The Orders Of St. John Care Trust

OSJCT Lake House

Inspection report

The Green
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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected the service on 8 April 2015. This was an unannounced inspection. We previously inspected the service in January 2014. The service was meeting the requirements of the regulations at that time.

Lake House is registered to provide accommodation for up to 43 older people who require personal care. At the time of the inspection there were 38 people living at the service. The service was arranged into five units, each with their own dining and communal space. There was a large dining and lounge area in the centre of the service but this was undergoing redecoration and building work so was temporarily unavailable for people to use.

Prior to this inspection we had received concerns about how people's needs were being met because of the levels of staffing. During the inspection we found there were not enough staff to meet people's needs or to keep them safe. People told us there were not enough staff to meet their needs and the rotas showed that target levels of

Summary of findings

staff had not always been achieved. Staff were not always available to support people in communal areas and left the units unattended whilst they had a break or went to help on other units. Staffing issues also meant some people were rushed and not given time to make choices.

People were not always cared for by suitably skilled staff who had kept up to date with current best practice because not all staff had attended training or received adequate supervision and appraisal.

People felt safe and told us they liked living at the home. People were complimentary about the staff and felt staff did their best to support them in a friendly and caring way. People's privacy and dignity was maintained during care tasks.

People were assessed regularly and care plans were detailed. Where required staff involved a range of other professionals in people's care to ensure their needs were met. Staff were quick to identify and alert other professionals when people's needs changed. Some records in relation to peoples care and treatment were not always accurate.

People did not always receive their medicines in line with their prescription and there were gaps and omissions in the recording of topical medicine administration.

The registered manager had left the service shortly before the inspection. 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. A registered manager was in the process of transferring from another of the provider's locations and was spending one day a week at the service during the transition process. A peripatetic manager was covering the service in the interim. Some of the improvements needed to the service had been identified by the interim management team and there was a plan in place to address them.

Senior staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions. Staff knowledge in this area required improvement.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People's medicines were not always managed or administered in a safe way.

There were not enough staff to meet people's needs or to keep people safe.

People felt safe living at the service.

Inadequate

Is the service effective?
The service was not always effective. There were gaps in staff training, supervision and appraisal which meant staff were not supported to improve the quality of care people received.

People's opinion of the food was mostly positive. People who had lost weight were referred for specialist advice.

People were supported by senior staff who acted within the requirements of the law. This included the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff knowledge in this area required improvement.

Requires improvement

Is the service caring?
The service was caring. However, issues with staffing meant people were rushed and not always supported to make choices.

People were complimentary about the care they received. Staff were caring and treated people in a friendly way. People were assisted with personal care discretely and in ways which upheld and promoted their privacy.

Requires improvement

Is the service responsive?
The service was not always responsive because an accurate record of people's care and treatment was not always maintained.

People were supported to maintain their independence.

Requires improvement

Is the service well-led?
Improvements were required to ensure the service was well led. Quality assurance systems were in place and had identified some of the issues we found during the inspection. However, the impact of the staffing establishment and the impact on people had not been identified.

Staff worked well as a team and felt confident to raise any concerns they might have about areas of poor practice.

Requires improvement

OSJCT Lake 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 checked whether the provider was 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 the 8 April 2015. It was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our visit we reviewed the information we held about the service. This included notifications, which is information about important events the service is required to send us by law. We also contacted three health or social care professionals who regularly visit people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with 12 people and five of their relatives. 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 also spoke with 11 members of staff including care staff, ancillary staff, and the chef.

We looked at records, which included eight people's care records, the medication administration records (MAR) for all people at the home and six staff files. We also looked at records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Medicines were stored safely. However, medicines were not always administered safely. One person was administered an incorrect dose of medicine called Warfarin on four occasions in one week. Warfarin is a medicine to help prevent blood clotting for people who may be at risk from certain diseases. To use Warfarin safely, the dose needs to be adjusted to maintain the desired effect and reduce any side effects. Although a new dosage sheet for the person had been received at the service the dose of medicine had not been administered in line with this.

