The Orders Of St. John Care Trust

OSJCT Longlands

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
OSJCT Longlands is a residential care home providing accommodation and personal care to up to 48 people. The service provides support to older people, some who are living with dementia, in one adapted building. At the time of our inspection there were 45 people using the service.

People's experience of using this service and what we found
Not all known risks had been assessed or mitigating strategies implemented to keep people safe from harm. People were at increased risks of skin pressure damage and risks from their health conditions. Staff had not always received appropriate training to understand people's health conditions.

Medicine management required improvement to ensure people received their medicines as prescribed.

Care plans and risk assessments were not always kept up to date and factual. We found conflicting information had been recorded. Staff did not always have the information to support people safely.

Unexplained injuries had not always been investigated to identify a cause and reduce the risk of reoccurrence.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Oversight of the service required improvement. Systems and processes were not always effective in identifying improvements needed and mitigation of risks.

People and relatives had not been asked to feedback on the service. However, staff had completed annual feedback surveys, had regular supervisions, and were offered regular meetings.

People were supported by staff who had been safely recruited and who had completed an induction before working at OSJCT Longlands. Staff felt supported within their roles.

People told us they felt safe at OSJCT Longlands and were supported by staff who were kind. Relatives were positive about the support staff offered people. People and relatives told us they felt safe.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 25 December 2018)

Why we inspected
We received concerns in relation to staff understating people's needs. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for OSJCT Longlands on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to risk management, medicine records and management oversight at this inspection.

We have made a recommendation regarding understanding the Mental Capacity Act and Deprivation of Liberty Safeguards.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

OSJCT Longlands

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by 1 inspector and 1 assistant inspector.

Service and service type
OSJCT Longlands is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. OSJCT Longlands is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who worked with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service and 4 relatives about their experience of the care provided. We spoke with 10 members of staff including, the registered manager, operational managers, maintenance staff and care workers.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 6 people's care records and multiple medication records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Using medicines safely; Assessing risk, safety monitoring and management

- People were at risk of skin pressure damage. Records did not evidence people were supported with repositioning within the specified timeframes to reduce the risk of skin pressure damage. For example, records for 2 people who required support to reposition themselves every 2 or 4 hours to reduce the risk of pressure damage evidenced gaps of 10 hours or more.
- People were at risk of potential abuse. When a person had an unexplained injury, the provider had not completed any investigations to identify the potential cause and to put mitigating factors in to reduce the risk of reoccurrence.
- Staff did not always have the information required to support people safely. Not all care plans and risk assessments held up to date, factual information. For example, we found conflicting information regarding how many staff were required to support people with specific tasks and missing information regarding how staff should support people with distressed behaviour.
- People were at increased risks from known health conditions. For example, three people with health conditions did not have all the necessary information recorded in their care plans or risk assessments regarding the signs and symptoms staff should be aware of, or the mitigating strategies required to mitigate the risks of epilepsy or diabetes. Staff had not received training epilepsy or diabetes. The registered manager updated all risk assessments and booked staff training after the inspection.
- Medicine management required improvement. Records were not consistently recorded to evidence staff followed the providers policy on medicine administration. Staff had not received yearly medicines competency assessments in line with best practice.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had policies and procedures in place regarding safeguarding people. Staff received safeguarding training.
- People and relatives told us they felt safe at OSJCT Longlands. One person said, "I feel safe here, staff come when I need them." Another person told us, "I am safe, and the staff are kind."
- When people require as required medicines staff had the necessary information to ensure medicines were given as prescribed and documented the reasons for giving the medicines.

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 MCA 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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not consistently working within the principles of the MCA. Some people had the appropriate legal authorisations in place to deprive them of their liberty. However, not everyone who required a DoLS authorisation had been referred. The registered manager acted on this immediately after the inspection.

We recommend the provider reviews management understanding in the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

Staffing and recruitment
● People, relatives, and staff told us they felt there were sufficient staff to meet people's needs. One person told us, "There is enough staff. If I need them, they are available to me." Another person said, "Staff are excellent, there is enough of them." A relative told us, "[Person] has been attended to regularly and frequently even when they have not asked for any attention."
● The provider used a dependency tool to identify how many staff were required on each shift.
● Staff were recruited safely. The provider completed pre-employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Learning lessons when things go wrong
● Incidents and accidents were analysed to identify trends and patterns for falls. The information was then communicated to staff so they understood what strategies could be implemented.

Preventing and controlling infection
● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning records were not consistently completed, and we received conflicting information regarding if people had individual slings to support with manual handling needs.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- The provider followed government COVID-19 guidance on care home visiting.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Systems and processes were not always effective in identifying health and safety concerns. For example, we observed windows without restrictors and exposed hot water pipes, which had not been identified in the health and safety audits completed.
- Systems and processes were not effective in ensuring records were kept up to date. We found care plans held conflicting information within them, limited information recorded regarding the signs and symptoms to look for to mitigate the risks of epilepsy or diabetes and records of support offered with repositioning had not been completed. The registered manager had identified some of the concerns previously and was arranging training for staff. However, these issues had not been resolved and information recorded was still incorrect or missing.
- Systems and processes to ensure safe medicine management had not identified the concerns found on inspection regarding missing signatures or missed medicines.
- Systems and processes were ineffective in identifying when a person sustained an injury that required an investigation. Unexplained injuries had not been investigated to identify a potential cause.
- Systems and processes had not identified when mental capacity assessments and best interest decisions were not completed. Mental capacity assessments had not been completed for each decision required. For example, mental capacity assessments had not specifically been completed for personal care, medication or use of equipment.
- The provider had not requested feedback from people or relatives. People told us they had not been asked for feedback.

The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of Regulation 17 (1) (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager implemented changes, mitigated risks and updated records immediately after the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristic

- People and relatives told us they had not seen or been part of the care planning process. One person said,

"I have not seen it, and no one has discussed it (care plan) with me." A relative told us, "I haven't been involved again (since person moved in) and haven't seen a copy of the care plan."
● Relatives told us the staff kept them up to date on any changes. One relative told us, "Staff inform me immediately if [person] has had an injury or been unwell."
● Staff were offered regular meetings to share information about the service and discuss any issues. Staff told us they felt supported within their roles. One staff member said, "Now it (OSJCT Longlands) runs brilliantly, a lot has happened since the new manager came here, [Registered manager] has been fantastic and listened to us, I really feel valued and important."
● People's communication needs had been assessed and strategies implemented to support staff to effectively share information with people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●The registered manager was aware of their duty of candour responsibility and had systems in place to ensure compliance.
● Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns were not acted upon.

Continuous learning and improving care; Working in partnership with others
● The registered manager was open and transparent throughout the inspection.
● The registered manager worked in partnership with other health and social care professionals.
● Relatives were positive about the service and the registered manager.

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 The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided