The Orders Of St. John Care Trust

OSJCT Athelstan House

Inspection report

Priory Way
Burton Hill
Malmesbury
Wiltshire
SN16 0FB

Tel: 01666848000
Website: www.osjct.co.uk

Date of inspection visit:
25 April 2018
26 April 2018

Date of publication:
15 June 2018

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?	Requires Improvement

Summary of findings

Overall summary

At the inspection of 17, 18 19 and 23 May 2017 we found breaches of Regulations 9, 12, 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider wrote telling us the actions they were taking to make improvements. At this inspection we found Regulations 12, 13 and 18 were met and Regulation 9 partially met.

This inspection took place on the 25 and 26 April 2018 and the first day was unannounced. The registered manager was aware of the subsequent visit.

Athelstan House is a care home providing nursing and residential care for up to 80 people. At the time of the inspection there were 53 people living at the home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is arranged over two floors with Primrose and Lavender on the ground floor and Foxglove and Heather on the first floor. In Lavender people were receiving nursing care and residential care was mainly delivered to people in Foxglove and Heather. Re-admissions into Primrose the empty unit will be over a period of time.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Safeguarding processes were in place and ensured people at the service were safeguarded from abuse. Staff had a good understanding on of the types of abuse and the actions needed where there were concerns of abuse. People generally said they felt safe.

Risk assessments were in place but not regularly monitored to assess the effectiveness of the action plan.The staff we spoke with were knowledgeable about people's individual risks and the actions needed to minimise the risks. Individual risks to people included falls, risk of malnutrition, choking and mobility impairments.

Quality Assurance systems were in place but areas identified at the inspection were not reflected in the audits. There was inconsistent action for some people identified at risk of malnutrition and for one person that had sustained an injury. Weight monitoring charts were not in place for one person that was at high risk of malnutrition. Staff had not reported extensive bruising for one person. The registered manager took prompt action when we identified this and reported the incident to appropriate authorities. Appropriate reporting action had been taken in the upstairs units. .

The robust medicine systems in the residential units ensured safe systems of medicines. However, the same situations were not found in the nursing units. Medicine audits had identified gaps in when required

medicines (PRN) but the timeframe for meeting the action was not met.

Gaps in the administration of medicines were not reported and we observed unsafe medicine administration by a registered nurse. The registered nurses comments indicated their awareness of gaps in the recording of medicines administered. checks were not taking place. Where audits had identified shortfalls these had not been actioned.

Medicine profiles included a photograph of the person and essential information such as known allergies and how the person preferred to take their medicines.

Care plans upstairs in the residential units had elements of person centred care and were reflective of people's current needs overall. In the nursing units we found inconsistencies. For one person at high risk to weight loss the care plan stated that staff should support them to be weighed once every two weeks but this had not happened since April 2018. Mental capacity assessments were not always in place and records needed to be clearer.

The safety of the living environment was regularly checked to support people to stay safe. For example, fire risk assessments, fire safety equipment checks and fire training for staff.

Staffing rotas were designed using dependency tools. People and their relatives said there had been improvements in the staffing levels and in recruitment of new staff.

Staff said the training had improved. The trainer said training had improved and that there were one to one opportunities for staff. A moving and handling trainer was onsite. The registered nurses said they had access to training but sometimes it was difficult be assessed and maintain their competency.

The staff we spoke with knew how to ensure people were given choice and supported to make decisions. Mental capacity assessments were not always in place for crash mats and sensors. Relatives were asked to sign bed rails consents but staff were not always aware if a lasting power of attorney was in place.

There were good activities resources. The activities coordinators tracked the activities they provided. Relatives also praised the care staff for the social interactions they had with their family members. Some relatives said this was not always recognised as part of social interaction. Feedback was very positive about the caring approach from the staff. Staff were very respectful of people's rights.

Staff said the leadership was strong and the management team and registered manager was approachable and visible. They said the deputy and head of care made a good management team. There was a strong relatives group and they told us there had been improvements since the appointment of the registered manager. Relatives praised the registered manager and deputy for their commitment and that they were visible at weekends.

We found 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 the 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 was not consistently safe.

Staff in the nursing units were not following medicine procedures. Medicine records were not signed to indicate the medicines had been administered.

Risks were identified but action plans were not followed. Where people sustained injuries they were not reported. Members of staff were knowledgeable on actions necessary to reduce risks.

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

People said they felt safe and were able to describe what safe meant to them.

Staff attended safeguarding of vulnerable adults training which meant they knew how to recognise the types of abuse and how to report their concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity to make complex decisions were not clearly documented.

Staff enabled people to make choices.

The needs of people were assessed before their admission to the home.

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

People's dietary requirements were catered for

Is the service caring?

Good

The service was caring

People were treated with kindness and with compassion.

We saw positive interactions between staff and people using the service.

Staff knew people's needs well and how to reassure them when they became distressed.

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

Is the service responsive?

Requires Improvement

The service was not fully responsive

For some people care plans were not person centred.

People told us the staff knew their needs and how to deliver care in their preferred manner.

People had access to in-house and community activities.

People were supported to maintain contact with relatives.

Is the service well-led?

Requires Improvement

The service was not fully well led.

