The Orders Of St. John Care Trust

OSJCT The Coombs

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 26, 27 and 28 October 2017. It was unannounced and carried out by one inspector.

At the last inspection on 5 and 6 April 2016 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured people's medicines were correctly administered. They had not always assessed people's nutritional risk and had not ensured care plans contained relevant information for staff guidance. The provider had sent us an action plan telling us they would meet these regulations by 31 July 2016. During this inspection we found the actions which the provider told us they would take, to make improvements, had been completed. The provider was meeting the requirements of the regulations.

The Coombs is a care home which can provide care to a maximum of 36 people. At the time of this inspection 34 people lived there. Care was provided in the main house and in three smaller connected units. People in care homes receive accommodation and nursing or personal care as single packages, under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Coombs provided care to older people, people who lived with dementia and those at the end of their life. There were nurses on duty at all times.

There was an experienced registered manager 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.

People were kept safe. Improvements had been made to how people received their medicines and in how their nutritional risks were assessed. Other risks which could potentially impact on people's health and wellbeing were identified and managed. There were enough staff to meet people's needs. Staff had been trained and were supported to meet people's needs safely and appropriately. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The provider's policies and systems supported this practice and ensured people's diverse needs were equally met. People's health needs were responded to and met.

Staff were reported to be kind and compassionate and we observed these qualities in practice. People's abilities, as well as their disabilities, were understood by staff who adapted their care around this. The care delivered was tailored around people's individual needs and wishes. People were supported to have quality of life through meaningful activities. Their right to private family life was upheld. There had been improvements in people's care plans which were personalised and contained relevant information for staff to follow. People's care was planned with them. People and others were able to raise a concern or complaint and this was taken seriously, investigated and resolved. The staff team reflected on information received in order to learn from this and improve the service.

Improvements to the service were made through effective monitoring and a commitment by the staff team to provide the best service possible to those they looked after. There was strong and supportive leadership in place and staff who felt valued and supported by the senior staff in the care home. People, relatives and staff contributed to the running of the care home and their ideas, suggestions and feedback were valued.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received their medicines as prescribed. They were provided with the support they needed to take these safely and when they required them.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

There were enough staff to meet people's needs and the use of the same agency staff supported the care home when needed. Staff recruitment was taking place to ensure personalised care could be maintained at all times. Good recruitment practices protected people from the employment of unsuitable staff.

People were protected from risks which could potentially have an impact on them. These were identified, assessed and managed.

People lived in a clean environment. Arrangements were in place to reduce the risks associated with infections and to reduce the spread of infection.

Is the service effective?

Good

The service was effective.

People's nutritional risks were assessed and managed and they received the support they needed to maintain the nutritional wellbeing.

People received care and treatment from staff who had been trained appropriately and who received the support they needed to meet people's needs.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

Staff ensured people's health care needs were met. People had access to health care specialist when needed.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and who delivered care in a compassionate way. People's dignity and privacy was maintained.

People's preferences were explored and all the staff who worked together to provide care which was personalised to each individuals' needs.

People's end of life care was delivered with compassion and skill. This ensured people remained comfortable up to the point of their death and those who mattered to them were supported.

Is the service responsive?

Good

The service was responsive.

People's care was discussed with and how their needs were to be met had been planned with them.

People had opportunities to socialise and partake in activities. Staff had worked hard to make these activities meaningful to people.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed. Complaints were reflected on in order to learn and improve the service provided.

Is the service well-led?

Good

The service was well-led.

People and staff benefitted from having a registered manager in place who communicated effectively with them. There was a supportive senior staff team in place.

The registered manager was open to people's, relatives and staffs' ideas and suggestions.

The provider's monitoring systems ensured the service's provided to people were safe and were of a high standard. These arrangements led to successful improvement.

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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 26, 27 and 28 October 2017 and was unannounced. The inspection was carried out by one inspector.

