The Orders Of St. John Care Trust

OSJCT Wyatt House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 17, 18 and 19 July 2018.

Following our previous inspection on 21 and 22 March 2017 the service was rated 'Requires Improvement'. We found the provider needed to make improvements to how the home was managed. It required consistent management by a manager who was registered with the Care Quality Commission (CQC), improvements were needed to people's care plans so they accurately reflected people's care needs and the provider's quality monitoring processes needed to be more effective in making improvements which could be fully embedded and sustained.

At this inspection we found some improvements had been made. People had benefited from a consistent manager being in post who was registered with the CQC. Some care plans had been re-written but several still did not reflect people's needs. Quality monitoring processes had taken place but these had not, identified the shortfalls in the management of people's risks, identified during this inspection, or successfully achieved full improvement in people's care plans, required following our previous inspection.

We requested that the provider send us an immediate action plan on how they were going to ensure people's risks were fully assessed and safe and effective care was planned. An action plan was subsequently received which we will follow up in due course.

Following this inspection an overall rating of 'Requires Improvement' was awarded. This is the third consecutive time the service has been rated 'Requires Improvement'.

Wyatt House is a 'care 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 can
accommodate 30 people in one adapted building. At the time of our inspection 29 people lived there. The home specialises in the care of people who live with dementia and who also require nursing care.

Wyatt House is a circular design with an inner, secure garden. People are accommodated across two floors. One floor provides accommodation for a small group of people who need less support and which promotes their independence. On the second floor people required all support with their daily needs which the design of the home and its fittings supported. The circular design is experienced on this floor, which allows people to walk freely, without interruption; but a seated area also provides a place to rest. People could access an outside seating area safely from this floor, but they were supported by staff to visit the whole of the garden. There was ample car parking in and around the home's grounds and wheelchair access to the home.

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.

Although the provider had processes in place to assess people's risks, these had not always been completed, in a timely manner, to ensure people would remain safe. Some people had been left with risks and areas of need, which had not been fully assessed or addressed through the planning of safe and effective care. A breach of regulation was identified in relation to this. Practices were not consistent as we saw that other risks had been well assessed and appropriate care planned and delivered to reduce these.

People's care plans still did not always give accurate detail about the care people required. This was despite staff completing regular reviews of these. This had potential for people to receive unsafe or inappropriate care and a breach of regulation was identified in relation to this.

Since the last inspection and since the registered manager had been in post the provider had carried out quality monitoring checks of the home's overall performance. There had however, been less consistent follow up following these checks to ensure necessary areas of improvement were completed. The system in place had not been sufficiently effective and a breach of regulation was identified in relation to this.

There were arrangements in place for complaints and areas of dissatisfaction to be raised, although, the action taken in response to issues raised about people's laundry, had not led to these being resolved. We made a recommendation about the management of complaints.

People's medicines were managed safely and people were supported to take their medicines. People lived in a clean home where infection control measures were in place. There were enough staff to meet people's needs and staff had been safely recruited. There were arrangements in place for staff to receive appropriate training and support. Staff understood their responsibilities with regard to protecting people from abuse and poor practice.

People had access to health care professionals. People were supported to make decisions about their care and treatment and where necessary, people's representatives were consulted. The principles of the Mental Capacity Act were followed to protect those who lacked mental capacity. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

People had a choice in what they ate and drank and in what activities they took part in. Staff were particularly kind and caring towards people and knew individual people well. This helped them to deliver people's care, support people's independence and promote people's self-worth. Staff responded straight away to anyones distress. Family and friends were welcomed and kept informed about people's progress, where appropriate. Activities were tailored to people's abilities, likes and preferences; they were meaningful to people and some had a therapeutic value.

People's end of life wishes were explored and they were supported to have a comfortable and dignified death. Staff supported people and others during times of loss and bereavement.

The registered manager had provided consistent leadership and was respected and liked by staff and relatives. There were arrangements in place which helped the registered manager to communicate effectively with all staff and relatives. We observed people, staff and relatives feeling comfortable enough to communicate with the registered manager when they needed to. The registered manager had made significant improvements to how the service operated and this was evidenced through past and present audits. The home was advertising for a deputy manager to help support staff further and to help embed and

sustain the improvements already made.

We found two 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 was not always safe.

People's health risks were not always assessed sufficiently well enough to ensure the care needed to reduce or mitigate these, was provided in a timely manner.

Environmental risks were managed well in order to keep people safe. This included reducing risks associated with the spread of infection.

People's medicines were managed safely and people received support to take their medicines as prescribed.

There were enough staff to meet people's needs and staff were recruited safely so as to protect people from those that may not be suitable.