Quality assurance systems and processes for assessing the delivery of care were in place. However, not all the findings of this inspection were identified for improvement.

The views of people was were gathered from feedback received and action taken to improve their experience in relation to meals.

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

OSJCT Athelstan 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 and 26 April 2018 and was unannounced. The registered manager was aware of the visit arranged for the second day of the inspection. At the time of the inspection there were 53 people living at the service.

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

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

This inspection was undertaken by two inspectors, a specialist advisor and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We spoke with 15 people and eight relatives. We spoke with the GP and occupational therapist during the inspection. We spoke with the registered manager, deputy, head of care (residential) and peripatetic manager. We also spoke with four care leaders, six support staff and one staff on induction. The activities coordinator, chef and house keeper also gave us their feedback about working at the home.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included 12 care and support plans as well as six care records in relation to specific areas. We reviewed the staff matrix provided in the PIR, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of

the day.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we found breaches of Regulations 9, 12, 13 and 18. We found that staff did not feel confident to raise concerns which placed people at risk from abuse. Risk assessment action plans were not followed by the staff which placed people at greater risk. The staffing levels and faulty equipment prevented people from gaining staff support as needed. Following the last inspection the provider wrote telling us about the intended improvements. At this inspection we found improvements had occurred in relation to Regulations 13 and 18 and partially in Regulation 12 and 9.

Risks had been identified and risk assessments provided clear guidance for staff on how to reduce the risks. Risk assessments were in place for areas such as falls, mobility, malnutrition and skin integrity. When these risks had been identified, care plans provided clear guidance for staff on how to reduce the risks to people.

People were assessed for the risk of malnutrition and dehydration. People's weights were monitored. However, risk assessments had not always been regularly monitored to ensure the actions were effective. Care plan guidance in relation to weight monitoring was not always followed. For example, in one person's plan it was documented that they had a poor appetite and needed a fortified diet. The plan stated the person should be weighed every two weeks but there was no recorded weight since 01/04/2018 (three weeks prior to our inspection).This meant the staff if people at risk were sustaining their weight or their health was deteriorating.

For another person food and fluid intake was not monitored despite significant weight loss over a year and progress notes stating that monitoring charts were reintroduced. The eating and drinking care plan dated 25/03/2018 stated low risk of malnutrition but on 25/03/2018 staff had documented in the progress notes "Food and Fluid intake charts were reinstated". On four occasions between 16 and 25 April 2018 the staff had documented in the daily notes issues with weight loss and poor appetite. Comments recorded by staff included, "Very limited food and drink", "Poor appetite" and "Continues to decline food offered." This meant because staff were not fully aware of people's fluid and food intake steps were not taken on developing regimes to improve their appetite.

Some people were having their fluid intake monitored. However, fluid charts did not have a daily target written on them and had not always been totalled at the end of each day. It was unclear how staff escalated concerns about poor intake because this had not always been documented.

Accidents and incidents procedures were not followed. We noted a photograph of a large bruise on one person's right forearm. This photograph was dated 09.04.18 and attached the Tissue Viability Care Plan dated 2016. The progress notes stated "resident was found to have a large bruise right forearm, unknown how it was done." We saw the bruising on the person's arm was considerable and had not dissipated considering the bruise was noted two weeks previously. There was no evidence that medical attention was sought or relatives informed about the injury. A body map used to indicate the location of the injuries detailed other injuries sustained from November 2017 to March 2018. However the significant bruising found on the forearm was not detailed.

We asked a registered nurse and the deputy manager about the bruising but they were not aware that this person had sustained an injury. The deputy manager investigated on the reporting of the incident and concluded that internal and external reporting had not taken place. They agreed that this was not the correct way to respond to finding an injury. Feedback was given to the senior management staff at the end of the day. Immediate action was taken by the management team which included contacting relatives and requesting a visit from the GP. Referrals were made to the safeguarding team and notification to CQC. We were reassured that an internal investigation was to take place.

Medicines were not always managed safely. We looked at all of the medicine administration records (MARs). On the residential units staff had signed all of the charts to indicate that people had received their medicines as prescribed. There was a process in place for checking daily that the charts had been fully completed. When gaps were identified there were records to show that staff had investigated the gaps and had checked the medicines had been administered and had reported the gaps as medicine incidents. However, the same checking process was not in use on the nursing unit. We identified 14 gaps on the MARs, some of which were from at least 22 days prior to our inspection. One of the gaps was in relation to a dose of insulin. There was nothing documented to indicate that staff had identified the gaps or investigated them. The exception to this was one entry where staff had documented, "says she's already had although not signed, so omitted." There was nothing written to show that staff had undertaken a stock check to confirm that medicines had been administered.

We saw on one MAR chart a person had been prescribed a medicine "at night." However, the MAR chart had been signed twice daily for four days. Staff had underlined "at night" and put a line through the morning boxes for subsequent days. This showed that staff had identified the previous errors. However, the incident had not been reported which meant the repeated errors had not been investigated. Additionally, none of the missing signatures had been reported.

We observed the nurse on duty administering medicines in an unsafe way. On one occasion they said they did not need the MAR chart because they knew which medicine the person was due. On another occasion we observed them give a relative some medicine for another person. They did not have sight of the person whose medicine it was, which meant they could not be assured the person received it. The provider's medicines policy clearly defined the steps staff should take when administering medicines, including "Take the MAR chart to the resident and ensure the medicine is administered appropriately."

