plans detailed people's future wishes and included for some people their wishes regarding spiritual needs and funeral arrangements. The priorities of care were recorded for one person on end of life care and included oral care, pain management and pressure care. There were good links between external providers such as hospice staff and their interactions were recorded in the care plans. A relative whose family member had experienced end of life care recently said the staff were "not intrusive for them as a family and that all levels of staff had been approachable."

Staff documented people's daily events, which included tasks and routines completed. Also recorded were people's behaviours and emotional state and how people spent their day. A member of staff said care plans gave them guidance on how to meet people's needs and they were kept informed about people daily changing needs during handovers.

People were supported to maintain contact with relatives and those that mattered to them. A relative said "we can visit any time, we are always welcome no matter what time. They are happy for us to go to the room if we want a bit of quiet or stay in the lounge and join in. One person told us "There are always activities but not all of them are suitable for all residents." Another person told us "I have the TV, my radio and magazines and the staff do pop in occasionally."

Relatives spoke highly about the efforts of the activities coordinator to promote inclusion and said that "activities had improved dramatically in the last year and with the arrival of a second activities coordinator," albeit that both were still only part time and neither worked any weekends except for specific events; for example, fetes, bar-b-ques and the like.

There were two folders in the entrance foyer containing photos of outside visits and activities in the home which were wide and varied. Outside activities were numerous and varied, and people's input about activities were gained during Resident and Relatives meetings.

We saw well illustrated weekly activities programme sheet which was colourful and included a number of outside musical events. Where people had spiritual needs two faith services were arranged each month by different churches.

The activities coordinator told us relatives funding had bought an electronic tablet with blue tooth and a powered speaker and headphones, which was being very well used in the home now – both for group activities and for individual residents to listen to music in their rooms if unable to come out. People also told us there was free Wi-Fi available.

We observed an outside entertainer leading chair exercises and they were very good at including those who were reluctant to get involved. This entertainer worked within people's limits; for example, for one person with mobility needs the size of the ball and angle was changed, which made it possible to catch and throw the ball back. During our inspection days, we also observed the activities coordinator playing a game of large chip, and this was very successful and enjoyed by those that were present.

There were good descriptive records for activities. The registered manager said "staff are consistently going into people's room. The activities coordinators are doing one to one activities with people. We do what we can and we put on activities. There us a lot of things [activities] going on. I go around and I speak to people. Some people just want to be alone. People see a friendly face everyday."

People had access to the complaints procedure. A relative told us "I know there is a complaints procedure

but I have never had to use it. If you talk to staff it gets sorted out before that is necessary." The log of complaints showed there were no outstanding complaints for investigation.

Good

Is the service well-led?

Our findings

At the previous inspection we found a breach of Regulations 17 of Health and Social Care Act Regulated Activities Regulations 2014. Shortfalls were not always identified and action plans were not always developed. Where action plans were in place improvements were not embedded into consistent practice. We wrote to the provider telling them we proposed to impose conditions. The provider kept us informed on the improvements made and where shortfalls were identified the action plan listed the date for completion. We found improvements had taken place.

Systems were in place to assess and monitor the delivery of care. There was an overarching improvement plan that related to care planning, recruitment and mental capacity assessments. The timescales for meeting the improvements were listed with the staff responsible for achieving the plan. Area for ongoing improvement included developing community links and care planning. A wide range of internal audits were used to assess and develop the quality of care. Where shortfalls were identified action plans were developed on the improvements needed. For example, the audit identified that procedures for "when required" medicines were lacking detail.

A registered manager was in post. Relatives told us there had been improvements since the current registered manager was appointed. Their comments included "it is so different now" and "I can go and talk to the [registered] manager any time – her door is always open and you see her around the home too." A member of staff said "the registered manager helps all the time. I am happy she is our [registered] manager. I can see the changes already." Another member of staff said "I am glad I stayed, I made the right choice. I put my trust in the [registered] manager that she would make the improvements she told us were to happen. We suddenly turned the corner and things have been going well since then."

The culture of the home was positive culture, open and honest. Trust-wide engagement surveys were used by the provider to gain feedback across their services. The feedback received for this home related to high levels of agency staff. The registered manager told us changes in shifts meant the use of agency staff had significantly reduced. Internal surveys were used to gain feedback from people about specific areas such as care plans.

The staff told us the team worked well. A member of staff said having consistent staff in units meant that people living with dementia recognised them. Another member of staff said "I do my best for people. There are staff meetings and the care is person centred." There was a "shining staff" award nominated by people to recognise staff for their contributions to care and treatment delivered.

Arrangements were in place for staff to receive feedback, which enabled them to take appropriate action. The registered manager told us there was a daily handover of information for all levels and roles of staff. They said "we only share relevant information. It's important to share information where we are and what we are doing." In addition "one to one sessions with staff ensured there were opportunities for staff to discuss their performance and their personal development.

The registered manager had considered the importance of continuous learning and ensuring sustainability of the service. The registered manager explained that recruitment and retention" in the local area as a whole was a challenge. They said "the last year has been challenging. We have faced each challenge as they arose and we have learnt. It's about building on what we have introduced. We have a good staff team. We build relationships with staff, relatives and social and healthcare professionals. Good support is the key. We retain staff and move forward." They also told us having "open and honest relationships with the team, sharing information and acting on staff suggestions" ensured sustainability."

Systems were in place for continuous learning. Accident and incidents were analysed and where people were identified at risk of harm, their care and treatment was closely monitored. The registered manager said action plans were in place and there were "reflective meetings. We sit together" and discuss incidents. "We admit we don't get things right. It's honest and truthful."

Links and relationships were strengthened with the local community and external agencies. The registered manager was taking steps to establish good connections with the local community. A healthcare professional told us the staff had invited people from the local community to participate in a theme evening. People living in a retirement village were invited to join events being held at the home and youth groups such as Scouts were holding activities at the home. The activities coordinators were making contact with over 50+ clubs for people living at the home to attend or to hold these meetings at the home.