The Orders Of St. John Care Trust

OSJCT Chestnut Court

Inspection report

St James
Quedgeley
Gloucester
Gloucestershire
GL2 4WD

Tel: 01452720049
Website: www.osjct.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected OSJCT Chestnut Court on the 5, 10 and 11 April 2018. OSJCT Chestnut Court provides accommodation, nursing and personal care to up to 80 older people and people living with dementia. It also provides short term respite for people as part of the local discharge to assess scheme. At the time of our visit 72 people were using the service. The home is split into four units, Ash, Beech, Maple and Willow. OSJCT Chestnut Court is located in Quedgeley, Gloucestershire. The home is close to a range of amenities, such as a supermarket, school, GP practice. The service has developed close links with these services. This was an unannounced inspection.

We last inspected the home on 5 and 19 April 2017. At the April 2017 inspection we rated the service as "Requires Improvement". We found the provider was not meeting all of the requirements of the regulations at that time. People were not always protected from the risks associated with their care, such as the risk of choking. Additionally not all staff understood their responsibilities to raise safeguarding concerns. The provider had sent us an action plan and told us they would meet the required regulations by 31 December 2017.

During our April 2018 this inspection, we found all the required improvements had not been made. Staff understood their responsibilities to raise safeguarding concerns; however people were still not always being protected from the risks associated with their care. We also found new concerns in relation to people not always receiving personalised care, care records were not always complete, staff did not receive sufficient support and the provider's quality monitoring systems had not always been effective in driving improvements. We again rated the service 'Requires Improvement' overall.

We have also rated the key question 'Is the service well-led?' as 'Inadequate' as the provider had failed to meet the regulations over three consecutive comprehensive inspections. The provider had therefore not demonstrated that they were able to consistently meet the requirements of their registration and operate effective systems to ensure that OSJCT Chestnut Court met the requirements of the Health and Social Care Regulations and people were not placed at risk of receiving inappropriate care.

A registered manager was not in position at the service; the service had not had a registered manager since October 2015. An Area Operations Manager and Area Operations Director for the service informed us that recruitment for a new manager who would register with CQC was ongoing with interviews being held. 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.

People were not always protected from the risks associated with their care. People could not always be assured that care and nursing staff would take prompt, effective action to ensure people's risks were reduced. Care and nursing staff did not always follow up or report on concerns. People's care plans did not

always document their risks and the support they required from staff, at times this could have an impact on people's safety and wellbeing.

People did not always receive personalised and dignified care. We observed some interactions between staff and people which were not personalised to the person's needs and did not respect their wellbeing or dignity. However, we witnessed many examples of caring and compassionate interactions between staff and people. People sometime went long periods of time without engagement and their requests were not always responded to in a timely manner. People's preferences and wellbeing needs and decisions had not always been recorded; meaning people sometimes received care and support which was not in accordance with their preferences.

People had access to diets which met their nutritional needs. People also enjoyed a range of activities, arranged by a dedicated activities team. The activity co-ordinators had built strong links within the community and provided activities which were tailored to people's needs and interests.

There were enough staff deployed to meet people's needs. The service was currently in the process of recruiting to a number of care and nursing hours and was reliant on agency staff to ensure there were suitable staffing numbers to meet people's needs. While staff received communication, this was not always effective and there was not always firm direction and leadership on the individual units.

Management support was being provided by the provider, and an interim manager was in place supporting a newly employed deputy manager. Area Operations and HR managers were providing daily support to the service. A range of systems were being implemented to improve the quality of care and support people received, however a number of these systems had only recently been implemented. The provider had implemented a detailed action plan for the service.

People, their relatives and staff stated the service needed continuity and stability. Representatives of the provider agreed with these views. Staff felt they did not always have the support they needed, however felt they could see improvements being made to the service. Staff told us they had the training they needed, however did not feel confident they could ask for additional training due to previous requests not being acted upon.

We found one repeated breach and three new breaches 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?

Requires Improvement

The service wasn't always safe.

The risks associated with people's care were not always being managed effectively. Where staff had identified concerns regarding people's health and wellbeing, there was no record of the action taken to ensure people's safety.

There were enough staff deployed to meet the personal care needs of people. People felt safe living at the home and staff understood their responsibilities to report abuse.

Is the service effective?

Requires Improvement

The service wasn't always effective.

Care staff had access to the training they needed to meet people's needs. However, staff felt they did not have the support they required and the majority of staff had not received "Trust in Confidence" meetings (one to one supervision).

People were supported to make day to day decisions around their care. However the documentation around people's capacity to make decisions were not always current or complete.

People received the nutritional support they needed. People were supported with their on-going healthcare needs. The provider had long term plans in place to create a dementia friendly environment in the two dementia units.

Is the service caring?