Some people had been prescribed additional medicines on an as required (PRN) basis. Although there were protocols in place for the use of these, they were not always personalised. For example, one protocol we looked at specified where the person tended to experience pain and that they were able to ask staff for pain relief. Other protocols we looked at did not contain as much detail. For example, some people had been prescribed medicines to relieve anxiety and agitation. However, the protocols did not detail the signs people might display if feeling anxious or agitated and did not inform staff of action they should take to relieve the symptoms before resorting to the use of medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they generally received their medicines on time. "The staff do my medicines and I've never had any problems, they're given on time and I trust the nursing staff." However, some people in the nursing units said, "I usually get my tablets on time, just occasionally they're a little bit late but you expect it that they can get held up." and "It takes a long time to get medicines". "The staff give my medicines, which goes well, the only thing is I'm not sure what I'm having as they don't always tell me, and this morning they were a bit early

at 06:40 am, I'm not sure why that was."

Comments from people in the residential units included, "Staff give it to me", "They look after that [medicines administration] and suits me.". "I have a lot of tablets and patches, the staff bring it at the right time they are very good" and "The staff help me with my medication".

Medicines were stored safely across all units. The temperature of the clinical room and the medicines fridges was monitored. Controlled medicines were stored safely. Regular stock checks were undertaken of controlled medicines. We carried out a random stock check with one of the nurses on duty and found the stock balance to be accurate.

Some people were prescribed creams and lotions. There were topical MARs in place, including body maps and clear instructions for care staff on where to apply creams. The majority of the charts we looked at had been signed to show the creams had been applied as prescribed, however this was not seen consistently. For example, we looked at the chart for one person who had been prescribed a lotion to be used as a soap substitute. The chart had been signed daily by staff during April. However another person had been prescribed a cream to be applied to pressure points twice a day. On nine days during April the chart had only been signed once.

The staff we spoke with knew people's individual risks and the actions needed to ensure they stayed safe and free from harm. A member of staff gave us examples on how risks to people were minimised. For example, regular repositioning and equipment such as air mattress and pressure cushions were used for people at risk from pressure sores. For people at risk of malnutrition this member of staff said supplements and enriched diets were served. People's food and fluid intake and weight was monitored.

People that needed support with transfers said, "I have to use the hoist. The staff know what they're doing and can make me comfortable." "I was falling at home, since I've been here I've not been allowed to walk (after a report from the physiotherapist) because they said I wasn't safe and wasn't going to get my strength back but the staff manage the hoist well". "The staff hoist me into the wheelchair, the only thing is that I stay there all day and it's quite uncomfortable, I'd like to spend less time in there. "Moving and handling plans detailed any equipment staff needed to use, such as hoists and slings. When people used mobility aids to move around independently the moving and handling documentation listed this.

Some people were at risk of falling. Some relatives raised concerns about the number of falls their family members had experienced. Falls prevention plans were in place and included guidance for staff such as ensuring people wore well-fitting footwear, keeping floors free of clutter, and making sure the call bell was within reach.

Skin integrity plans included guidance for staff on how to reduce the risk of people developing pressure ulcers. These plans included instructions for staff on how frequently people should have their positions changed and details of any pressure relieving equipment in use. Air mattress settings were documented and all of the mattresses we looked at were set correctly and records showed these were checked regularly. Position change charts had been filled in and showed that people were regularly supported to relieve pressure in line with care plan guidance.

Personal Emergency Evacuation Plans (PEEPs) were in place for people. People's ability to understand the actions to take when fire alarms were activated was recorded. Also detailed was the number of staff and aids used with a description on how to support the person for a safe evacuation of the property. For example, one person was unable to understand fire safety procedures and one member of staff was to use a

wheelchair to assist this person to leave the property safely.

People in the residential unit stated, "I ring the buzzer and they come and always knock on the door. I don't need [staff] at night as I sleep through", "If I buzz the staff come quickly. If short of staff I might wait a few minutes. I don't think I have had to use it at night" and "I only use the buzzer at night and sometimes they are quick sometimes takes a little longer.".

One person had a wrist buzzer which I asked her about and she said, "I spoke to staff as they did not seem to be coming when I pressed the buzzer, they tested it with me and I was not strong enough to press it so they got me this which needs less power and it has a light so I know it has worked".

Visitors told us the staffing levels had improved over the last year and the use of agency staff had decreased. They said, "Things have improved beyond all recognition. They used to have three staff for 20 dependent people and it wasn't enough, it was really difficult. They've implemented the care leader role and they have at least four carers on duty and the use of agency staff is now very low", "They've got a good crew [staff] now and they work well together "and "I think they've sacked some staff who weren't up to scratch, they're rightly fussy and so they have had gaps, but it's got better.".

There were sufficient numbers of suitable staff available to support people to meet their needs. The comments from staff included, "We've got more new staff now. Some are new, some are more experienced, but we all know what we're doing" and "Yes, we have enough staff now." A member of staff said the registered manager had recruited new staff and stated, "new staff are coming and they are staying." Another member of staff said staffing levels had improved and "I don't come in and look at the rota and see only me and the nurse anymore".