Prior to the inspection we reviewed the information we held about the service since the last inspection on 5 and 6 April 2016. A Provider Information Return (PIR) was not requested prior to this inspection however, we took this into consideration during the inspection. This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed statutory notifications which are information the provider is legally required to send us about significant events.

During the inspection we spoke with five people who lived at the care home and one relative in order to learn about their experience of the care home. We also spoke with eight staff which included the registered manager, deputy manager, two registered nurses, one team leader, one senior care assistant, the maintenance person and the chef. We spoke with one visiting health care professional and requested the views of another following our visit.

We reviewed records relating to the care of eight people. These included medicine administration records, care plans, wound management records, risk assessments and documents relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. We reviewed three staff members' recruitment records and the service's training record. We also reviewed records and documents relating to the management of the care home. These included maintenance records, health and safety records, a selection of audits, the care home's improvement plan and minutes of meetings held with staff and relatives. We also referenced seven of the provider's policies and procedures during the inspection.

Good

Is the service safe?

Our findings

At the last inspection on 5 and 6 April 2016 arrangements were not always in place to ensure people received their medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the actions which the provider told us they would take had been completed. Improvements had been made and the service met the requirements of this regulation.

We observed staff administering medicines and looked at the new arrangements and practices adopted since the last inspection. People were supported to take their medicines but also, where safe to do so, people were able to manage their own medicines. One person self-administered some of their medicines. People who had medicine prescribed to be taken, when they needed it, were asked if they required this. For example, two people were asked if they required pain relief. We observed good practice in how medicines were administered and recorded.

Additional checks had been introduced to ensure people received their medicines when they were prescribed. The provider's monthly medicine audit had been completed every month with additional mid-month checks carried out. Staff automatically checked people's medicine administration records (MARs) before they started administering medicines. This was to ensure the member of staff administering medicines before them had correctly completed the MARs. Gaps where staff signatures should be potentially meant a medicine had not been administered. There had previously been a high number of gaps seen on MARs which had not been followed up. The registered manager told us this was now rare and when it occurred it was followed up straight away to establish if the medicine had been administered or not.

There had also been a change in how the pharmacy packaged people's medicines. This enabled staff to count the medicines left. They now kept a running total of each medicine and could quickly identify if the medicine administration records tallied with the stock left. This was a further fail-safe measure to ensure people had received their medicines correctly. The registered manager told us the above arrangements and practices were fully embedded with their own staff. They said, "There is a whole different culture and practice in place around medicine administration. There is a better sense of responsibility and accountability within the team."

We saw all medicines were stored securely and within the manufactures recommended temperature levels. Records were also kept of medicines not used and returned to the pharmacy. One member of staff told us they had received "very good" training to be able to administer medicines. They also confirmed that the competencies of staff who administered medicines were formally reviewed. The provider's medicine policy stated that this would be completed every three years. It stated that staff who administered medicines also had to have an annual support (supervision session) which focused on medicine administration.

People told us they felt safe. One person said, "I feel very safe here" and another person who had experienced falls at home said, "I feel safer here."

The registered manager told us there were enough staff on duty to meet people's needs. However, told us making sure there were enough staff was their main challenge. They confirmed the provider always supported the use of agency staff to ensure safe staffing numbers. They told us they always tried to use the same agency staff because they knew people's needs and the care home's routine. They explained that existing staff were very good at offering to work additional hours to help cover staff sickness or staff annual leave but this was not always possible. During the inspection the registered manager was working additional hours to help cover staff sickness.

We observed people receiving care and support when they needed it and call bells being answered promptly. The registered manager was recruiting more staff as there were some vacancies to fill. We spoke with one member of the care staff who interviewed staff with the registered manager. They told us they had interviewed three potential staff the day before the inspection. The registered manager explained there were busier times of the day, where without an additional member of staff, it was not so easy to meet people's particular preferences. These busier times were sometimes covered by existing staff who were happy to stay on duty or arrive earlier. However, for the week of the inspection this had only been achieved once. The registered manager explained that this did not mean people did not get their care or were left unsafe, but at times when staff were helping people to bed or helping them to get up, others may not be able to do this exactly at the time they would prefer.