Good

The service was caring. Care staff knew people well and what was important to them.

People's dignity when receiving personal was promoted and care staff assisted them to ensure they were kept comfortable.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's well-being needs were not always effectively acted upon to ensure people

received the support of healthcare professionals.

People had access to activities, however care and nursing staff did not always take opportunities to engage with people and meet their wellbeing needs.

People and their relative's complaints were being acted upon by the management team.

Is the service well-led?

Inadequate

The service was not well led. Management support was being provided by the provider to improve the quality of care and support people received. However the service had been without consistent management for two years. People, their relatives and staff felt this was a concern.

An interim manager and a new deputy manager were in post. They were implementing quality systems however these had not yet been fully embedded.

We rated "is the service well-led" as inadequate due to the concerns found at this inspection and due to the inspection history of the service. The provider had implemented a detailed action plan which they planned to share with CQC on a weekly basis so we could monitor the progress.

OSJCT Chestnut 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 planned to check 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 5, 10 and 11 March 2018 and it was unannounced. The inspection team consisted of two inspectors, a specialist advisor and an expert by experience. The expert by experience's area of expertise was in caring for older people. At the time of the inspection there were 72 older people living or receiving respite care at OSJCT Chestnut Court.

We did not request a Provider Information Return (PIR) prior to this inspection, however we had received an action plan from the previous manager of the home in December 2017, we used this action plan to help inform our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We sought feedback from healthcare professionals in relation to the care and support people received.

We spoke with 10 people who were using the service and six people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 19 staff members; including six care staff, two care leads, the chef, three nurses, two activity co-ordinators, the deputy manager and four representatives of the provider. We reviewed 16 people's care files. We also reviewed staff training and recruitment records and records relating to the general management of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2017, we found that people were not always protected from the risks associated with their care. Where people's needs had been assessed care and nursing staff did not always follow guidance to safely meet people's needs. People's medicines were not always managed effectively. Additionally staff did not always understand or act in accordance with their responsibilities to raise safeguarding concerns to ensure people's safety. These concerns were a breach of regulation 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to send us an action plan in relation to these concerns. At this inspection we found some action had been taken and staff understood their responsibilities to raise concerns. However people were still at risk from receiving unsafe care and treatment and further improvement was needed before the service met all of the legal requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

People were not always protected from the risks of developing pressure ulcers to their skin. For example, one person had three areas of pressure damage on their body. They could not move independently. This person required regular support from staff to change their position to relieve the pressure on their skin as part of their skin risk management plan set by the care and nursing staff. The person had also been prescribed topical creams to provide protection to skin areas identified as at risk of pressure damage. We were told between the 5 April 2018 and 11 April 2018 one of the person's wounds had deteriorated.

Care staff we spoke with told us they did assist the person with repositioning and applied their topical creams. However, staff had not kept a clear and consistent record of the support the person had received in relation to repositioning and the application of topical creams. Nurses could therefore not determine whether this person had received the care they had planned to prevent further skin damage. The person was at risk of not receiving care and support as they required. We discussed our concerns in relation to people's topical cream administration records not always being completed with a head of care who confirmed that they had identified improvements were needed in the completion of topical cream charts.

People could not be assured that staff would take timely action to protect them from the risks associated with their care. For example on 3 January 2018 staff had recorded that one person, who could walk independently with a walking aid, was found at the top of a communal staircase by a visitor. Staff recorded that electronic monitoring was required to alert them when this person was mobile due to the high risk of them falling. The person's care assessments were reviewed monthly and it was noted repeatedly that electronic monitoring support was to be sought.

On 28 January 2018 one member of staff recorded 'alarm mat required' for this person. At the inspection we found the person still did not have sensor or alarm mats in place, despite recent reviews stating they were required. Recent records showed the person had fallen, often when in their room. One member of staff told us, "A sensor mat would really help. We prefer (person) in the lounge so we can keep an eye on her. (Person) falls if their (walking aid) is not there." We discussed this concern with the Deputy Manager who informed us

they would seek electronic monitoring advice or look to assist the person to move to another of the units where the risk to their safety could be reduced.

People's healthcare concerns were not always reported promptly so that action could be taken to ensure timely medical attention to reduce the risk to people of their health deteriorating. For example, care staff had recorded a concern regarding one person's ongoing records in March 2018. There was no follow up action recorded on this information. Staff we spoke with were unable to tell us what action had been taken or if there was still a concern with this person's health. The Deputy Manager and Area Operations Manager were unaware of this concern and were looking into the concern.

People could not always be assured that care and nursing staff had the guidance they required to protect people from the risk of choking. People with swallowing difficulties and who were deemed at risk of choking had been seen by the community speech and language therapy team and the community dietician for safe eating and drinking assessments. However, there were not always clear guidelines for staff to follow to support people to eat and drink safely. Care plans did not always include information about people's risk of choking, what action to take if a person choked, what stage of thickened fluid they should have and the texture of their food to prevent choking.