People told us they felt safe. One person said, "I feel safe because the staff are very kind, and my (family member) lives nearby and can get to me easily", and another said "I wasn't safe at home, but here I'm very secure as there are people here all the time and they are very safety conscious". Safeguarding systems, processes and practices were developed and implemented to safeguard people from abuse. Staff attended safeguarding of adults training and records confirmed this. The staff we asked knew how to recognise the types of abuse and were aware of their responsibility to report allegations of abuse.

People were protected by the prevention and control of infection procedures. We observed the property to be clean, decorated in bright colours and generally free from odours. Infection control audits were used to assess and identify areas for improvement. Action plans were in place on meeting shortfalls identified. The infection control lead told us the head of care residential with the deputy were to make up the lead "group". They said the deputy and the soon to join head of care were going to address persistent issues where infection control procedures were not being followed by staff.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection we found breaches of Regulation 18. We found that appraisals and one to one meetings with a line manager were not taking place. Staff were not able to attend training to develop their skills and to meet people's needs. Following the last inspection the provider wrote telling us about the intended improvements. We found that improvements had occurred in relation to the support staff received to undertake their individual roles and develop their skills.

People said that regular staff were competent and knew what their care needs. One person told us "The staff are mostly able to meet my needs and the regular ones know how I like things". Some relatives said that staff understood and knew how to manage their family members' care. One relative said "They understand my [family member] has "funny turns" and they manage these very well, they put [family member] to bed, take blood pressure, monitor and give more care until [family member] comes round again".

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

People told us, the staff were respectful of their decision. Comments from people included "If I say 'no', the staff listen to meant I don't do it if I don't want to". "One member of staff said I had to have breakfast in bed and I refused because it doesn't work, last time porridge went all over the bedclothes. My daughter got involved and it's been agreed in my plan that I'll be up for all meals".

Consent to care was not always sought in line with legislation and guidance. Mental capacity assessments had been carried out to assess people's ability to consent to living at the service and to receive their care. When people lacked capacity records showed that best interest decisions had been reached in conjunction with members of the team and people's relatives. However, consent for the use of sensor mats had not always been sought. For example, on the nursing unitLavender, several people had high low beds and crash mats in place to prevent injury in case people fell out of bed. Sensor mats were also in use on top of the crash mats to alert staff if this happened. We looked at the plans for six people with sensor mats in use. Of those, only one plan contained a capacity assessment and best interest decision record. In three of the others, although there was reference to the use of mats there was no evidence of a capacity assessment or best interest decision. In the remaining plans there was no reference of a sensor mat being in use, despite them being in place. In one plan it had been documented that the person lacked capacity to consent to 24 hour care, but that the person "had consented to the use of sensor mat". There was no consent form in place and no capacity assessment.

Where a lasting power of attorney (LPA) was appointed for health and welfare decisions the documentation was not clear. For one person the emotional care plan stated a close relative supported the person with complex decisions. The advance decisions care plans for the same person stated that a LPA was appointed

for health and welfare decisions. However, evidence of a LPA was not kept on their care records. The registered manager said copies were kept in the office but this practice was to be reconsidered. In future copies of the LPA will also be kept in care records.

The comments from staff showed they had a good understanding of the MCA principles. Staff gave us examples on how people were enabled to make decisions. A member of staff said people made day to day decisions that included menu choices, the clothes they wore and activities. Another member of staff explained that an indication of capacity was "when the person was able to retain and understand" the decision and consequences.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. DoLS applications were made and authorisations to deprive a person of their liberty were in progress.

New staff received an induction when they started work at the service. A care leader on induction told us they were shadowing more experienced staff to gain an overview of people and their routines. They said there was set mandatory training including The Care Certificate (a set of standards that health and social care workers were expected to adhere to).

People had their assessed needs, preferences and choices met by staff with the right skills, knowledge and experience. The staff we spoke with said the registered manager encouraged staff to undertake training and they had access to all relevant training. However, some staff said they were not helped to maintain their professional practice updated. Nursing staff said although they were able to meet their registration requirements it was difficult for them to maintain their competencies. For example, one said "We can attend the training, but then we have to be assessed as competent. I did tissue viability training last year which was good. But other training, like syringe driver training, we don't always have the opportunity to get assessed because we might not have anybody with a syringe driver".

A learning and developmental trainer told us the support they provided to staff with accessing and completing training were set as mandatory by the provider. They said for some staff there were one to one training sessions while other staff were supported with their online training. Specific training was accessed for staff to meet the responsibility of their role. For example, maintenance staff had attended training in legionella.

Systems were in place for staff to receive support with their personal development and their performance. Staff told us appraisals were annual and there were six monthly one to one meetings (supervision) with their line manager. A member of staff said they discussed their personal development, training and concerns at their supervision meetings. Another staff said they had a supervision meeting with the registered manager. However, a member of staff said "I haven't had a [supervision] for quite a while."