People were protected from those who may not be suitable to care for them. Staff recruitment files demonstrated a robust recruitment process in place. Relevant checks were carried out prior to staff starting work in the care home. Staff who were successfully recruited completed a probationary period where their on-going suitability and progress was monitored.

People were protected from potential acts of abuse. Staff had access to and were aware of the provider's safeguarding policy and procedures. These were in line with the local authority's safeguarding policy and agreed protocols. This meant, when appropriate, senior staff shared relevant information with other agencies and professionals in order to protect people. The provider's whistleblowing policy supported staff in reporting concerns about other staff without the fear of reprisal. There was a zero tolerance of any form of discrimination. The provider's policy on equal opportunities, diversity, anti-oppressive practice and sexuality promoted good practice in this area.

People lived in a well maintained care home. The maintenance records showed that various health and safety related checks were carried out to ensure risks to people were reduced. These included a weekly fire alarm check and monitoring water temperatures. Visual checks were also carried out, for example, on emergency escape routes, wheelchair tyres and window restrictors to ensure they were in working order. Contracts were in place with external specialists to regularly service for example, the passenger lift, fire alarm system and firefighting equipment, call bell system and the care hoists. A contract was also in place to monitor the health of the water system.

People lived in a clean environment. The care home had a team of cleaners who worked hard to keep the environment clean and fresh. Infection control arrangements were followed to reduce the risks associated with and to manage outbreaks of infection. A few people had recently experienced a respiratory infection, which had also affected some staff. A steady progression of people and staff succumbing to similar symptoms had occurred over a period of 10 days. The correct protocol had been followed and advice had been taken from Public Health England (PHE). The provider's infection management process had been implemented. This had included additional cleaning, restrictions on visiting and a specific record maintained of who was affected, when, and a time line kept of individuals' symptoms. This enabled management staff to track the infection's progress and to report back accurately to PHE and the provider. At

the time of this inspection there had been no further new cases or symptoms in a period of five days. The care home was still taking advice from PHE who were, according to the registered manager, "airing on the side of caution" but staff were preparing to relax some of the restrictions that had been put in place.

Two people with on-going infections, acquired before their admission to the care home, were being supported. The deputy manager discussed with us the actions that had been taken to prevent the spread of this infection. These precautions had been successfully adhered to and no other people or staff had been affected. These had included separate toilet facilities, additional cleaning with specific cleaning products, support for people with regular hand-washing and a reduction in the numbers of staff involved in these people's care. The deputy manager explained that in managing both infections, staff had applied limitations to those who still wished to visit. For example, they only visited their own relative and remained in one place.

We also discussed the care of five people who had similar other types of infections. An analysis of all care practices, equipment in use and staff support given to these people had taken place and a common cause had been ruled out. Each of these people had additional health issues which made them potentially susceptible to this kind of infection. These people had been appropriately referred to their GP and had been commenced on antibiotics. The appropriate support was being given by staff, which included the encouragement of more drinks and hygienic use of the toilet and increased hand washing.

Risks were identified and managed. These included other risks to people's health which were assessed on an individual basis. We reviewed for example, risks assessments, for developing pressure ulcers and falling. The assessed level of risk determined the action which followed. People at risk of developing pressure ulcers had been provided with, for example, pressure reducing mattresses and cushions and staff helped people to move on a regular basis.

Some people had been assessed by an occupational therapist or physiotherapists and provided with equipment to help them walk safely. For example, one person used a walking frame to help with their mobility. When they fell and sustained an injury from the frame the equipment was reviewed. As this was assessed as still being an appropriate frame for the person's needs, an adaption was made to the frame to reduce the risk of a similar injury occurring again.

