The Orders Of St. John Care Trust

OSJCT Stratford Court

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

OSJCT Stratford Court provides accommodation and personal care for up to 48 older people. At the time of our inspection 45 people were living at Stratford Court. The home was last inspected in November 2013 and was found to be meeting all of the standards assessed.

This inspection took place on 10 February 2016 and was unannounced.

OSJCT Stratford Court is due to close in April 2016 and CQC have received an application to cancel their registration. People who use the service and the majority of the staff team are moving to a new, purpose built service, being opened by the provider. This was a focused inspection and was carried out in response to a number of concerns we had received from members of the public and relatives of people who use the service. We were not planning to complete a full inspection of the service before it closed. However, in response to the concerns we received, we completed this focused inspection, to assess the areas of concern that had been raised.

There was a registered manager at the service, although they were not in day to day charge and CQC had received an application to cancel their registration. 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 and associated Regulations about how the service is run. A new manager had been appointed to the home and was available on the day of the inspection.

The home was not cleaned effectively. We saw some areas where further cleaning was needed to ensure people were cared for in a clean and pleasant environment. Examples included one person's walking frame which had dried food stains on the legs, arm chairs with dried food debris on the arms and seat, lap tables with dried food debris on the side and underneath and hand rails that were sticky to touch.

Medicines held by the home were securely stored and people were supported to take the medicines they had been prescribed. However, more information about support for people to take 'as required' medicines was needed. This would help to manage the risks of people receiving too much or too little of their 'as required' medicines and give staff clear information about the support people needed.

Staffing levels in the home had not been sufficient. Most people who use the service told us there had been problems with the number of staff available. Comments included, "It (staffing) is a big problem. They're very busy, we need more staff. It takes a long time for staff to come when we need help" and "Staffing is a problem". One person was more positive about staff availability, telling us, "Staff come quickly when I call them and they are always walking past my room". However, the provider had taken action to address the concerns and recruit more staff.

Risks people faced were assessed and action taken to manage the risks. Details of the support people

needed in relation to managing risks were set out in their care plans. The risk assessments contained detailed information about people's needs and support to manage identified risks.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was not always safe.

The home was not cleaned effectively. Some areas of the home and furnishings were dirty. Action was needed to ensure people were cared for in a clean, hygienic and pleasant environment.

Medicines were safely stored and recorded, although more information about support for people to take 'as required' medicines was needed.

Staffing levels in the home had not been sufficient. However, the provider had taken action to address the concerns and recruit more staff. Risks people faced were assessed and action taken to manage the risks.

OSJCT Stratford Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection took place on 10 February 2016 and was unannounced.

This was a focused inspection and was carried out in response to a number of concerns we had received from members of the public and relatives of people who use the service. The service is due to close in April 2016 and we were not planning to complete a full inspection of the service before it closed. However, in response to the concerns we received, we completed this focused inspection, to assess the areas of concern that had been raised. Because we have not assessed all areas of the service, we have not produced a quality rating for this service.

The inspection was completed by one inspector. Before the inspection we reviewed previous inspection reports and all other information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider.

During the visit we spoke with the manager, area operations manager, head of care, six people who use the service, six care and housekeeping staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for five people. We also looked at records about the management of the service.

Inspected but not rated

Is the service safe?

Our findings

We received concerns from members of the public and relatives of people who use the service that the home was not always clean. The manager told us they had identified problems with the systems in place to clean the home and cleanliness of the home was included in a 'home action plan' which had been developed to address the issues. On the day of our inspection, senior housekeeping staff from another of the provider's services were in the home to provide training and direction to the home's housekeeping staff. This was initiated by the manager in response to concerns about the standard of cleanliness in the home. Part of this work was to establish clear cleaning schedules to ensure all cleaning tasks were completed.

During the inspection we looked at all of the communal areas of the home, bathrooms and a sample of bedrooms. We found there were no strong unpleasant smells, although there was an underlying stale odour in the home. In discussion with the manager, it was felt this odour was the result of carpets and soft furnishings that would need to be replaced if the home was not closing. The manager said they would continue to clean the carpets to help with this issue and said none of the furnishings were being transferred to the new service when it opened in April 2016.

The bathrooms were worn and had stained and damaged flooring and tiles in places. Staff had taken action to keep bathrooms as clean as possible, and all baths, showers, sinks and toilets looked clean. We saw some areas where further cleaning was needed to ensure people were cared for in a clean, hygienic and pleasant environment. Examples included one person's walking frame which had dried food stains on the legs, arm chairs with dried food debris on the arms and seat, lap tables with dried food debris on the side and underneath and hand rails that were sticky to touch.

Staff told us there had been some problems with cleaning arrangements, with comments including, "General cleanliness could be much better. Staff have not been given proper direction. They have a good handle on this now and housekeeping staff from another OSJCT service have been brought in to help" and "We now have more housekeeping staff. Previously only the basics were being done".

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines held by the home were securely stored and people were supported to take their prescribed medicines. We saw medicines administration records had been fully completed. This gave details of the medicines people had been supported to take, a record of any medicines people had refused and the reasons for this. There was a record of all medicines received into the home and disposed of.

Some people were prescribed 'as required' medicines. These were medicines that people needed support to take in certain circumstances, for example, pain relief and sedatives to help when people became distressed. People's care plans did not always contain sufficient information about these 'as required' medicines and when staff should support people to take them. For example, some people were prescribed a sedative to help when they became anxious or distressed. There was no information about how people

demonstrated anxiety or distress, or the actions staff should take to support people before supporting them to take the medicine.

The manager told us a recent medicines audit had highlighted the same concerns and work had started to develop protocols for people to take 'as required' medicines. We saw that some of the protocols had been completed and were available in people's care plans. A care leader had been seconded to the service from one of the provider's other homes to help with the work to update the care plans, including work to put the 'as required' medicines protocols in place. Details of the shortfall and the planned action were included on the 'home action plan' that had been developed to ensure action was taken.

We received concerns from members of the public and relatives of people who use the service that there were not always enough staff available to meet people's needs. The manager told us they had identified problems with the staffing arrangements in the home and had recently undertaken a recruitment programme to employ more staff.

Most people who use the service told us there had been problems with the number of staff available. Comments included, "It (staffing) is a big problem. They're very busy, we need more staff. It takes a long time for staff to come when we need help" and "Staffing is a problem". One person was more positive about staff availability, telling us, "Staff come quickly when I call them and they are always walking past my room".

All of the care staff we spoke with said staffing levels had been a problem. Staff told us they were still able to provide the care people needed, but expressed concern that sometimes they felt rushed and not able to spend the time they would like to with people. Staff were aware of the actions taken by the management team to fill vacancies and were confident that action had been taken to improve the staffing situation.

The manager told us they had significant staff vacancies in the service and had previously found it difficult to recruit new staff. The management team had undertaken a recent recruitment programme and following a final round of interviews the day before the inspection had made job offers to fill all of the vacant positions. The manager had been using a small number of temporary staff from an agency in order to fill staffing gaps and provide consistency of care to people.

We received concerns from relatives of people who use the service that risks people faced from other people who used the service were not being effectively managed. These risks mostly related to physical aggression form people as a result of the effects of their dementia.

During our Short Observations Framework for Inspection (SOFI) we observed interactions between people who used the service. At times, people became angry with each other or distressed as a result of other people's actions. We saw staff intervened promptly to diffuse tensions. Staff took time to explain when one person was distressed at what they mistakenly thought another person had said to them. Staff also intervened when two people were annoyed with each other during lunch. Staff provided support that helped people to relax and prevented tensions escalating.

Details of the support people needed in relation to managing risks were set out in their care plans. The manager had identified work was needed to develop the care plans, however, the risk assessments contained detailed information about people's needs and support to manage identified risks. We saw details of distraction techniques and verbal de-escalation techniques that were used for some people to support them when they became distressed. There were also assessments of risks people faced in relation to falls, malnutrition, pressure damage to skin and how to safely evacuate the building in the event of a fire.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had not ensured the premises and equipment used at the service were effectively cleaned. Regulation 15 (1) (a).