People were protected from potential abuse because staff adhered to the provider's policies and procedures, which aimed to protect people from harm.

Is the service effective?

Good

The service was effective.

People were supported to maintain their nutritional wellbeing and they had a choice in what they ate and drank.

People had access to appropriate health professionals who could help support their health needs.

People were supported to make independent decisions and their care was delivered in the least restrictive way. The principles of the Mental Capacity Act 2005 were adhered to so people who lacked mental capacity were protected.

People received care from staff who were supported and who received training to be able to meet their needs.

Is the service caring?

Good

The service was caring.
People were cared for by caring, thoughtful and compassionate staff.

People were supported to express their needs, choices and to make simple decisions.

Staff knew people well and were able to tailor their care around people's ability to accept care as well as people's preferences.

Family members and others who mattered to people were made welcome and supported to be involved in people's care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always give staff the information they needed to be able to respond effectively to people's needs.

There were arrangements in place for people and visitors to raise a complaint and have this investigated. Actions taken had not always led to complaints and areas of dissatisfaction being resolved.

People were supported to take part in activities which were designed to promote wellbeing and a sense of fun and belonging.

People at the end of their life were supported to have a dignified and comfortable death.

Is the service well-led?

Requires Improvement

The service was not well led.

The provider's quality monitoring systems had not always identified shortfalls, which had subsequently had an impact on people. Necessary action had not always been completed in a timely way to ensure safe and effective care was always provided.

People had benefited from improved and consistent management from a registered manager who understood their responsibilities and who worked hard to meet these.

Communication with staff, relatives and visitors to the home had improved and relevant information made more accessible these groups.

Feedback from people, relatives and other visitors to the home was monitored.	

OSJCT Wyatt 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 17, 18 and 19 July 2018 and was unannounced. It was carried out by one inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case a person who has cared for a person who lives with dementia.

Prior to visiting the home, we reviewed the information we held about the home. This included notifications of events which have an impact on people and the home which the provider must legally send to us. We looked at information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually. This was submitted by the provider on 6 April 2018 and it gave some key information about the service, what the service does well and improvements they plan to make.

During our visit to the home we spoke with seven people who lived at Wyatt House and five relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed eight people's care files which contained care plans, risk assessments and other relevant care documentation, including weight monitoring records. We also reviewed 15 people's bathing records and relevant care plans. We reviewed records pertaining to the Mental Capacity Act and Deprivation of liberty Safeguards.

We spoke with 10 staff which included the registered manager, one of the provider's operations directors, one nurse, one team leader, three care staff, the activities co-ordinator, a cook and an agency member of staff. We spoke with one health care professional about people's care and sought their views on the services provided by the home. We reviewed two staff recruitment files and the staff duty roster.

We reviewed records relating to the management of the home. These included complaints records, quality

monitoring audits and the home's compliance improvement plan. We attended one staff handover and looked around the building.

We requested to be forwarded to us and received the home's Statement of Purpose and staff training record.

Requires Improvement

Is the service safe?

Our findings

We saw evidence that some risks had been fully identified, assessed and action taken to reduce these or eliminate these altogether. However, we could not be satisfied that people's risks were always sufficiently assessed and managed to ensure these were either reduced or eliminated altogether. The necessary care around people's risks was not always planned, in a timely manner, to ensure safe and effective care was provided. We found three examples of this.

The first around the assessment of the potential risks of developing pressure ulcers following admission to the home. Prior to admission a pressure reducing mattress had been put in place for the person following the initial pre-admission assessment of needs. However, during the first inspection day we observed the person seated in an armchair that did not have a pressure reducing cushion in place. We spoke with the person and they were unable to reposition themselves. They also had their socked covered feet resting on the floor. Late afternoon we spoke with staff and ascertained that the person had not been moved or repositioned all day. We checed the person's care records and there was no completed risk assessment or care plan in place with regard to this risk. The pre-admission assessment recorded multiple health issues which would put this person potentially at risk. We raised our concerns about the current lack of safe and effective care in place to reduce or mitigate these risks. The registered manager addressed this straight away and a pressure reducing cushion was put in place and the person's feet protected. On examination at this point one area of skin already showed the signs of pressure damage; the skin was red. We were later informed that the provider's pressure ulcer risk assessment had to be completed within 48 hours of admission. In this case, the lack of a timely and full assessment of this person's needs had left them at risk of potentially developing pressure ulcers.