The introduction of electronic equipment had been appropriate for another person in trying to reduce the risk of them falling. Staff had correctly considered how they would do this in the least restrictive and most unobtrusive way. A sensor mat had therefore been used. This alarmed where staff could hear it when the person stood up and applied pressure to the mat. This alerted staff and they could arrive and provide additional support. All actions implemented, as a result of a risk assessment, were reviewed on a regular basis. In this case staff had reported the person stepping over the mat to avoid it. The risk assessment was reviewed and the mat had become a hazard in its own right so it was removed. Staff had returned to increased observation checks on this person so they could try to provide support at the appropriate time.

Staff were constantly aware of potential risks and altered their practice and arrangements around these. For example, on some days it was necessary to ensure one person was seated where staff could unobtrusively observe them, because at times, they stood up but could not walk safely. On other days this person remained in bed and their risk became one of isolation so staff adapted their care accordingly around this person's particular needs.

Good

Is the service effective?

Our findings

At the last inspection on 5 and 6 April 2016 people's level of nutritional risks had not always been correctly identified and assessed. This potentially put people at risk of not receiving the support they needed to maintain their nutritional wellbeing. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the actions which the provider told us they would take, to make improvements, had been completed. Improvements had been made and the service met the requirements of this regulation.

We reviewed assessments used to determine people's nutritional risk and we found these had been correctly completed and maintained. Nurses and senior care staff had received additional training in completing these since the last inspection. All staff had received training in how nutritional risks were assessed and met. The registered manager said, "All care staff are far more engaged in the whole assessment and reviewing process." Changes had also been made to how care staff communicated with the catering staff about nutritional risk and dietary needs. The chef told us that rather than just being told who needs what diet they were now involved in the risk assessment process and the planning of people's nutritional support. These improvements had led to an overall better understanding in how to assess people's nutritional risk and a collective team responsibility in ensuring people's nutritional wellbeing.

People's weight and appetites were monitored and any concerns were discussed with their GP. A fortified diet was provided to those who needed support to maintain their weight. This involved adding extra butter, cream and full fat milk to foods during cooking. Fortified drinks such as milkshakes and warm milky drinks were also provided in between meals. Snacks such as packets of crisps, chocolate bars and biscuits were available for people to help themselves. We saw these being replenished around the home. Fruit was offered at various times of the day. We observed people receiving the support they needed to eat their food and to drink enough fluid.

Where appropriate staff adapted their support. One person's health had significantly and expectedly deteriorated and they were spending more time asleep. Staff had continued to monitor this person's weight and had tried to offer fortified foods. In this person's case, the GP and staff had agreed not to carry on weighing the person, but to support them to 'eat for pleasure'. A similar arrangement was in place for another person who was nearing the end of their life and who was refusing most foods. We observed a member of staff ask this person if they would like their favourite milky drink. This was provided with patience and care and the person thoroughly enjoyed it. The member of staff was pleased that they had been able to help the person enjoy their favourite drink. People with swallowing problems or who were at risk of choking were assessed by a speech and language therapist. We reviewed the relevant care plan for one such person. The guidance given by the therapist about what this person should avoid and how their food should be provided was clearly recorded in the care plan for staff guidance.

People told us they liked the meals. One person said, "The food is good and we get a choice", another person said exactly the same. Another person told us they were able to make daily choices about what they ate. They said, "If you tell the kitchen staff what you want early enough in the morning they will always try to

get you what you want." Another person told us they alternated between porridge and a cooked breakfast each morning. We observed people being given drinks and biscuits in-between meals. People also had a choice of where they ate. One person said, "I like to have breakfast and tea in my bedroom and I go down for lunch."

People were looked after by staff who had received relevant training and who were provided with the on-going support they needed to meet people's needs. All staff who started work for the provider completed training which supported them to carry out their work safely. This included for example, training in health and safety, fire safety and evacuation, safeguarding, safe moving and handling or safe moving and handling of loads. Staff were provided with refresher training and more specific training related to their role. The staff training record recorded what training had been provided, what required updating and what had been booked. The registered manager was fully aware of who required what training and liaised with the provider's training department to ensure staff received this. Staff new to care completed the care certificate. This was a framework of training and support which aimed to provide this group of staff with the knowledge and skills to be able to deliver safe and effective care to a recognised standard once completed.