Staff signed medicine administration records when they had administered people's medicines. However, records in relation to the application of topical creams were not always signed to show people had received their topical creams. During the inspection a tablet was found on the floor in the lounge. A relative told us they had sometimes found tablets that had not been taken. They said "I normally hand tablets in when I find them". This meant staff could not ensure people were receiving their medicines in line with their prescription which may impact on their health and well being.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not sufficient numbers of staff to meet people's needs. Before the inspection we had received concerns about the staffing levels. During the inspection people, their relatives and staff told us more staff were needed. Comments from people included, "They are short staffed, Saturdays are the worst", "Not enough, staff are busy, busy, busy", "they are very good but they haven't got enough people" and "they rush about". People gave us examples of how this affected their care. For example, one person said, "Sometimes I ring the bell and nobody answers it". Another person said, "I can ask when I feel I need a bath, but it doesn't always happen that day, they haven't got enough staff". Staff confirmed that they did not always have time to help people bath but always supported people to have a wash. Comments from staff included, "There isn't enough staff, they either leave or are off sick", "We need more staff", "It's a bit of a struggle" and "We need more time with them [people]. We're rushing them." A visiting health professional also raised concern about the staffing levels.

The provider used a dependency tool to calculate staffing levels according to people's needs'. However, the amount of staff on duty did not always reflect this. For example, there were 18 occasions in the four weeks prior to the inspection where the target numbers of staff had not been met.

There were five units at the service each staffed with one care worker. There were people on each unit who required the assistance of two members of staff to enable them to move and for personal care needs. Staff told us "It's always one [staff] per wing." There was a 'floating' member of staff who would work from 7am to 11am and between 6pm and 9pm. Their role was to work across the units helping out where two members of staff were needed. On the day of the inspection one member of staff had called in sick. A member of staff allocated to work in the day centre was sent to cover one of the units at 9am. The head of care and a care leader were present in the home on the day of our inspection. They visited the units to administer medication, liaised and assisted any visiting health professionals and helped out where they could. Housekeeping staff had also been trained in moving and handling tasks so they could help. However, there were occasions during the inspection where people who required the assistance of two members of staff had to wait for assistance because a second member of staff was not available to help. One of these people was not assisted to the toilet in a timely way.

Risks to people's personal safety had been assessed, reviewed regularly and people had plans in place to minimise the risks. However, because of the issues with staffing plans were not always followed. For example, one person had been placed on a short term acute care plan because they had an infection. The care plan stated they should have their fluid intake monitored for three days. Monitoring had commenced the day before the inspection. No monitoring had taken place on the day of the inspection. We spoke with the staff member on this unit who told us they were not aware this person's fluid required monitoring. They told due to staff absence they had been asked at short notice to work on the unit and had not received a handover.

There were other times during the inspection when care plans and risk assessments were not followed because staff left the units unattended when they went on a break, to assist in another part of the home or to find another member of staff to help them. For example, one unit was

Inadequate

Is the service safe?

left unattended for 30 minutes. There were people on this unit who had been assessed as at risk of falling. Staff told us, "I regularly get called off this unit to help on other units" and "We could do with more staff to eliminate the issue of leaving the unit to assist". We asked staff what would happen if someone needed assistance when they were not on the unit. They told us "We come back if they ring the bell". Not all people on the unit had access to a call bell. A falls prevention sensor mat was activated for a person at risk of falling and of having fits. Their care record stated "answer immediately when the alarm goes off". It took 10 minutes before a housekeeping assistant entered the unit and answered the call bell.

Two people had care plans which stated they should sit on specialist pressure relieving cushions because they were at risk of developing pressure ulcers. Although these people had specialist cushions, they did not sit on them for two hours. We discussed this with the member of staff supporting these people. They had set up the cushions in preparation for people to sit on in their lounge chairs. They told us they had been waiting for another member of staff to help them support people to move into the lounge chairs. This meant there were not enough staff to ensure people's needs were met in a timely way.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During the inspection we were informed that a recruitment campaign was in process and interviews were scheduled. Following the inspection the provider informed us the set staffing levels for each shift had been increased.

People told us they felt safe. One person said before they came to live at the service they did not feel safe but now they always felt "safe, safe, safe". People's relatives told us they did not always feel their relative was safe. For example, one relative said, "I am concerned about falls and not sure if my mother is safe here". Another relative said, "I am worried [relative] is not safe". Care and ancillary staff had good knowledge of the provider's whistleblowing and safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly.

Equipment used to support people's care, for example, hoists, stand aids and specialised baths were clean, stored appropriately and had been properly maintained. The service kept a range of records which demonstrated equipment was serviced and maintained in line with nationally recommended schedules.