Procedures were in place for people to receive consistent support when they were referred for admission to the home. Some people said that their family had visited on their behalf and had chosen the home for them. Comments from relatives included "My [family member] was transferred here because they needed more care and it was where the vacancy was; the care plan was just continued.". Personal assessments were completed before an admission and covered people's physical, mental and social needs. For one person their personal assessment included their medical condition, preferences with personal care and assessments of risk. The head of care explained the procedure for discharges. They said for people on

respite care returning home there was a verbal feedback. The "Hospital and Care Setting Transfer" information forms were used for people transferring to hospital or to a care setting.

People's preferences for the food and drinks they preferred had been documented in their care plans. Special requirements such as adapted cutlery or plate guards were also included within the plans. One of the plans we looked at was for someone with a PEG in situ. The feeding regime was documented as well as information on how to position the person when artificial feeding was taking place. One person who had to have a texture modified diet said they found this unappetising; "It wasn't very nice this lunch time, but I ate it, it's always just different blobs of purée on the plate, you can't identify what it is but I know I have to have it for safety I just don't enjoy it".

People's dietary requirements were catered for. The chef told us staff provided the catering staff with "notifications" on people's preferences dates of birth and special dietary needs such as textured and enriched diets.

People told us "We get a choice and we say the day before what we would like or can have something else.". However there were mixed opinions about the quality of the food. For example, "I really dislike the food, it's not the kind of food I'm used to, you get a huge plateful of vegetables piled up and it's very off putting. I seem to get cauliflower every day and I hate it. I do like some things here such as the roast dinner and baked potato with cheese. My [relative] brings me food from home".

Other people told us "The food is remarkably good. If I don't like it they have one different things e.g. eggs or a lighter lunch," "The food is good, there's a new chef and the turkey especially is so delicious, well cooked and succulent, the cakes are wonderful, the only thing I don't like is the semolina with a dollop of jam that's not wanted". "The food is very good, there's plenty of choice, I'm having salmon salad tonight and there's enough to eat, in fact they overfill the plate at times".

The chef told us they devised menus and these were on a three weekly rotation. The chef said the menus had changed to give people a varied diet. For example, vegetarian options were added to the menu choices. People made decisions on menu choices the day before and staff supported people to select their preferred meal from the two choices available.

The quality of the meals was monitored. The chef said they attended relatives meetings, gained direct feedback from people during visits to the units and from recorded feedback in the daily audits forms.They said that meals were checked before they went to the units and "if they were not ok I am not sending it [meals] out." Comments from some relatives that were part of the improvement/ development group catering sub group included "The new chef has improved the choices and there is fruit available now. The cakes are very good". "The group has been working with the new chef, there's a rolling three week menu now, the quality of the meat has improved, and when it's good it's excellent. There are still a few problems with consistency, as when the chef isn't on duty it sometimes isn't of the same standard".

We observed lunch in both nursing unit upstairs dining rooms. The menu was written on a chalk board in purple chalk which did not show up well however there were individual menus on the tables with pictures of the dishes. Staff checked with people that they were still happy with their choice and what vegetables they wanted.

Some people had meals in their rooms which were taken on trays. We saw one person receiving assistance and the member of staff was sitting down and engaging with them. One person arrived in the middle of lunch having been out. She was warmly welcomed and whilst staff were getting her lunch they were

chatting about what she had done.

People were supported with their ongoing health care needs. People and their relatives told us their family's members had access to NHS facilities such as optician services and to dental care at the adjacent medical centre. They said there were regular routine visits from the GP or as needed if they were unwell. Comments from people said "The doctor comes every Friday, but the staff will call them over if you aren't well", "I can see my doctor when I need to on Mondays and Fridays".

Reports of visits from healthcare professionals confirmed people had regular visits from their GP and access to specialists such as Speech and Language Therapists (SaLT) and physiotherapists. The purpose and outcome of the visit was recorded and for some people there was additional guidance on how to meet the person's medical needs. For example, textured meals. People also had access to NHS facilities including opticians and dentists.

Records in the nursing unit showed that staff had discussed weight loss concerns with the GP. On some occasions it was recorded where people's relatives had asked for their family member to be reviewed by a dietician. Staff said it was sometimes difficult to gain the GP's approval for these referrals.

People's individual needs were met by the adaptation, design and decoration of premises. We observed clear signs for toilets and dining rooms in the units. There was access by lifts to all floors with wide corridors that were kept clear and had interesting pictures on the walls. At the ends of corridors there were chairs where people could sit and look out of the windows. Overall the home was light and airy with the lounges having pleasant views over fields.

Good

Is the service caring?

Our findings

At the previous inspection dated May 2017 we rated this key question as Requires Improvement as people raised concerns about the caring nature of the staff. During this inspection people told us about the staff's caring and compassionate approach.

People told us the staff were caring. Their comments included "You can't fault the care, and I like all the staff, they know me and what I like". "They help with dressing and have good humour/jokey". "They always ask are you ready to get up now or do you want a few minutes longer". "They don't rush around they have time to talk." Some people praised specific members of staff. They said there were staff that stood out because they took an interest in them as a person and went 'the extra mile' to support them. Comments from people included "I love [staff names] they show me pictures of their family and they really care". "The [day] staff are affectionate and kind they're very caring and lovely to me".