To ensure all staff received refresher training some changes had been made to how this was provided. One of the two training co-ordinators for the care home told training in certain subjects was now delivered "in house". They told us for some staff this had made things "a lot easier". They also said, "This is far better because we can tailor training to staffs' particular needs." They explained that specific examples could also be used to make the training more relevant to their staff. For example, the recent respiratory infection had been discussed and used as an example during the latest refresher training in infection control. Staff were provided with regular support sessions.

People were supported to make independent decisions and to have control over how their care was provided to them. Where people were unable to do this we checked to see if the service was working within the principles of the Mental Capacity Act (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 make 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to lawfully deprive a person of their liberty. We also checked to see if the provider had properly trained and prepared their staff in understanding the requirements of the MCA in general, and the specific requirements of the DoLS.

Only one person had authorised DoLS in place, as they could not provide consent for living at The Coombs or make decisions about their care and treatment. Applications for the same reasons had been submitted to the supervisory body for two further people, but had not yet been authorised. In the care records of two further people there was evidence to show that their mental capacity with regard to where they lived and their ability to make decisions about their care and treatment had been reviewed. In both cases it had been determined that they had mental capacity to make decisions in both these areas.

The provider employed a specialist nurse to support staff with the assessment of people's mental capacity, in reviewing people's mental capacity and in making decisions in people's best interests. In the relevant care

plan for the person who had authorised DoLS in place, it stated that the person was able to make "simple day to day decisions." Care plans for the areas where they could do this stated the person's preferences and what support they needed to do this. Other people's care records recorded the fact they had given consent to live at The Coombs and their care plans stated where they needed support to make decisions. Staff had been provided with training on the MCA and DoLS and on-going learning took place through the involvement of the specialist nurse.

People had access to health care professionals when needed. Staff were able to recognise deterioration in people's health when it happened and knew when to seek appropriate advice from their GP. One person with an identified infection, which had been first identified by the care home staff and then referred to their GP, had become poorly after starting treatment for this. This had been identified by staff and quickly reviewed by one of the care home's nurses. They said, "The problem with [name] is when they get poorly they get very poorly very quickly." They were therefore aware that this person required close monitoring which they continued to do. One health care professional said, "They're [the staff] are on the ball. I'm quite comfortable leaving it in their hands." This professional told us the staff "immediately" contacted them if they needed to. Another health care professional confirmed that staff liaised and referred to them particularly well and followed their instruction/s.

People's care records recorded their visits to and by a chiropodist [foot care]. One person said, "A chiropodist comes ever six weeks and I have my feet done." People also had access to NHS dental and optical services, hearing aid support services, diabetic care services, mental health practitioners and physiotherapy and occupational therapy services. The registered manager told us people had been supported and treated by the NHS rapid response service. In some cases people who become poorly can be treated by this service in their own home [in this case the care home]. For some people, in particular those who are very frail or live with dementia, this can avoid an upsetting and traumatic admission to hospital.

Good

Is the service caring?

Our findings

People told us they considered the staff to be kind and caring. One person said, "Oh they're lovely, honestly. Another person said, "I can't fault the staff, they are lovely." Another person told us the majority of staff were kind and helpful. We reviewed the comments placed on a website used to review care homes. These included: "The staff are really kind and considerate" and "All staff are wonderful." Another comment described staff as being "kind", "patient" and "supportive." A further comment said, "A friendly home with the utmost of care and consideration being shown to all the patients and also to all the visitors. It is a pleasure to go there and nothing is too much trouble for the staff." One health care professional said, "The staff are extremely caring."

We observed staff to be kind and compassionate towards people. Staff took time to listen to what people had to say. They were patient with people who took longer to do things. One person however felt that some staff could be more patient with them. They were patient with and supportive towards those who were confused and disorientated. One person who lived with dementia required a lot of guidance and support. Throughout the inspection we observed each member of staff provide this person with a friendly interaction. Each member of staff showed genuine affection towards this person who sometimes repeated what they said several times over. People were treated with respect. We heard one member of staff refer to a person as "love". We asked the person if they minded being referred to like this. They said, "No, it's meant in the right way." One person told us how the staff sometimes gave them a cuddle. They said, "Even us oldies need a cuddle sometimes." One review comment made by a relative said, "Mum said they listened to me and didn't just treat me like a silly old lady."

We observed people being asked what they would like to do and where they wanted to go or sit. Staff gave people options and choices. One review comment by another relative said, "I was impressed with the willingness of all the staff to accommodate mum's wishes and let her choose what she did and didn't want, could or couldn't do." The Coombs provided personalised care to people. They had taken the time to find out what people's preferences were, how they wanted their care provided and what was important to them. All staff, not just the care staff, contributed to people's wellbeing and quality of life. For example, the kitchen staff knew what individual people liked and disliked when it came to their food. The cleaning and laundry staff interacted with people and formed caring relationships. The maintenance man created areas in the garden for people to look at from their window and put bird feeders up for people. It was a whole home approach.

People's care was delivered in private. Staff recognised that people's bedrooms were their personal, private spaces and therefore they knocked on the door before entering. In the evening we observed people's bedroom curtains being pulled when people were sat in their bedroom with the lights on. One member of staff said, "I'll pull your curtains for you so people cannot see in, it will be cosy as well."

People's right to private family life was respected and people could receive visitors as they wished. One review comment by a relative said, "I feel valued and most welcome at all times." The relative we spoke with during the inspection confirmed they were able to visit at any time they wished.

One person told us how they could not hear without their hearing aid and how staff always made sure they had this in their ear and that it was working. They said, "This makes such a difference you know." We observed staff cleaning one person's pair of glasses so they could see better. Staff carried out other little tasks such as these, which made a big difference to people's comfort and their ability to communicate and interact.

We followed the care of one person who received end of life care. This person passed away during the inspection. The care we observed this person receive, as well as one other person who was near the end of their life, was exceptionally kind and compassionate. They were physically handled with the utmost care and made comfortable at the end of any care delivered to them. Each time we visited them they looked comfortable and not distressed. Staff were constantly monitoring them to ensure they remained free of any end of life distress. The person who passed away was seen by their GP twice on the day of their passing. This was to ensure they were comfortable and that end of life medicines were not needed. Staff were trained to administer these medicines if these were required to keep the person comfortable.

Staff were trained to verify a death and we observed this being done. The member of staff doing this spoke to the person who had passed away whilst they did this. This showed that this member of staff still cared for and respected this person. We observed no change in how staff delivered this person's final care to how it had been delivered when they were alive. The same amount of respect, dignity and privacy was afforded to them. We were aware of staff supporting family members before and after their relative's death.

The registered manager explained that the care home had started to work towards the Gold Standards Framework in End of Life Care. They had stopped because the commitment required in evidence gathering and attending training several miles away proved too much for the staff team. However, they explained that the local hospice was next door so staff had attended training sessions and forums in the past. A good working relationship was in place and therefore the staff were able to access updates in best practice and advice when needed. The registered manager told us that many people came into the care home for end of life care. They therefore told us that the staff were comfortable providing this sort of care and had the knowledge and skills to be able to do this. The newly appointed deputy manager had worked in the NHS and had specialised in the care of people who were terminally ill. They therefore came to their new role with skills and knowledge which would further enhance the good end of life care The Coombs already provided.

Good

Is the service responsive?

Our findings

At the last inspection on 5 and 6 April 2016 people's care plans were not always sufficiently comprehensive to ensure they contained relevant guidance for staff. This potentially put people at risk because information available about their care and guidance for staff was not always kept up to date. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the actions which the provider told us they would take, to make improvements, had been completed. Improvements had been made and the service met the requirements of this regulation.