The second was around the assessment and care planning for risks associated with diabetes. In a staff handover meeting we heard that one person had felt unwell that morning. Their blood sugar levels had been low and this had been rectified by giving them an early breakfast. We reviewed this person's care records which showed that their blood sugar levels had varied significantly from day to day since admission two weeks previously. A simple care plan was in place recording the fact this person was diabetic, what type of medicine they took for this and that they should have a balanced diet. There was no risk assessment in place and the care plan did not state what should be done about the variable blood sugar readings. It did not state what was a 'safe' range of levels for this person and what should be done if the person's levels were outside of what was considered safe, for them. There was no protocol in place for risks associated with hypoglycaemia or hyperglycaemia. We spoke with one nurse about the variable blood sugar levels and raised our concerns about the lack of care planning around this condition and the potential risks associated with this. They told us they were going to get this person reviewed by the GP who was due to visit later. This person's medicines were subsequently reviewed but also, GP agreed blood sugar level parameters were set and recorded for guidance in the person's care plan. Guidance also included what to do if these parameters were not maintained.

The third concern was the lack of effective risk management around a situation which had resulted in one person being injured. Following this accident the risk was assessed and action recorded and taken to

address this, despite the risk assessment being incomplete. This action however had not been maintained or incorporated into the person's care plan to ensure they remained safe. We found this person to be in a position which potentially put them at risk of a similar occurrence but also of choking. We raised our concerns about this. Staff told us how they normally repositioned this person to reduce the risk of choking, however, a lack of communication between staff on this day had not led to safe and effective care being delivered. Later, during the inspection the person was harmed for the second time in the same way.

Whilst by the end of the inspection the registered manager had informed us how these matters would be addressed, the occurrences demonstrated failures to ensure care was provided to people in a safe way. The systems and processes in the home did not always result in people's risks being sufficiently assessed. Actions were not always successfully taken to ensure people's care was delivered in a safe and effective way. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Environmental risks were assessed and managed. There were arrangements in place to monitor, maintain and service all equipment. This included moving and handling equipment; hoists and slings and the fabric of the building which included windows restrictors and its main systems. These systems included, fire detection, water and heating, electrical and gas, nurse call bell and security systems. All staff were responsible for people's health and safety.

We observed the home to be clean without offensive odours being present. The cleaning staff who were fully aware of their responsibilities in relation to keeping people safe when they cleaned. They knew how to adapt to people's needs and clean around these, they adhered to good infection control practice and took action to avoid spreading infection. For example, colour coded cleaning equipment was used and special arrangements were in place to keep the home clean when there was a known infection. All soiled laundry was segregated and handled safely. Care staff and kitchen staff also adhered to safe practices. Care staff wore protective gloves and aprons when delivering personal care and helping people with their food. Kitchen staff wore protective clothing and the kitchen and food servery areas were kept secure, clean and had limited access.

People's medicines were managed safely. People received their medicine as prescribed and time was taken to support them to take these. Medicines were kept secure at all times. Medicine records were well maintained by the staff. Prescribed medicines were reviewed every six months by the GP that visited the home to ensure what was prescribed was still effective and relevant.

We observed people receiving care and support when they needed it. There were enough staff to meet people's needs. The registered manager used agency care staff, when needed, to maintain safe staffing levels. Information was forwarded to us following the inspection which showed the numbers of staff of duty were determined by the provider's dependency tool. The registered manager told us they could use their discretion in how staff were deployed. Since being in post the registered manager had recruited more staff and was still actively recruiting. The home required another member of night staff and a deputy manager. The Provider Information Return (PIR) stated that a head of dementia was to also be recruited. This was to help support this area of care; there had been no suitable candidates to date.

Recruitment records showed that the service adhered to the provider's recruitment procedures and only recruited staff after successful completion of various checks. These included clearances by the Disclosure and Barring Service (DBS). An enhanced check was required which checked the potential member of staff against all police records as well as against the list of people barred to work with vulnerable adults. References were sought and the person's previous employment history explored. These checks helped the

provider make better employment decisions in order to protect people from those who may not be suitable to care for them.

There were arrangements in place to help protect people from abuse. The provider's policy and procedures on this were known to the all the staff we asked about this, this included care and cleaning staff. None of the staff spoken with were hesitant in telling us what they should do if they observed or suspected abuse. Senior staff adhered to both the provider's policies and procedures on this as well as the local authority's joint working protocols. This meant they reported and shared relevant information with other professionals to help safeguard people. Staff were fully aware of the provider's whistle blowing procedures. They told us they had confidence in the registered manager to deal with anything they reported to them. There was guidance in the staff room on both these processes.

Good

Is the service effective?