There was compassion shown to people and their relatives. A relative said staff offered exceptional support to them as well as their family member; "We'd gone to an appointment and return transport didn't come, so they sent out a [wheelchair] taxi, and when we got back, because it was dark and they know I'm not able to drive at night, they asked me if I'd like to stay the night which was so kind as they could have just ignored my needs or offered to call a taxi but they really cared".

The registered manager with support from the management team (deputy manager and head of care) ensured staff treated people in a kind and caring manner by the staff. Staff told us the registered manager and the management team were visible in the units. The registered manager told us there were audits of care such as the dining experience. there were also systems in place that ensured staff were given the opportunity to amend their practice where required. The staff were supported to develop their skills, their performance was monitored and communication with them was open.

The staff understood it was important to build relationships with people. A member of staff said they introduced themselves and explained their role before offering personal care. They said "I like to know about their family life and their past employment to build trust". Another member of staff told us knowing people's likes and dislikes helped them build trusting relationships with people. We observed some positive interactions between people and staff. For example, we saw a staff member laughing together with a person about some reminiscing they had been doing.

We observed another staff member chatting with people in the dining room mid-morning. They made everyone a drink and then asked each person individually if they were happy with the music that was playing or if they wanted it changed or switched off.

On another occasion we saw a member of staff with one person who they had just helped to transfer into a chair. They got them a drink and said "Here you are. Here's a cup of tea, your call bell is just here and there is the television remote. Ok?"

Visitors said visiting times were unrestricted and they were made welcome when they arrived. One relative said "I come in twice a day to help with feeding [family member]; I do it because I want to, although I know the staff would do it if I couldn't I always feel welcome". "I love it here, it's like a family, there's such a friendly, happy atmosphere as well as visiting, I also volunteer here.".

One visitor mentioned that access could be difficult at weekends. "There's no-one on the desk [reception] at weekends so the unit staff have to let people in. You can wait a while to be let in if they're busy, it can be frustrating".

People were each treated with dignity and respect and staff were respectful of people's rights. Comments from staff included "I always ask people if they want to get up, or if they want to wait until later. I let them choose what they want to wear by holding up two tops for example" and "I show two options, like two plates of food. One person can't speak, but they will do a thumbs up or down as yes or no." One male member of staff said "I always ask people first if they're happy for me to help them or if they'd prefer a female member of staff. I respect their wishes."

Staff knew how to respect people's rights to privacy and gave us examples on how this was achieved. Their comments included "knock on people's door before entering". "Doors were closed during personal care". One person said "That's very good here. All the staff, even the cleaners, ask permission before they come in and do anything. It makes me feel respected although I tell them not to worry. They call me [first name] which is what I like".

Staff said they believed care was good. Comments included "We do try our very best. During the snow some staff stayed here overnight and worked extra shifts", "I think the care is good. We have time to sit and talk with people which is great. Most people just want some company" and "We've got good equipment, more time to talk to residents, more activities, better gardens and better food. It's just really nice here."

Some aspects of people's equality and diversity rights were reflected in the care and support they received. Staff gave examples of how they had provided support to meet the diverse needs of people using the service. For example, for one person English was not their first language. The person's relatives had devised a chart to inform staff what words meant and how they sounded. Staff we spoke with were aware of this chart and knew some of the words the person used. A member of staff told us how they respected people from other cultures and religions. They said that at a recent Christian festival one person because of their beliefs they were not included in the celebrations. However, the staff had not taken steps to recognise the dates of this person's religious festivals and their clothing.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we found breaches of Regulations 9. We had found that care plans were not person centred and were not updated following reviews. They were inconsistent and lacked detail. At this inspection we found the care plans in the residential unit had improved.

Some people said they knew that they had a care plan but left it to their family to deal with, others said that they hadn't seen it. People said their care was delivered the way they preferred. For example, "I like to get up early, I like going to breakfast in the dining room, and then I watch TV and the staff help me to do that". "I prefer to stay in my room and I don't really like going outside as the sun affects me and gives me a headache, and I can choose to stay here". "I get a choice of a wash, a shower or a bath and the staff follow my exercise sheets to help me".

We found that care plan included some aspects of people's individual preferences and interests. Summaries of what was important to people were kept in people's care records. Despite some information lacking in the plans, care staff we spoke with knew people well. They knew their preferences and their routines and knew the best way to communicate and support people. One staff member said "I try and read the care plans, but I find out about people by talking to them and their families. I ask questions."

Staff in the residential unit told us they relied mainly on handovers to give them up to date information about people. A member of staff said care plans were used more as a reference but not consistently read. This member of staff also said care leaders developed the care plan and they had "improved. We are more switched on about them". A care leader told us "We put in a lot of work on them. We are getting there. I hope staff read them. We refer to them a lot and if they don't [read them] we had wasted a lot of time."

Care plans in relation to people's health needs were detailed. For example, diabetes plans contained guidance for staff on how to monitor people's blood sugar levels and what to do if these were low. Epilepsy plans described what staff should do in the event of a seizure.

Wound care plans were in place. These contained details of wounds, how staff needed to dress the wound and how often. However, up to date photographs were not always easily available and the plan did not reflect the current state of the wound. In the plan it was written that the person was a high risk of pressure sores. The person had developed a sore during April, which staff had noted and the wound was being treated. The latest entry in the wound assessment for the day of our inspection was that the skin was now intact but remained vulnerable. There were no photographs in the care plan of any stage of the wound healing process. We asked one of the nurses about this and they showed us some photographs on a camera. They agreed the photos should have been printed off and put into the care plan.

There were plans in place to meet people's emotional needs, but some of these lacked detail. For example, in one plan (nursing unit) it was written the person had been prescribed a medicine for restlessness and agitation. Although the signs of agitation were listed, there was nothing written to inform staff how to relieve the symptoms before resorting to the use of medicine. In another plan however (residential unit), it was

written the person sometimes experienced hallucinations and the guidance for staff on what to do in these instances was clear.

Care plans in the residential unit were up to date and reflected people's physical, mental, emotional and social needs. However, the follow up action taken was not clear for two people whose emotional needs had deteriorated. The care plan for one person stated "has become quiet and withdrawn since a recent fall". A member of staff said this person previously participated in activities and the GP was aware of the current situation. For another person the progress notes stated "less cheerful and not easy to know what she wants". The Emotional care plans was then updated from the progress notes and stated "Any changes in her character could indicate a change to their emotional and physical wellbeing. Usually settled and cheerful." The Head of Care told us they would speak to the activities coordinators and arrange for one to one time with these individuals. For example, hand massages.

People's communication needs were assessed and care plans devised on how staff were to assist the person to express their wishes and preferences. Communication plans were more detailed. Some people were unable to communicate verbally and in these plans it was clear how staff should try and communicate with people. For example, picture cards were in use. In one plan it was written the person had declined the use of these, but was able to nod and shake their head to indicate their agreement and that they could point to what they wanted. For one person English was not their first language. The person's relatives had devised a chart to inform staff what words meant and how they sounded. Staff we spoke with were aware of this chart and knew some of the words the person used.

The advanced care plans in the nursing unit contained minimal information on people's choices and preferences for their care at the end of their lives. Having this information in place enables care staff to ensure people are supported to have a comfortable and dignified death and that any special requests are met. Treatment escalation plans were in place. These detailed people's choices about where they wanted to be cared if their health deteriorated.

The advance care plans in the residential units included more detail on people's preferences for priorities of care and burial arrangements. For example, all documentation for one person reflected their preference with their jewellery including the advance care plan. It was this person's preference to have their end of life care at the home and for their burial they wanted to be dressed in "comfortable clothing, glasses and gold earrings." There was a special request for "no black ties." For another person their preference was to stay at the home for their end of life. Specific burial instructions were also included in their care plan.

People and their advocates had been involved in regular care plan reviews. Records showed that when relatives had asked for specific things to be included in plans, the plans had been amended.

People were very positive about activities. One person said "I go on outings; four of us went to Kemble airport. [Activities coordinator] is very good at looking after us; she drives the bus and also likes gardening". "I go to some activities when I chose to". "I no longer go to activities said I do a lot in my room activities come to me now". "Staff offer you to go, you don't have to but they always ask I go to the singing and I go to service of course". "I listen to music in my room. I like operatic music". One person who liked reading said "staff organised talking books for me" (from the ways she spoke this had clearly made a big difference to her, another person said that having talking books was being organised.

Several people commented on being able to go to a religious service "I used to go to the Abbey and they come here once a month". I understand there is also a "non-denominational service each week which

several people said they went to. One person who mainly stays in her room said "once a month they come from the Abbey to give Communion and they come to my room"
The activities team included three staff and volunteers. The activities programme was in a picture format and included the regular activities which happened over five days a week. For example arts & crafts, exercises to music, quizzes. At weekend the volunteer church group organised Sunday services, and gardening weekends in season.

The team gathered individual details about personal interests from the one page profiles, and also carried out one to one activity sessions which incorporate this knowledge and aim to make the time meaningful. The Activities lead produced a monthly matrix which showed patterns of attendance, and helped the team assess who would benefit from additional one to one time and to set priorities. This approach had helped some people to participate in group activities as they has built up relationships with the team.

People's comments indicated their confident to raised concerns. Comments from people included "If you don't like (something) you just tell them and they alter it". "If I had an issue I would go to my key worker". "If I wasn't happy would talk to staff or the [registered] manager". There were no complaints received at the home since the last inspection.

One person said "I get on with them all, and I feel comfortable with the staff. I had a problem once when a member of staff said I couldn't have a clean pad so I spoke to [registered manager] and it was sorted out. He said they had no business saying that to me". "You can't fault the care, and I like all the staff, they know me and what I like". One person in the nursing unit said "some of the night staff (agency staff) are bad but other staff are very good and some staff even anticipate my needs e.g. for toilet". This information was passed onto the registered manager who told us where there were issues with agency staff they were not asked to return.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection dated May 2017 we rated this key question as Requires Improvement because a registered manager was not in post and records were not accurate and up to date. While there were improvements found at this inspection the action plan devised to drive improvements was not consistent with all the findings of the inspection. For example, some actions were not met within the timescale or were part of the plan.

Systems were in place to assess and monitor the delivery of care. There was an overarching improvement plan that related to care planning and the management of risk, staff development, and nutrition. Action plans listed the shortfall and the progress on meeting the outcomes was listed and colour coded. The findings of this inspection were similar to the outcomes identified in the improvement plan. However, not all areas identified at the inspection were part of the improvement plan.