Care plans recorded people's needs and how these were to be met. They gave staff guidance on safe ways of working and how people preferred their care to be delivered. People we spoke with could not remember being shown their care plans, but they did remember for example, being asked what their likes and dislikes were, how they preferred to spend their day what their preferred daily routine was. The majority of care plans were personalised, for example, they recorded if a person preferred a male or female member of staff to support them with their intimate personal care. Some care plans had clearly evolved over time and contained detailed information about all areas of a person's care and support. Where some were not so personalised, for example in the case of one person who had not lived at The Coombs for long, the content still identified where they required support. They gave sufficient guidance to staff to be able to deliver safe and appropriate care.

People received the care they required and in a way they wanted it delivered. People were listened to and their diverse needs met. One person said about their care, "They [staff] know how I like things done." Another person said, "I'm happy with my care." A further person said, "They look after me well." One person's relative told us they were 98 percent happy with the relative's care. They told us about a few things they wished were done differently. We advised this person to organise a care review meeting with the care staff, where these things could be discussed. This was organised with the relative straight away. These meetings took place every six months or when needed, but had not happened yet for this person. We saw records of these having taken place with other people receiving care, or where people wished or where it was appropriate to do so, with their relative/representative.

People's needs were assessed and their expectations were discussed prior to moving into the care home. We saw detailed pre-admission assessments which had been completed by the registered manager. They visited people either in hospital or their own home prior to people moving to The Coombs. This assessment allowed the registered manager and her senior team to decide if they could meet a person's needs. Information gathered at this point was relayed back to the rest of the team who then prepared for the person's admission. Some admissions were emergencies. In these cases as much information as possible was gathered about a person's needs, so staff were as prepared as they could be for the person's arrival. The registered manager explained that sometimes people and family members reached a crisis point and a pre admission assessment had to be done quickly. They said, "We will always try and support people in situations like this."

People's choices and preferences around what activities they took part in had been thoroughly explored

with them. Although we did not meet the activities co-ordinator during the inspection, people spoke highly of her. This member of staff had been nominated for a regional award and commended at the provider's national awards for "outstanding contribution" for their work in making activities more meaningful to people. People told us they "always enjoyed" the activity they took part in. One person said, "There's lot's to do." Another person had become the resident spokesperson and they helped support people with their activities. They told us they reminded people what was on at various times of the day or week. They showed us a printed timetable of planned activities which went out to everyone.

Activities were planned by the people and the activity co-ordinator and other activities were chosen by the group that met on the day. The activity co-ordinator had built up relationships with external theatre groups, entertainers and art groups. In 2016 they had organised for the care home to be part of an arts council funded scheme called 'The Making of Me'. Professionals from drama, dance and poetry visited the care home across ten weeks and ran groups in these areas of art. In 2017 people had wanted to continue with some of these areas of art. In particular a poetry group had formed and had been led by a person who no-longer lived at The Coombs. In memory of this person, people named the group Evelyn's group and subsequently links were made with a local poet. This person visits the care home on a regular basis and supports people to write and appreciate poetry. One person we spoke with told us they had joined this group since arriving at the care home and enjoyed it. The registered manager explained that people living with dementia also belonged to this group. They said, "It is when you listen to some of the writing that you then appreciate what is inside a person who lives with dementia."

The activities co-ordinator also organised music and singing groups which were well attended. We observed one person sitting each day, in a particular part of the care home, playing their choice of music. Making activities meaningful had been successful at The Coombs because all the staff recognised the importance of this to people's quality of life. One person told us about their plans to grow vegetables next spring/summer. They said, "I'm going to be given a little plot of garden to grow radishes and spring onions." The registered manager told us that one member of staff regularly supported people's activities by staying on in their own time.