Care staff we spoke with felt they had the information they required to ensure people's nutritional needs were met. One member of care staff said, "(person) has a pureed diet. They need this as they struggle with solid food." However, specific details regarding the consistency of foods and fluids to prevent choking were not always clear. For example, one person's care plan only stated they required their drinks to have a soup consistency, whilst others provided clear guidance on the amount of thickening agent required for a set amount of liquid to achieve the required consistency. Due to the use of agency staff within the service there was a risk that people could be placed at increased risk of choking by staff who did not know people well.

There was not always clear guidance for nursing and care staff to follow around the safe administration of medicines. For example, on 10 April 2018 an inspector found a loose tablet in one person's bedroom. This was brought to the attention of an agency nurse. The agency nurse told us the tablet was to assist with the person's blood sugar levels. The deputy manager and agency nurse informed us the person could hold the medicine in their mouth, and if the administering staff member did not observe them when they supported the person with their medicines they could spit up the medicine and thereby miss a dose. The deputy manager reassured us they had contacted the person's GP, who felt the missed dose of medicine would not have an impact on the person's health and wellbeing. However, there was no guidance in the person's care assessments or enclosed on their medicine administration records on this risk and how staff should assist this person to ensure they received their medicine as prescribed.

People's medicines were mainly stored securely and in accordance with best practice guidelines. On three of the units, we found that the medicine storage areas were kept locked; when they were not occupied. However on one unit, on the first day we found the medicine storage room had been left open and unlocked for over an hour. Staff from throughout the home, including agency staff were able to access this room, meaning people's prescribed medicines could be accessed inappropriately. On the door there was a clear sign stating the room must be locked when not in use. We discussed this concern with the Deputy Manager and the Area Operations Manager. The concern was solely linked to the failure of one member of staff, however other staff had not raised a concern about the room being open during this time.

People were not always protected from the risks associated with their care. Staff did not always take effective action when they had identified concerns regarding people's health and well-being. These concerns were a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

People we spoke with felt safe living at the home. Comments included: "I'm safe, the staff look after us and don't mistreat us"; "I'm safe, who wouldn't be safe here" and "I'm safe here, I have everything I need, including my brandy". Relatives told us they felt their loved ones were safe living at OSJCT Chestnut Court. Comments included: "We're happy they're safe" and "Overall we feel it's safe." Information regarding safeguarding was available for people and their relatives to access on noticeboards within the home.

People were protected from the risk of abuse. Care staff had knowledge of types and signs of abuse, which included neglect. They understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to their line manager or the registered manager. One staff member said, "I would feel confident in raising a concern. No delay. I would go to (deputy manager). If I need to I can call (area operations manager) or speak to a manager from another home". Care and nursing staff told us they had received safeguarding training and the manager and provider were in the process of ensuring this training was refreshed.

The Deputy Manager and provider worked with all staff to ensure that lessons were learnt from any known safety concerns and effective action taken to ensure people's safety. The service discussed incidents within the home and how they could learn from them to ensure care and nursing staff were up to date with people's changing risks and health care needs. We sat in on a daily heads of departments meeting called "11 at 11". During this meeting, incidents were discussed and information shared to ensure lessons learnt were shared and implemented to prevent similar incidents recurring.

People could be assured the home was safe and secure. Safety checks of the premises were regularly carried out. People's electrical equipment had been checked and was safe to use. Fire safety checks were completed to ensure the service was safe. Fire exit routes were clear, which meant in the event of a fire people could be safely evacuated. Equipment to assist people with safe moving and handling were serviced and maintained to ensure they were fit for purpose.

People could be assured the home was clean and that housekeeping staff followed recognised safe practices in relation to infection control. The home was clean and there were no malodours within the home. People felt the home was clean. Care staff wore personal protective clothing when they assisted people with their personal care. Care staff told us how they protected people from the spread of infection.

People and their relatives told us there were enough care staff deployed however they were concerned about the continuity of care as the service was reliant on agency staff. Comments included: "The staff levels are okay, it's just not always consistent and some of the agency don't seem as caring"; "I can always ask for support and I get it when I need it" and "Turnover of staff is very frequent including the Manager."

Staff felt there were enough staff deployed to meet people's needs, however they raised concerns about the high level of agency staff and high turnover of permanent staff. Comments included: "At present they're ensuring there are enough staff"; "Things have gotten better. However it's not permanent staff. We've lost lots of good staff" and "We have more good days than bad, however we struggle to have a stable team". The provider had a clear plan in place to ensure a consistent staff team would be in place .and had stated that they had recently recruited a number of permanent staff to work at Chestnut Court.