Our findings

People were supported to eat and drink and to maintain their nutritional well-being. Nutritional risks were identified and managed. Any concerns relating to people's weight or their appetite were discussed with the visiting GP. Many people walked with purpose and were in constant motion they were given additional support to maintain their weight. The cook told us this was done by fortifying people's food. They added a cream product to foods to increase the calorie content. Staff provided fortified drinks and snacks in-between meals and during the night if needed. Meals were prepared for other dietary needs such as diabetes. One person told us they were on a restricted diet due to their medications. They told us that all the staff knew what they could and could not eat.

We observed staff supporting people to either eat their meals independently, or where needed, giving more support to those who could not do this. Support at meals times and in-between meals was given in a way which maintained people's dignity. When staff assisted people to eat and drink this was done in an un-rushed way. People were provided with a choice of food for their main meals; sometimes this needed to be a visual choice at the time of eating. People who remained in their bedrooms or in bed, had drinks within their reach or were helped to have a drink on a regular basis. Staff provided a supportive and relaxed mealtime experience. Dining tables were laid attractively and music, chatter and laughter were all part of the dining experience. We observed two staff eating their lunch with people which provided encouragement and company.

People had access to health care professionals and health assessments and reviews were completed when needed. Health professionals usually visited people at the home, but where necessary, staff supported people to attend, hospital, dental or optical appointments. People's care records showed they had been seen by professionals such as specialist skin care practitioners, community mental health practitioners, dieticians, speech and language therapists, physiotherapist and occupational therapists. The home was visited on a regular basis by a local GP who the registered manager said staff could contact whenever they needed to. We spoke to the home's GP when they visited. They told us people's needs in the home were "extremely challenging and complex". They said, "I think the home does really well." They confirmed that the staff always followed their instructions, nurses were always well informed and had necessary information ready when they visited.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. 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). 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 lack mental capacity to take particular decisions, any made on their behalf, must be in their best interests and as least restrictive as possible.

We found staff were adhering to the principles of the Act. People were supported to make individual decisions and their care was delivered in the least restrictive way possible. DoLS applications had been submitted to the local county council (the supervisory body), the majority of which still needed to be processed by the supervisory body. Five people had authorised DoLS in place; one of these had an additional condition attached. This required an appropriate professional to review the care planned for this person's personal care (washing, bathing and dressing). The person could at times be resistive to this and the care needed to support this needed to be monitored. This had been reviewed by a social worker and the care plan and care was regularly reviewed by the home's nursing staff. We did not observe anyone being forced to do what they did not want to do. Care plans recorded clear instructions for staff when people were resistive to care and we observed staff following these. This usually involved leaving the person and staff returning later to deliver care at a time the person was more able to accept their intervention.

All care was planned and given in the least restrictive way. Examples of this included, staff providing people's care around the person's routines, preferences and their ability to accept care. For example, one person was given food and drink, which they could eat when they wanted to remain walking, instead of trying to persuade them to sit when they did not want to. Staff also encouraged and supported this person to rest when they did not recognise the need to do this. Bed rails were not used for people who may perceive them as a barrier. Instead specialised equipment such as beds which lowered to the floor and padded mats on the floor were used to keep people safe. Administering people's medicines covertly (hidden in food or drink) was only done as a last resort and where a decision had been made to do this in the person's best interests. The use of one to one support was closely monitored to avoid unreasonable supervision and control.

Staff were trained in relevant subjects to support safe and lawful care. Staffs' on-going development was supported through the provider's support sessions called Trust in Conversation. Since being in post the registered manager had worked closely with the provider's training department to ensure all staff completed necessary training. The training record showed that the majority of staff had completed training in subjects which the provider considered to be a basic requirement. These included, fire safety, safe moving and handling, emergency life support, nutrition and well-being, health and safety, infection control and the MCA and DoLS.

Where staff had not yet completed these subjects or had missed update training, there were arrangements in place to ensure they completed these. Staff new to care were supported to complete the Care Certificate; an agreed set of 15 minimum standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It should form part of a robust induction programme. All staff completed induction training and whilst we were at the home we observed staff arriving to do this. This training was delivered by the provider's training manager.

Additional training had been completed by some staff which included, safe use of bed rails, medication administration, advanced MCA and DoLS and fire marshal training. Visiting health care professionals also supported staff's training and knowledge in other areas of care, such as, care of the skin and pressure ulcer risks, prevention of falls, wound care and care of the diabetic.

Staff had completed training in dementia awareness and their practice was supported by staff with more knowledge on the subject. This included, two nurses with mental health nursing qualifications, one nurse with a degree in dementia care and the home's dementia link worker (a member of staff who has completed additional training to be able to promote and support best practice in dementia care). Nurses received support to re-validate their registration with their regulating body the Nursing and Midwifery Council (NMC). The Provider Information Return (PIR) stated that care leaders were completing competencies in clinical

observations so that they could support the nurses in monitoring people's health.