Requires improvement

Is the service effective?

Our findings

People were not always cared for by suitably skilled staff who had kept up to date with current best practice. We identified a number of areas where improvements were required and found gaps in staff training in these areas for both new and existing staff. For example, 19 staff had not attended initial or update training in the mental capacity act (MCA) or deprivation of liberty safeguards (DoLS), 24 staff who handled food had not attended training in food hygiene and 19 staff had not attended training in dementia care. One staff member who was looking after some people who were living with dementia told us, "I am still waiting for my dementia training and learning about the resident's needs, and not very confident yet".

Staff were not supported to improve the quality of care they delivered through a supervision and appraisal process. Eight staff had not received an annual appraisal since Jan 2014. Although all staff had received at least one supervision in the last 12 months, the provider had not followed their own policy of staff having supervision every three months. This meant staff were not given the opportunity to discuss areas of practice or identify and discuss their development and training needs.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We discussed the issues with training with the manager. They had identified the need for staff training and provided us with a training plan which showed dates had been booked for some of the required training.

People had enough to eat and drink. People's opinion of the food served in the home was mostly positive. Mealtimes were a sociable event and people who needed assistance to eat were supported in a respectful manner. However, the issues with staffing affected the lunchtime service. For example, One staff member was supporting all of the people on one of the units by themselves. There were three people on the unit who needed support to eat. The staff member made every effort to meet people's needs but had to share their time between three people. One person with significant dementia related needs required extra time and encouragement. This meant people were not assisted with their meal in a timely way. On another unit a housekeeping assistant was serving the meal. They were using a microwave oven for part of the process and did not give people their meal until all the plates of food had been in the microwave. One person told us their lunch was cold by the time they received it.

Where some people had lost weight there was a plan in place to manage the weight loss, the people had been reviewed by the GP and referred for specialist advice if required. People had regular access to other healthcare professionals such as, chiropodists, opticians and dentists to ensure their health needs were met.

People told us staff sought their consent before carrying out personal care tasks. Senior staff had completed best interest documentation around the administration of covert medicines and the use of bedrails. However, care staff did not demonstrate a good understanding of the Mental Capacity Act (2005) and the legal requirements for making decisions about care and treatment on behalf of people who lacked capacity to do so. This meant there was a risk that people would not always be supported in line with the principles of the act.

People were able to move around the home and gardens as they wished. Senior staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be restricted of their liberty for their own safety.

Requires improvement

Is the service caring?

Our findings

People were complimentary about the service. Comments included, “It’s a nice place to live” and “It is good, it’s all good here”. People also told us they thought the staff were “lovely”, “very kind” and “very good”. One person told us they could have “a laugh” with staff. We observed friendly banter and a good rapport between people and staff.

Throughout the inspection we saw many examples of people being supported by staff who were kind respectful and caring. However, because staff were busy they sometimes rushed people. For example, we observed an interaction where a staff member was rushing a person to make a choice from the lunchtime menu. The person was living with dementia and needed more time to understand the choices available. When the person became anxious and frustrated, the staff member chose for them. This meant this person was not supported to express their wishes and make a choice.

People told us their friends and relatives could visit whenever they wanted to. People were able to meet their relatives in the communal areas or in the privacy of their rooms. However, People told us that issues with staffing meant they could not always spend their time where they choose to. For example, one person told us they would have liked to go into the garden but when they asked they were told no staff were available to assist them.

People were assisted with personal care discretely and in ways which upheld and promoted their privacy and dignity. Staff were knowledgeable about how people preferred to be supported in relation to their personal care. For example, if people preferred a bath or a shower. People appeared clean, well kempt and were dressed appropriately for the weather.

People were involved in decisions about their end of life care. Staff described the importance of keeping people as comfortable as possible as they approached the end of their lives. They talked about how they would maintain people’s dignity and comfort by allowing them privacy, making sure they were clean and by keeping them hydrated.

Care plans contained information about how best to communicate with people who had sensory impairments or other barriers to their communication. This was useful in helping staff build positive relationships with people by communicating in ways that were appropriate to them.

People told us they had opportunities to decide how their bedrooms should look and we saw they were personalised to suit people’s tastes. People also told us they had been involved in making decisions about how the home was being redecorated.

Requires improvement

Is the service responsive?