Records relating to the recruitment of new care staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character.

We observed one nurse and one care staff assisting people with their prescribed medicines. For example, one member of care staff assisted a person with their prescribed medicines in a kind and compassionate way. They clearly communicated what the medicines were for and asked if the person wanted to take them. They gave the person plenty of time and support to take their medicines. The person was in control throughout, offered choice by the staff member and given a drink with all their medicines.

Requires Improvement

Is the service effective?

Our findings

People were supported by care and nursing staff who did not always feel they received the support they needed to meet people's needs effectively. Staff felt the changes in management and lack of a stable staff team had had an impact on their work and wellbeing. Comments from staff included: "As staff we're confused, we're not happy. I've seen so many managers come and go here; it's my biggest concern"; "Sometimes it is hard here as there isn't someone to speak to, it can be emotionally draining sometimes and these isn't the time or person to discuss this with"; "I haven't had a meeting with my manager since I've been here apart from at the start" and "I would like a bit more support and guidance."

The Area Operations manager had implemented a matrix of all "trust in confidence" meetings (the provider's supervision and appraisal meetings) staff had received in the home. This matrix showed the majority of staff had not received a "trust in confidence" meeting. The deputy manager and area operations manager were aware that not all staff had had the opportunity to discuss their concerns or needs in a structured way. They had implemented the matrix to enable them to introduce and monitor that a dedicated programme of meetings and support for staff took place.

Staff felt access to additional training and support had not always been accessible as requests had been lost when managers had changed. For example, two members of staff discussed the possibility of completing training which would enable them and care staff to effectively communicate with a person who was living at OSJCT Chestnut Court. They told us while the request was made however they had no response to the request. They said, "We ask for things, however they're never followed up."

Staff did not have access to the support they needed to carry out their role effectively. These concerns were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care and nursing staff told us they had access to the core training they required to meet people's needs. Care staff spoke positively of the training programme and understood the provider's policies and aims in relation to training. Comments included: "The training is good, I get all the training I need"; "Training is once a year, it's pretty much spot on. All my training needs are met" and "I think I have all the training I need to meet people's needs."

The area operations manager and deputy manager had a clear plan for the training and support of new care staff. This included new staff working at another of the provider's care homes which had been rated as "good" by CQC. Their aim was for new care staff to work alongside staff employed by the provider to be able to learn and understand the expectations of the provider. As part of their induction the staff members would receive a full course of training deemed mandatory by the provider as well as completing the care certificate.

Care and nursing staff had an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and knew to promote choice when supporting people. The 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Care and nursing staff understood and respected people's rights to make a decision. Staff explained how they embedded the principles of the MCA into their practice. Comments included: "We are always offering choice, at mealtimes we can show people the meal options, help them make a choice" and "I like to give people a choice, even if it's a choice of shirt. I don't think people with pureed diets get enough choice and variety." We passed this comment to the area operations manager and deputy manager for their attention.

People's mental capacity assessments to make significant decisions or day to day decisions regarding their care at OSJCT Chestnut Court had not always been clearly documented. For example, where people had been assessed as lacking the mental capacity to make a specific decision, there had not always been a clear record of the decision made for the person, how it was in their best interest and if it was the least restrictive option. Best interest decisions were not always documented and there was not always a clear record of who was involved in these decisions.

At the time of this inspection a number of people living with dementia were being deprived of their liberty within the home. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager was aware of their responsibilities to ensure where people were being deprived of their liberties that an application would be made to the supervisory body. However, where people were living under DoLS this was not always reflected in their care plans. For example, where a DoLS request had been made, there was no clear record that the restrictions on the person were being reviewed or a record if the DoLS had been authorised. A care lead had made an urgent DoLS request for one person, which would be active for seven days, however there was no evidence of a further request for this person to be deprived of their liberty. The person was living with dementia and staff explained they did not understand the risks to their health in the community. The area operations manager was aware of all concerns raised in relation to people's MCA and DoLS records and these concerns had informed the improvement plan for the service.

People's needs were assessed before moving to the service. Pre-assessments were detailed and showed that people's physical and mental health needs had been assessed. Assessments included information in relation to people's nutritional needs and needs around their anxieties and mobility needs. However these assessments did not always inform people's care assessments. For example, one person's pre-assessment identified a significant healthcare condition which could have an impact on the person leading them to suffer a seizure. There was no record of the support the person should receive if they were to suffer a seizure, or the signs and symptoms to alert staff that they had suffered a seizure. We spoke with an agency nurse who felt they did not have the information they required regarding the person's health and wellbeing needs to know how to provide effective care. They explained the information had not been recorded in handover notes. There was also no clear assessment in the person's care file. During the inspection the person suffered a seizure and a relative identified this concern and raised this with staff on duty.

People's care assessments were not always reflective of their needs. For example, one person's care assessments had not been updated to reflect changes in their health and wellbeing, including the support they required with their personal hygiene, the nutritional support they needed and the equipment they required, such as crash mats and low level bed. We raised this concern to the area operations manager and deputy manager. A care lead took immediate action to review the care plan to ensure key details in relation to the person's health and wellbeing were clearly recorded.

These concerns relating to people's care records were a breach of regulation 17 of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff had identified the support one person required around their diet had recently changed. While it was recorded in ongoing care evaluation notes that the person required prompting and encouragement with their meals, this was not clearly reflected in their care plan. On the first day of our inspection, the person was left with a meal in their bedroom; the person did not receive any support or encouragement to eat. The person did not eat their meal. One member of staff stated, "They aren't eating much at the moment, we are prompting drinks, and we're keeping a check as they are losing weight."

People's care plans reflected their diversity and protected characteristics under the Equality Act. People's sensory needs had been identified and staff were prompted to make sure people had access to equipment to ensure their continued independence. For example, checking hearing aids were in working order and glasses were accessible.

People had access to health and social care professionals. Records confirmed people had been referred to a GP, continuing healthcare professionals, occupational therapists and physiotherapists. People's care records showed relevant health and social care professionals were involved with people's care. For example, two people living at the home were living with diabetes. There was a clear record of their appointments in relation to this healthcare need, including annual check-up, podiatry and retinopathy checks (checks on people's feet and eyes respectively).

Where people were at risk of malnutrition, they had been provided with a diet which protected them from these risks such high calorie diets. The deputy manager had taken actions in relation to ensuring people received the support they required to protect them from malnutrition. This included a period of weekly weights, with the exception of people where their GP had advised against it. This had been communicated to staff through daily flash meetings, with a clear rationale for the decision. At weekly clinical meetings, the deputy manager, a unit lead and a member of the homes catering team discussed people's dietary needs and the support they required. A chef told us, "In the last 2 to 3 weeks, we have had weekly meeting with the Manager. I realise it's about informing us of weight loss management and how we are to deal with it. I'm glad now that we have these meetings as I am getting feedback whereas before, the food was just going out not knowing what was going on."

People and their relatives spoke positively about the food and drink they or their relatives received in the home. One person said, "I have everything I need." Fresh drinks were in communal areas which were distributed from special machines and people's rooms and were refreshed daily or more often if required. People received diets which met their dietary and cultural needs. For example, the chef informed us, "We have one vegetarian, a diabetic, a person that just wants fish and chips every day and another that wants chicken with everything. There are two main meals a day and anyone can have soup or a sandwich if they don't want what's on the menu or another alternative if they are allowed.

People were comfortable in their environment. The home had handrails installed around the home which were in accordance with best practice guidance from the Royal Institute for the Blind to ensure people with visual impairments could navigate around the home. The home was tastefully decorated with a range of communal spaces that people could enjoy with others and their visitors. The suitability of two of the home's dementia units were being updated to make them environment "dementia friendly." We observed people moving around their units freely without agitation or confusion.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the caring nature of staff employed at OSJCT Chestnut Court. Comments included: "Very caring and patient"; "pleased with everything, can't fault it" and "We are very impressed. There was a bit of a dip here two months or so ago but it seems to have picked up again now and we really have noticed the difference."

People often enjoyed positive relationships with care, nursing and other staff. The atmosphere was often friendly, inviting and lively in the communal areas with staff engaging with people in a respectful manner. We observed many warm and friendly interactions. Staff encouraged people to spend their days as they wished, promoting choices and respecting people's wishes. For example, one person was supported to choose where they wished to go in their unit. The person enjoyed sitting in one of the lounges in the home, so they could watch the world go by. When asked the person told us they enjoyed sitting in the lounge. They said, "It's good here."

People engaged staff and were comfortable in their presence. They enjoyed friendly and humorous discussions between each other. People talked to each other and clearly respected each other and were observed talking with each other. For example, three people enjoyed eating their lunch with each other, they enjoyed friendly conversations with staff, including asking who the inspector was and why were they in the home. It was clear that people and staff enjoyed these times of engagement.

People were supported to maintain their personal relationships. For example, People and their relatives told us that visitors could visit at any time and there were no restrictions in the visiting times. One person said, "My relatives can visit me when I want." The service communicated with people's relatives. One relative told us, "We've been able to visit at any time, there is never any problems. The permanent staff are good at letting us know things, there are some great daytime carers."

People's dignity was respected by care staff. For example, when people were assisted with their personal care staff ensured this was carried out in private. People living at Chestnut Court felt they were treated with dignity and respect and their wishes were respected. We received comments such as: "when they help me with my personal care, they respect what I like and help me keep dignified although sometimes in this situation, it's hard to do so" and "They are always respectful to me."