The layout of the building and the adaptions made to it helped support the needs of those who lived with dementia, as well as people's physical needs. Its circular design provided an uninterrupted route for those who walked with purpose and who preferred to be in constant motion. The registered manager had introduced a seating area half way round where people could rest. We observed one person, who walked with purpose most of the time, take numerous opportunities to rest in this area before they recommenced walking. The building's exits and entrances, as well as areas of high risk, such as the food serving areas and medicine room, were key pad protected. The use of both worded and pictorial signs and different colours helped people locate necessary facilities, such as the toilets.

The placement of various objects and pictures on the walls not only created points of interest and engagement for people but also acted as points of reference, again helping people to orientate themselves. Busy patterns for décor were kept to a minimum so as not to over stimulate people or confuse them. Communal bathrooms contained bath hoists and easy access showers and toilet areas were fitted with hand rails to provide support. Bedrooms and communal rooms were fitted with call bells so staff could be easily summoned when needed.

Good

Is the service caring?

Our findings

We observed people to be exceptionally vulnerable; many lived with advanced dementia, were totally dependent on staff for all their needs and the majority were between 80 and 90 years old; older in some cases. All the staff needed to be of a caring and compassionate disposition to understand the needs of this group of people and their relatives. We observed all staff to be exceptionally caring, both in the way they spoke with people and in the way they physically supported people. We observed that staff enjoyed being with and understood people who lived with dementia.

Staff were patient and gentle as well as respectful and thoughtful. People looked comfortable around the staff. People who could verbally communicate talked freely with the staff and clearly enjoyed their company. One person said, "If I get fed up I just go and have a chat with someone, [name of member of staff] is a lovely girl, friendly." Where people were unable to effectively express how they felt or tell staff what their needs were, we observed staff to be aware of what was needed. People who did not communicate verbally and where non-verbal communication was also limited, staff ensured that a link between them and the person was maintained throughout the day. We observed staff just saying hello to people as they passed by or stopping and checking on people.

Staff knew people well and although not always, staff could assess a person's wellbeing by reading their body language or facial expression. When people rejected help or company staff were non-judgemental and respectful towards the person; they often returned later when the person was more accepting of this. When staff spoke with us about people's care needs it was clear they understood that each person's journey with dementia was different.

Staff delivered care around people's preferences and their ability, at the time, to accept support. Care delivery was therefore personalised and tailored to the individual. Staff helped make people feel as if they mattered. We observed one person following the care staff with the tea trolley. The staff chatted with them and supported them to be involved in the activity, which the person clearly enjoyed. At another time we observed one of the housekeeping staff respond to a person's distress. They and another member of staff helped this person's wellbeing improve. In this case, doll therapy helped reduce this person's anxiety and distress. The member of the housekeeping team understood the importance of the doll to this person and related to the doll as if it were the person's baby. They did this in a caring and respectful way. The person began to settle and became less distressed.

Staff needed to be able to communicate with people who quite often could not do this effectively. We observed a gentleness and fondness towards people when staff communicated with them. We observed staff choosing the right moment when to communicate verbally with people. They approached people with a welcoming smile, spoke in a steady and non-threatening way so that people who were beginning to feel anxious, did not feel overwhelmed by their presence. Staff sometimes used hand jesters to support what they were saying verbally or to extend a sign of friendship. This helped people respond well to the staff so they could effectively meet people's needs without this being a challenge for people. We observed staff making suggestions and providing prompts which also helped people remember what it was they wanted to

say or do. One relative described the staff as being "very attentive, patient, excellent, and so kind."

Information about how to communicate with people was recorded in people's care plans. Some people required information to be provided in different formats. For one person this sometimes included printed information on different coloured paper. Staff aimed to build trusting relationships with people and work collaboratively with relatives so that they could support people's care needs and help them make simple choices about their daily activities. This was done by asking those who knew the person best to share information about the person and their life. Information was gathered about people's work, hobbies, what had been important to them, significant life events (good or bad) and who mattered to the person. This information was recorded and it helped staff know the person well so they could deliver people's care and support people to make simple choices about their daily activities. We were told that one relative supported their relative's particular communication needs with an iPad. The relative and staff worked together to ensure they and the person communicated effectively with each other so that the person's needs could be better understood.

Staff knew some people particularly well and were skilled at reading their body language and their behaviours which helped them to pre-empt and understand behaviours which could be perceived as challenging. In one case, reading the person's behaviour and responses to things helped staff support the person through the loss of their spouse who had lived in the home with them. Staff had been thoughtful and sensitive in how they approached this by slowly removing items in the room which triggered distress in the person. For example, the second bed which now remained empty and an armchair no longer sat in.