Findings from the audits lead to actions in a medicines action plan. However, not all actions had been met. For example, missing signatures on medicine administration records (MAR) on the nursing unit had been highlighted during internal audits. One of the action plan points was to implement a checking process for missing signatures. On 04/03/2018 it was documented, "All medication trained staff informed of this, to commence immediately." This had not happened. It had also been written "[When required] PRN protocols to be completed/person centred in Lavender. Complete by 18/03/2018." But again, this action had not been completed. Topical medicine administration records were not being signed and had been highlighted during audits but this issue had also yet to be fully addressed.

Risks were analysed for patterns and trends. For example, the falls analysis had identified the times when most people fell and they often occurred in bedrooms. The registered manager told us of the measures, equipment and aids used to prevent falls. The people at greatest risk of weight loss were also monitored and those with emerging concerns about their weight loss. However, one person with significant weight loss was not included in the audits analysis. For another person with extensive bruising the staff had not reported the incident.

Internal audits were undertaken on care planning, medicine management, infection control and health and safety. Each audit was given an overall score on meeting the outcomes. For example, the overall score for infection control was 75% and shortfalls identified were foods not labelled when opened and soiled linen bags not fit for purpose. An action plan was developed on how to improve the score. The safety of the living environment was regularly checked to support people to stay safe. For example, fire risk assessments, fire safety equipment checks and fire training for staff.

A registered manager was in post and staff's comments about the stability of the home included "more staff are coming and more are staying, lots of staff have come back", "I can really see the changes since the new manager started" and "They [management] have worked hard to improve morale." A member of staff stated "the different managers in three years made it hard for staff and they started to leave. We work better and together with the introduction of a care leader [in the nursing unit]. As a team we know how we work and

everybody brings something".

The staff we spoke with felt valued and supported by the registered manager and management team (deputy manager and head of care). A member of staff told us the registered manager had acknowledged their wellness goals following a period of leave. There was an agreement for light duties during a phased return. Another member of staff told us their personal development needs for progression was recognised. They had registered on vocational qualifications and to gain more experience in senior roles they were shadowing the head of care.

The staff we spoke with knew the values of the organisation and how they fitted into their responsibilities and accountabilities. A member of staff said the values of the organisation included high standards of care and having pride in "where you work". "We strive to make it the best place where you work". Another member of staff said the values included "working in a professional manner, being reliable, caring, good quality care and putting people first". "I do what I can. I speak to the family about their [family member's] history and get to know what they like and did. I offer choices and treat people as an individual."

The registered manager had considered the importance of continuous learning and ensuring sustainability of the service. The registered manager said their management style was to inspire staff and with their support implement the necessary changes to drive improvements. This registered manager then stated "I take satisfaction in helping staff to develop." The style included supporting staff, identifying their talents and strengths and addressing issues of performance.

The registered manager had an understanding of the key challenges. They said these challenges included the dynamics between some staff and learning from mistakes. The registered manager acknowledged the concerns we raised about the communications, commitment and accountability of some staff in the nursing unit. There was lack of interest when we showed some staff shortfalls in relation to medicine management. The registered manager explained that learning came from action plans devised from audits and listening to relatives when concerns were raised. Also, when there was an admission of failures it was possible to introduce improvements. In relation to sustainability the registered manager said "maintaining improvements. It's not a quick fix, which must be robust to stick."

The registered manager said there was a process of phased admissions to the empty unit in line with recruitment of staff. They said the staffing levels were to increase as people were admitted into the empty unit. The registered manager also told us how they ensured people had access to community support. For example, contact with the league of friends had gained funds for specialist equipment. There were links with other residential care homes within the geographical location and visits from local groups.

Staff received feedback from the manager in a constructive and motivating way. Staff told us team meetings had taken place. The appointment and the role of care leaders was the focus of the most recent staff meeting.

People and their relatives were asked for their feedback about the service. Some people and their relatives remembered being asked to complete feedback questionnaires. Their comments included "Yes, I had one recently and I think we get them every six months or so". Some people had mixed views on their ability to contribute to the development of the service. One person said, "We have residents' meetings and I feel listened to, for example someone asked for bubble and squeak on the menu, and we had that last night". "I have been to meetings but they go their own sweet way, I don't feel it makes an impact personally".

The activities coordinator organised the residents meetings and they were attended by relatives and chaired

by registered manager and management team. At the most recent meeting the registered manager updated the group with the re-opening of an empty unit and the phased admission to the unit. Actions from the meeting included menu changes, more live music, and combining the monthly library visit with a coffee morning.

Comments from the relatives we spoke with included, "staff have a more positive attitude, and feel things can change therefore there is a happier environment, more structure", "The home is much better now the new [registered] has made a difference. Saturday we had a birthday party for the Queen".

The service had notified CQC about significant events. We use this information to monitor the service and ensure they responded appropriately to keep people safe.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments had not always been reviewed monthly and guidance followed. Staff had not reported injuries sustained. Medicine procedures were not being consistently followed. Staff were not always documented when medicines were administered. Protocols for when required medicines did not detail the signs people might display if feeling anxious or agitated.