Care and nursing staff told us how they ensured people's dignity was respected. All staff members told us they would always ensure people received personal care in private and would ensure they were never exposed. Comments included: "I think it's important to assist people straight away. Give people the space and time to make changes" and "Talking to them is important, explaining what we're doing, even if they can't talk back, we know when they are uncomfortable." One relative told us, "Very pleased with the care. (Relative) Always looks clean and presentable with neat and tidy hair."

People were able to personalise their bedrooms. For example, people had decorations or items in their bedroom which were important to them or showed their interests. For example, one person's room

contained photos of their family and people who were important to them. Another person had a number of possessions they had brought from their own home, when asked they spoke positively about their room and enjoyed the privacy and comfort it provided them.

Requires Improvement

Is the service responsive?

Our findings

People may not always benefit from personalised care which is tailored to their individual needs. We found staff had identified people's needs and health concerns. However, they had not always followed up on going concerns or when referrals for specialist advice had been made to ensure people's health and wellbeing needs were met. Staff had not always considered what action they needed to take in the interim. This meant people's needs were not always supported whilst staff waited for specialist health professional's input. For example, during our inspection, one person was calling out and was in discomfort. We spoke with an agency nurse and the persons GP. The GP informed us that 12 days prior to the inspection medicine had been prescribed for the person; this medicine was prescribed to keep the person comfortable and free from pain. The prescription for this medicine had been misplaced, which meant the person had not received these prescribed medicines to ensure their pain would be managed. The agency nurse and the area operations manager took immediate and effective action to ensure this person received these medicines when we raised this concern.

Additionally, healthcare professionals and the person's relatives had made a best interest decision in September 2017 about the care and treatment of the person and when, where and how this care and support should be provided. A letter detailing this decision was included in the person's care file, however had not been included in the person's care plans or on the person's handover information. The person's relative had to inform the agency nurse of this information, which had then been recorded on the person's daily care records. The agency nurse had not been aware of this information, or that a previous prescription had been made for the person. This person did not receive care which was in accordance with their best interests and was at risk that plans made would not be followed.

One person had made a decision that they did not wish to be resuscitated in the event of a cardiac arrest. This request had not been acted on at the person did not have a Do Not Attempt Resuscitation order in place, which meant if they were to have a cardiac arrest, they may be resuscitated against their wishes. The deputy manager was made aware of this concern and told us they would take effective action to ensure the person's wishes and preferences were recorded.

People's preferences were not always taken into account when staff delivered their care. For example, one person enjoyed a drink of beer with their lunch from their own glass. On the first day of this inspection, the person requested their particular glass, staff stated they could not find this glass. However during the day, the glass was in plain sight within the nurse's station; however no staff member had identified this. The person said, "I wish I'd brought my own down now." This concern was raised to the area operations manager and deputy manager and the glass was available to the person during the other days of the inspection.

People's requests for support were not always acted upon. For example, we observed one person being offered a drink by a member of staff. The person requested a cup of tea; the staff member stated they would help another person first and then provide the drink. The person stayed in the lounge for 50 minutes, before an agency member of staff took them to their bedroom. The agency member of staff did not ask the person

if they wished to go to their room, and approached them from the side. The person was not startled by this sudden approach The person was taken to their room, however they had not been provided with a cup of tea. We informed the deputy manager and area operations manager about this concern.

During the afternoon, we observed one member of care staff assisting someone with a drink. The member of staff however had not assisted the person in a way which respected their dignity. The member of staff was sat next to the person, with a beaker mug in their hand to the person's face. The member of staff was watching television, whilst eating a biscuit. On seeing the inspector, the member of staff covered their mouth and focused on assisting the person with their drink. We raised this concern to the deputy manager and area operations manager who told us they would address these concerns.

People's care plans did not always contain personalised information about their care needs, or provide clear information on people's life histories or their interests and hobbies. For example, for three people there were "this is me" documents (recognised booklets to record people's life histories) however these had not been completed. Additionally the activities people enjoyed were not recorded within their care plans. We discussed this with the home's activity co-ordinators. They showed us that activities were recorded in their own activity files and there was no crossover with care staff notes. Activity co-ordinators also told us they were not involved in writing "this is me" documents, however they felt "all staff should be involved." During our inspection, activity co-ordinators had identified a number of people grew up seeing chickens hatch, via family or by working as a farmer. This information could be used to inform people's care assessments and provide care staff with vital information which could enable them to engage with people. One activity co-ordinator told us, "Communication isn't great. We don't link with carers as much as we should."

Other care records, including those relating to people's ability to use call bells at OSJCT Chestnut Court were not always personalised to people's needs, including generic information. We informed the area operations manager about this, who told us they were planning to review the relevant care plans.

There was not always clear guidance in place for care staff to assist them meeting the needs of people who were anxious or agitated. For example, care staff told us about one person who could become agitated and resistive to personal care, or exhibit behaviours which may challenge. Staff told us how they reassured and assisted this person. However there was no recorded guidance on how staff should assist them. One member of staff told us about how they assisted one person and said, "You always need to communicate with them, that's the best way, help them understand." This meant that staff may not always have a consistent approach when assisting people when they become agitated.

The area operations manager and deputy manager were aware that information about people's care were not always current or reflective of people's needs and actions had been implemented to improve people's care records.

People did not always receive care and support which was personalised to their individual needs. These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we also heard examples of staff responding promptly and effectively to people's changing needs and provided effective end of life care. For example, one person was receiving end of life care at the time of our inspection. Care and nursing staff had identified a decline in the person's health and wellbeing. We spoke with family members who praised the care their relative received and spoke positively about staff, some who had since left their employment at OSJCT Chestnut Court. They said, "The care staff have been fantastic. (Deputy Manager) has been excellent."

People enjoyed activities and stimulation which was appropriate to their needs and age. For example, over the course of our inspection, people enjoyed a visit from a company which brings animals into the home, in this case giant insects, a memory café in co-ordination with a local superstore and living chicks, chickens which were provided with equipment to hatch within the home, so people can see them hatch and live their early days. People told us they enjoyed the activities provided to them. One person told us, "I go to all the quizzes and any other entertainment or activity that's going on. I especially liked this morning with all the different animals."

The activity co-ordinators had built strong links with the local community. The memory café enabled people from the community to come and engage with people who lived at the home. The memory café included people making presentations about dementia related resources, for example a presentation was happening in relation to a robot which could act as a personal assistant. Activity co-ordinators told us people were supported to go shopping and go to the café in the supermarket. There was also strong links with the local school to provide further community engagement for people living in the home.

The activity co-ordinators told us how they provided stimulation which was effective to people's needs and wellbeing. For example, people who were unable to communicate and were cared for in bed were assisted with one to one activities such as hand massages and listening to music. Activity co-ordinators told us that activities were always aimed to improve people's wellbeing.

People and their relatives knew how to make a complaint if they were unhappy with the service being provided, however had felt that previous concerns and complaints were not always acted upon effectively; you can find further information regarding this in "Is The Service Well Led?" One person said, "I have never had to complain." The interim and deputy manager kept a record of complaints and compliments they had received about the service since they started in post. These complaints were acknowledged and responded to effectively. The interim manager had documented a clear response to each complaint and the action they had taken in response of the concern, such as labelling people's personal moving and handling equipment to ensure the concern was not repeated.

Inadequate

Is the service well-led?

Our findings

There has not been a registered manager at OSJCT Chestnut Court since October 2015. 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. People, their relatives and staff raised concerns about the management of the service and the lack of consistency. The service had placed an interim manager in the home and had recruited a deputy manager. At the time of the inspection management support was being provided by an area operations manager and experienced staff from other homes operated by the provider. Recruitment was ongoing for a new manager, with the intention of registering this manager with CQC when in post.

This is the third inspection of OSJCT Chestnut Court where the service has been rated. At all three inspections the service had failed to meet all the requirements of the relevant regulations. Effective action had not been taken following our inspection in April 2017 to make the required improvements; partly due to the lack of consistent leadership and management at OSJCT Chestnut Court and people were still not always protected from risks associated with their care. While the provider had identified a number of the concerns we had identified prior to our inspection, actions at this time were still ongoing and had not been fully implemented and evaluated to ensure people would always receive safe and effective personalised care. The provider had not demonstrated that they were able to consistently meet the requirements of their registration and operate effective systems to ensure that OSJCT Chestnut Court met the requirements of the Health and Social Care Regulations. Therefore we have rated this question as 'Inadequate'.

People and their relatives discussed the need for stability at OSJCT Chestnut Court. Comments included: "Management changes and stability is an issue here"; "There is no leader of teams. There is no key worker or key nurse. I used to know who the Manager was but I don't now. They seem to keep changing" and "We feel that it (home) has deteriorated dramatically in the last two years."

People and their relatives had felt their concerns had not always been acted upon. Relatives told us that due to changes in management, when concerns had been raised these had unfortunately not been passed forward. One relative told us, "Turnover of staff is very frequent including the Manager. When we have told the Manager of our concerns, we feel that it is not passed on and the same thing occurs time and time again." Another relative contacted us that they felt their concerns hadn't been addressed and their confidence in the management was low.