Staff welcomed visitors and supported people's family and friends when needed. One group of relatives told us they visited regularly but not frequently and they told us staff were always very welcoming. They said, "They always recognise us and call us by our names which is lovely. They [staff] are always eager to update us on how [name] has done since our last visit." They also commented that "all support" for their relative's 90th Birthday had been "forthcoming" and they had appreciated this. The Provider Information Return (PIR) stated that the home planned to hold an answer and question evening for relatives. The home's GP and one of the provider's Admiral Nurses (a specialist practitioner in supporting people with dementia and their families) would be present at this. The registered manager and GP told us they still planned to hold this.

People's privacy and dignity was upheld. Personal care was delivered in private and in a way which was dignified. People's personal space, their bedroom was respected as such by the staff. The Provider Information Return (PIR) stated that one person had requested a key to lock their bedroom when they were not using it, which had been provided to them. Couples were sometimes admitted to the home and their privacy, as a couple, was respected. Information about people was kept confidential and secure. The provider ensured necessary requirements under the Data Protection Act and General Data Protection Regulations (GDPR) were met. This included making sure that care records were properly archived, people were given information on how their information maybe used and all electronically held records were secure.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection we found care plans were not always giving enough detail about people's care needs to ensure staff could be fully responsive to these. During this inspection the registered manager told us some care plans had been re-written, but overall progress on improving these had been slow. After observing people and the care delivered to them, as well as talking with staff about people's needs, we found care plans were not always reflective of what we saw or heard. Care plans did not always contain relevant and necessary information about people's current care needs. In some situations, the practical planning of people's care (so not just the written care plans), had not been sufficient to always ensure safe and effective care.

Before admission, people's needs were assessed and predominantly people's relatives were involved in this process. They were consulted about the care people were to receive and had an opportunity to speak on behalf of their relative. If the person was able to engage in this process they were fully involved. We observed relatives during the inspection being updated by staff and the registered manager about their relatives' care. Where people could also be involved in this process they were. We saw good examples of where people's preferences, likes and dislikes were added to their care plans, therefore some care plans were personalised. The registered manager told us some staff were more skilled at writing personalised care plans than others. Care staff told us they were not involved in the writing of care plans but were consulted by the nurses who wrote these. The care staff had access to people's care plans so could read these.

We found care plans had not always been well maintained, so they did not always contain relevant and accurate information about people's current needs. Care plans had been reviewed each month, as per the provider's expectation, but the changes to people's needs and abilities tended to be recorded in the monthly review only. This meant the content of the main care plan did not always alter when people's care needs altered. In some cases, this necessitated a read through of several monthly reviews to find out what the latest care requirements were and when they had changed. It was not unusual for us to either observe care being given or learn about people's care from the staff and the care plan be different from this.

Two examples of this were, one person's eating and drinking care plan stated the person required a "prompt" and were to be "encouraged" to eat at meals times. We observed the support given to this person at two mealtimes and this was not what we observed. A member of staff told us this person now required staff to physically support them to eat and drink. This person's dementia had progressed and they were now unable to independently feed themselves or make decisions about their food and drink. Another record of wound care given to a person did not reflect the instructions last given by the wound care specialist nurse which were recorded in a care plan review. The care plan itself was difficult to follow, because of numerous amendments. We ascertained from other records that what was on the care plan was not what was happening in practice.

We reviewed 15 people's personal hygiene care plans with other records kept (daily care records and bathing records) of who had been provided with, or offered a bath or shower since May 2018. The majority of the care plans stated the same, which was "Offer [name] a bath or shower once a week". This did not

demonstrate personalised care planning, although one person's care plan stated, "Would enjoy a shower at least once a week." The last 'bath' provided for this person was in May 2018 with no other entry of a bath, shower or refusal of either in-between. A member of staff however confirmed this person was supported to wash daily at a sink. This member of staff went through the current bathing needs of the 15 people on our list. Only one person was not able to have a bath or shower any longer, although they confirmed some people sometimes declined. They confirmed that the wording in one person's care plan, "Will request a shower" was no longer relevant because this person's dementia had also progressed and staff now needed to "suggest" and "encourage" a bath or shower.

Unclear and inaccurate care plans and other care records did not give a true account of the care people received and could potentially lead to unsafe or inappropriate care being delivered. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were arrangements in place for people, their relatives and other visitors to make a complaint. The provider's complaints procedure was displayed for guidance in the main home but not in the smaller unit. We fed this back to the registered manager who rectified this by the second day of the inspection. All complaints were recorded, along with when they were acknowledged, the investigation, the findings and when the complaint was concluded. One complaint, received about the care of a person, had been investigated and not upheld. The investigation records showed that each point had been investigated and responded to fully. Another complaint had been investigated and the complainant had remained unhappy with the response. This had involved staff respecting the wishes of a person, who was able to make an independent decision about their treatment, but where the relative had not been happy with this. Some lessons had been learnt from this complaint however, in how information about medicines was gathered when people were admitted for short periods of time.