Our findings

Before people came to live at the home their needs had been assessed to ensure they could be met. Care plans were mostly detailed and regularly reviewed. However, an accurate record of people's care and treatment was not always maintained. For example, one person had a tissue viability care plan which documented they had no broken areas to their skin. The person told us and district nursing records confirmed the district nurse was visiting them to dress a pressure ulcer twice a week. This put them at risk of not receiving appropriate care and treatment in relation to their skin integrity by staff at the service. Another person had a care plan in relation to what support they required if they were having an epileptic fit, but this was not kept with their risk assessments, it was recorded on a care plan for mental health and stored in a different section of the care record. Staff were aware of how to support this person but this information would not be an obvious place for temporary staff to look for this care plan which could be needed in an emergency situation.

Some people who were at risk of malnutrition and dehydration required their food and fluid intake to be monitored, however records were not always completed and did not include enough detail to inform staff if adequate nutrition and hydration had been taken. There was no evidence charts were reviewed by staff. This meant that records could not always be used to determine if people were eating and drinking enough and this information would not be available to inform the care provided by visiting health professionals.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's Care records reflected people's preferences in how they wished to receive their care and support and gave guidance to staff on how best to support people to maintain their independence. For example, one person's personal hygiene plan advised staff that the person would like to brush their own teeth but staff should apply the toothpaste to the brush. Another person's record advised staff to encourage the person to wash their own face and hands. Other records that supported the delivery of care were maintained. For example, charts to record how people's position was being changed to reduce the risk of pressure ulcer development. These were up to date and there was a record of the care being carried out.

People told us they would have liked there to be more activities. An activities coordinator was employed by the service. They organised group activities and also visited people in the units. However, people told us since the home was in the process of redecoration there were less activities and social interaction because the main communal space was undergoing building works. People also told us because the mini bus had been "off the road" since January trips outside of the home had also been limited.

The provider sought feedback from people and their relatives about the quality of the service. For example, residents and relatives meetings were held. People knew how to make a complaint and the provider had a complaints policy in place. Any concerns received about the quality of care were investigated thoroughly and recorded. The manager discussed concerns with staff individually and more widely at team meetings to ensure there was learning and to prevent similar incidences occurring.

Requires improvement

Is the service well-led?

Our findings

The registered manager had left the service a month before the inspection. 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. A registered manager was in the process of transferring from another of the provider's locations and was spending one day a week at the service during the transition process. A peripatetic manager was covering the service in the interim.

Since the registered manager had left the service the provider, peripatetic manager and other staff had carried out a range of quality monitoring to review the care and treatment offered at the home. Some of the issues we found during the inspection had been identified and actions had been put into place to address them. However, the actions were not always followed and therefore improvements had not been made, sustained or embedded. The issues found with staffing and the impact this had on people had not been identified. The service's key performance data had alerted senior staff that the service had a high number of people who experienced falls when compared with the provider's other locations and although there was an action plan in place to try to minimise the falls a link had not been made with the issues with staffing. For example, staff leaving communal areas and units unattended for periods of time where people had been assessed as at risk of falling.

Care staff were not always supported to improve the quality of care they delivered through effective leadership. Care staff were directly supervised by care leaders. However, apart from when they were giving out medicines or assisting at the lunch meal care leaders spent most of their time engaged in paperwork and liaising with other healthcare professionals. This meant care staff mostly worked alone and unsupervised on the units.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff did see themselves as part of a team and willingly worked across the units to support their colleagues. Staff were aware of the organisation's values and worked hard to uphold them. There was an open culture in the home where staff felt confident to raise any concerns they might have about areas of poor practice. One staff member told us "I have told the manager when I was concerned about an agency worker". Appropriate action had been taken by the registered manager to deal with concerns raised about staff performance and where necessary disciplinary action had been taken.

The management team had recognised that improvements to the service were required and had taken account of people's views through satisfaction surveys and residents and relatives meetings to make some positive changes to the service. For example, improvements to the communal lounge and dining room area.

Visiting health professionals told us they had recently seen positive changes in the service that had directly improved the experience for people. For example, in the way staff communicated with them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users in relation to the proper and safe management of medicines. Regulation 12 (1) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity did not always receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to; assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; and an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided was not always maintained. Regulation 17 (1) 2 (a) (b) (c).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Regulation 18 (1).

The enforcement action we took:
We have issued a warning notice informing the provider they must make improvements by 30 July 2015.