Staff employed by the provider discussed the impact a lack of management consistency had on their wellbeing, skills and ability to carry out their roles successfully. Most staff told us they felt undervalued and were concerned about the future of the service. Comments included: "I think there have been more managers than I've had hot dinners. We're all fed up. There is a lack of support and consistency. I feel undervalued"; "I feel there has been no stability, who do you go to if you've got a problem? You don't know if you're coming or going. Four managers in a year, no consistent lead on this unit"; "Once stability of management is in place I think it'll get better" and "I've never seen managers come and go as they do here. It

feels like we're not going anywhere. We feel unvalued."

Care and nursing staff (including agency staff) did not always feel they received the communication they required regarding people's needs. Comments included: "There is limited management and support, communication is not great"; "I don't feel I get the information I need. Sometimes I won't know about their (people's) needs until I've gone into the room." and "Communication isn't great, I don't feel concerns are passed forward."

There was not always clear leadership within each of the four units of OSJCT Chestnut Court. For example, on the first day of the inspection, we identified the unit leader and a senior member of staff stayed within the units nursing station. Care staff lacked guidance which led to people receiving care and support which was not tailored to their individual needs. There was no oversight of who was responsible for responding to people's call bells, for example the main source of alarm was in the nurses station and no one had been delegated to hold and respond to calls, which meant people went for up to 30 minutes without support. On another unit, one member of staff was left to attend to six people in the home's dining rooms, while four members of staff had a meeting (which included a healthcare professional) for an hour. During this time two people went without any engagement for an hour. Care staff told us that due to the use of agency staff there was no always firm leadership or direction within the units. One member of staff said, "We have a lot of agency, there is no consistent leadership."

Quality assurance systems previously used by the provider had not always been effective in driving improvements to the service. For example a baseline audit carried out by the provider in January 2018 and an external local authority review in December 2017 had identified a number of shortfalls within the home. Actions had been recorded, however it was not always clear who was responsible for these actions or if they had been completed. For example, concerns around how people's needs were assessed and documented had been identified in audits carried out by the provider and external local authority review in December 2017. We found at this inspection these concerns were still present and the required improvements had not been made. The provider had implemented new action plan during our inspection and had carried out a further audit of the service on 4 April 2018. Following our inspection they provided us with an action plan detailing how they were aiming to improve the service.

Effective actions had not always been taken to improve the quality of service people received over a period of time. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The area operations manager provided a weekly action plan update to CQC following the inspection to enable us to review and monitor the progress the provider was making to ensure the service was meeting all of the relevant regulations.

People, their relatives and staff spoke positively about the deputy manager and area operations manager and hoped they would provide stability to the service. Comments included "(Deputy manager) is really good, makes sure it well staffed, we were short and he sorted it"; "(Deputy Manager) has been excellent, they have really listened to us"; "(Interim manager) has been absolutely brilliant. Understand and leads us in one direction. (Area operations manager has been brilliant" and "It's better, they're explaining the reasons for things better."

A care lead had come to work from another of the provider's homes. They explained the challenges they felt the home faced. "I came in to knuckle down. Get everyone working as a team, with structure. There is an engrained culture here." The deputy manager and area operations manager discussed their aims to improve

the service and improve the caring culture within the home, including training staff at other homes. Representatives of the provider expressed their wishes and needs to get stability and management right within the home.

The interim manager and deputy manager had implemented weekly clinical meetings and daily flash meetings to improve communication and ensure people's needs were known and any changes communicated to ensure their wellbeing. During the inspection we sat in on one of these meetings. The deputy manager, care lead and chef discussed people's ongoing needs, and ensured that the support being provided was recorded and known by all staff. Where actions or referrals were required to be made, these were clearly communicated and documented. Meeting minutes were recorded which clearly detailed where action had been taken.

The deputy manager was using flash meetings to ensure important messages regarding the home and people's daily needs were communicated. Staff members were asked to feedback information to staff on their respective units. One member of staff raised a concern about information not being spread throughout the home. It was agreed that a record of each flash meeting would be kept in each nurses station in a specific folder. This action was agreed and implemented immediately. Staff were to ensure the purpose of this folder was communicated and ensure staff passed on any feedback from these meetings.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care which was personalised to their needs and wellbeing. People's consent to their care had not always been assessed or documented. Regulation 9 (1)(a)(b)(c) 3(a)(b)(c)(d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were not always effective systems in place to ensure the quality of the service people received. There had been a lack of consistency regarding the management of OSJCT Chestnut Court which had impacted on staff and people. Regulation 17 (1)(2)(a)(b)(c)(e)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive the support and guidance they required to carry out their role. Regulation 18 (2)(a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not always protected from the risks associated with their care. Staff did not always effectively respond to concerns or risks identified to people's wellbeing. Regulation 12 (1)(2)(a)(b)(d)(g).

The enforcement action we took:

We issued a warning notice to the provider informing them they must be compliant with the regulation by 31 July 2018.