Relatives we spoke with all reported a frustration with clothes going missing or clothes that were not their relatives' being found in their wardrobes and being worn by their relative. Three out of five relatives spoken with, at some point had raised dissatisfaction with this and had been told it was their responsibility to name their relative's clothing. One relative told us they used a marker pen but after so many washes this faded. Another relative told us they "had given up asking about this now." Relatives who had found their relative in other people's clothing had found this upsetting and told us it did not uphold their relatives' dignity. This was obviously an unresolved area of dissatisfaction. The registered manager reiterated that it was the relatives' responsibility to make their relatives' clothing when we fed back this information. Various other ways of marking and naming clothing were discussed at the time of the inspection but it remained unclear to us that further action was going to be taken to try and address this.

We recommend that the provider seek advice, from a reputable source, about the management and resolving of complaints and areas of dissatisfaction.

Activities were delivered to people in a way they enjoyed and which was meaningful to individual people. The activities coordinator said that the aim of their intervention was to demonstrate to people that they were valued and to improve their quality of life. They said, "To get that momentary spark of joy or recognition" and they went onto to say "The key to getting this is to know residents as well as possible." Activities were used for different reasons, one being to support people's ability to accept the care and support they needed and for maintaining people's physical and mental wellbeing. For example, we observed one person be supported to walk to the dining room to have a meal; they could be reluctant to do this at times. The activities co-ordinator used singing and dancing as a distraction and motivator to get the person to do this. The person was clearly engaged in this activity and looked relaxed. This was achieved successfully because the activities co-ordinator knew the person well; they had built up a relationship with

the person and knew what motivated them, they knew how to read the person's non-verbal cues and knew what songs they liked.

Some people remained in bed and were not able to engage in communal activities, however, activities, which were meaningful, to them were taken to them. One person liked to colour in pictures so crayons and pictures were left within reach of this person. We observed them using these several times as we passed by. Another person's love of music and singing was known to the activities co-ordinator. This person's ability to communicate effectively and to do anything for themselves was now severely compromised by their dementia. Volunteers from a local charity visited the home on a regular basis to provide singing therapy to people as a group. Before starting their group activity they visited this person. We observed a noticeable change in this person, who before their arrival had been repetitively picking at their bed clothes and verbally mumbling. Once the singers stated singing the person's engagement was obvious. Their eyes followed the volunteers, the repetitive behaviour stopped and their facial muscles relaxed.

The activities co-ordinator gave examples of how group singing benefited people in other ways. This included, lung exercise, movement and exercise and reminiscence. Some people who did not always talk freely sang freely. Other activities were garden based and included the building of insect houses and mobiles. A raised trough had been planted with vegetables, which people sometimes watered and tended. Activities were used to help people feel included.

People's end of life wishes and preferences were explored with them and if more appropriate, with their relatives. These were recorded so that staff were aware of these at the appropriate time. The registered manager and nurses confirmed that the local GP practice gave very good support to people at this time. Anticipatory end of life medicines were prescribed in case these were needed to relieve pain or distress at the end of a person's life. An end of life noticeboard gave information to visitors on what the home's aims were at this time, how they as a relative could be involved and where bereavement support could be found.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection in March 2017 a home manager had been appointed in October 2017. They had been successfully registered with the Care Quality Commission (CQC), as registered manager of Wyatt House, in January 2018. The home had previously been without consistent management for some time and without a registered manager for over a year. The registered manager explained they had therefore needed to make significant improvements to the home's systems and processes, its compliance with necessary regulations and the provider's expected requirements. One health care professional told us "The service has been transformed since [name of registered manager] has been in post." A relative told us they had noticed improvements since the registered manager had been in post. They said, "There are now adequate staff, before there were not."

In November 2017 the provider carried out a full internal audit and showed that improvements were needed to areas such as those reported on in our March 2017 inspection. This included improvements in the provision of staff training, completion of staffs' planned one to one support sessions and needed improvements to the contents of care plans and care plan reviews as well as other provider requirements. In January 2018 the provider re-audited the home and significant improvements had been achieved overall. In May 2018 a provider's action plan was set with the registered manager and one of the actions still needing to be fully completed was a review of people's care plans and an improvement in the contents of these. Other actions had also been added, for example, senior staff completion of training around the new General Data Protection Regulations (GDPR).

During this inspection we found care plans were not always accurate and containing relevant information about people's needs and their risks. Some care plans had been clearly re-written and improved on, whilst others had been reviewed on a monthly basis, but the content of the main care plan had not been altered to reflect changes in people's abilities, needs and care. The care plans were therefore not always giving staff accurate and up to date guidance on people's care needs. The registered manager was aware of this through their auditing of the care records. When followed up by the registered manager staff had explained to them that they did not always have time to re-write and amend care plans. Progress on this necessary improvement had therefore been slow and was still not complete.

We also found that the necessary systems and processes, needed to ensure people's risks were sufficiently assessed and care was planned around these risks, in a timely manner, were not effective. There were examples of people having not received safe and effective care.

The provider's arrangements for the line management of the home had changed since the last inspection and for some months the registered manager had not had the support of an area operations manager (AOM). The registered manager explained that there were senior managers they could contact if they needed advice however and this was witnessed during the inspection. Arrangements had been made by the provider to continue some quality monitoring of the home during this time; seen in the provider's internal audits completed and a visit by a provider representative in May 2018. The next planned visit by a representative of the provider however, was unknown. This suggested a fragmented home line management structure, which

had not been able to provide the home with the support it required to successfully get all necessary improvements completed; example, the contents of people's care plans. It had also not identified a shortfall in risk management and had not identified a lack of accurate care planning in relation to people's risks.

The provider's quality monitoring systems were not always effective enough to protect people from unsafe and inappropriate care. This is a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We reviewed other audits which had been completed by the registered manager, which showed improvements had been achieved and that others were making progress. For example, in April 2018 a care plan audit identified that no reference had been made to a person's loss of weight in the person's relevant care plan review. Following this the subsequent reviews referred to the person's weight and the improvements being made to this. In March 2018 a medication audit showed that particular guidance (protocols) were not always in place for medicines prescribed to be used 'as required'. A re-audit on 4 July 2018 showed this action had been met and protocols were being completed for these medicines.

We met the provider's newly appointed regional operations director who told us the AOM support was under review.

The registered manager held meetings with staff to communicate their expectations and to give them updates and to share feedback from audits. They also sought feedback from staff on ideas and suggestions to improve the services provided. Staff had worked hard to improve the information available to people and relatives on, for example, the home's noticeboards. Detailed information was seen on noticeboards dedicated to safeguarding, management of falls, dementia care and end of life care. A newsletter had also been started to improve communication with families, friends and other visitors. Relatives we spoke with had found both these initiatives helpful.

Feedback on the services provided was gathered from relatives and other visitors, informally by the registered manager. Comments and feedback left on a website used for this purpose were monitored by the registered manager. We discussed the feedback left by one relative which had also been received as a complaint by the home. The circumstances behind an injury to a person had been investigated and, although thought to be an unwitnessed accident caused by another person living in the home, an apology that this had happened at all was given. The points of complaint were also investigated and not substantiated. Other comments made this year (2018) praised the care and support given to people and their relatives. One comment said, "Mum was treated with care and dignity during her stay, staff genuinely showed interest in Mums well-being, trying to involve her and interact rather than leave her alone and isolated." The relative who wrote this also reported feeling "supported under difficult circumstances." A volunteer who regularly visits the home commented that they found the atmosphere welcoming. They said, "The staff [are] friendly and helpful. The residents engaged and cared for." Other comments prior to this were predominantly positive and praising staff for their kindness and care.

The registered manager ensured they were up to date with necessary knowledge by reading relevant journals and visiting professional websites, by liaising with visiting professionals and attending the provider's management meetings. They had for example, attended Gloucestershire's Dementia Conference in 2017 to ensure the home was able to meet Gloucestershire's Dementia Strategy and ensure best practice in dementia care could be delivered.

They understood and fulfilled their responsibilities as registered manager which included making sure the CQC received all appropriate notifications, that the rating awarded to the home was prominently displayed

and improvements in the services provided to people were made. The improvements that had already been made now needed to be successfully sustained and those identified as required in this report need to be fully met.

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 People's risks were not always sufficiently assessed, in a timely manner, to ensure safe and effective care was delivered in order to reduced or mitigated risks and keep people safe. Regulation 12 (1) (2) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's care plans did not always record accurate detail about people's care needs for staff guidance or always record the care which was being delivered to people. Regulation 17 (2) (c). The quality monitoring processes in place had not been fully effective in identifying when risks to people were not being adequately managed and when a lack of progressed actions then went on to have an impact on people – for example, care plans containing inaccurate detail about people's care needs. Regulation 17 (2) (a) and (b).