People were able to make a complaint, have this listened to, investigated and resolved. The provider's complaints procedure was seen in the reception area. It was also in the 'Residents Handbook' which contained useful information for people. A copy of this was in each person's bedroom. One person had not been made aware of this on admission but this was rectified during the inspection. We fed this back to the registered manager who told us people were usually shown this but they would ensure this did not get missed in future.

Three complaints were recorded since the last inspection; two verbal and one written. All had been responded to within the provider's timescale of 28 days. One complaint had involved a breakdown in communication between staff and a relative. This had been fully investigated and an apology given to and accepted by the complainant. Another had been around the length of time a person waited for help after ringing their call bell and then staffs' responses once this was answered. The third complaint was in response to how an agency nurse responded to a relative's query. All investigations were recorded as were the actions taken to resolve these. In response to concerns raised, one agency nurse had not been used again and a reflective session was carried out with 18 staff on language and tone used when responding to concerns/complaints.

Good

Is the service well-led?

Our findings

The registered manager provided strong leadership in a quiet and supportive way. Staff spoke highly of her and were committed to her values and visions for the care home. One member of staff said, "[Name of registered manager] wants 150 percent for the residents." Three other members of staff made comments which included "very approachable", "will always help out if she can" and "you can talk to her about anything." One health care professional commented, "The Manager [name] is a very caring person." One person said, "[Name of registered manager] visits the units most days, sometimes more than once, to see how people are." Following the death of one person the registered manager visited the unit to speak with people who lived there and to see if the staff were alright.

Since the last inspection the registered manager had made alterations in how she and various staff got together to discuss things. On a daily basis she now met with the staff leading teams and areas of work. She told us this was a short meeting which provided a recap on who was 'resident of the day', what was planned for that day in each department and a catch up on previous issues. 'Resident of the day' involved one resident's care and welfare being reviewed by all departments. For example, the maintenance person and registered manager reviewed all aspects of health and safety for that person, the cleaning team would focus on a deeper clean of the person's bedroom if this was acceptable to them, the kitchen staff would speak with the person to make sure they were meeting their likes and dislikes related to food. The care staff would review all care plans, risk assessments and aim to have a discussion with the person about their care.

Minutes of other meetings showed that regular meetings were held with all staff. Meetings were also held with residents and relatives. In staff meetings, issues relating to the care home, care practice and staff terms and conditions were discussed, but also safety alerts were shared by the provider. These included, for example, a discussion about any serious incidents which had occurred in other care homes nationally. These incidents were reflected on for learning purposes and staff made aware of new actions or changes in practice where needed. In the last staff meeting a representative of the provider had been present to discuss with staff the results of the last staff survey. A group of staff within the provider's services had set up a voluntary helpline for staff to be able to raise concerns around pay, reward and recognition. This group would ensure staff comments/concerns were communicated back to the provider's senior management team. One member of staff in the care home had a particular interest in staff welfare and was available to support staff where needed. There were opportunities for people, relatives and staff to be involved in making decisions and suggestions about how the care home ran. The resident spokesperson told us they represented people at the resident and relative meetings. They would take forward a comment or suggestion on behalf of someone, if that person did not wish to or could not do so in person.

There had been some changes to the care home's senior management team. The registered manager had a newly appointed deputy manager who was getting to know what was needed for their role. They were being supported by an experienced nurse who had the knowledge to do this. All three senior staff complemented each other in skills and knowledge. They were supported by team leaders, senior care staff and an administrator. Staff told us the wider team worked well together and that they felt valued by the senior staff in the care home.

There were systems in place to monitor the quality of care provided and to ensure the care home remained compliant with necessary regulations. Audits were completed to help staff review areas such as infection control, care planning, medicine management and health and safety. We reviewed these audits and saw that necessary improvements were identified and an action set to achieve these. Actions were transferred onto the care home's improvement plan.

During the inspection one care plan (which had not yet been captured in an audit) had not been adequately written or reviewed. This had not had an impact on the person it was about but potentially could have had. A thorough review of what had been missed was carried out and an improvement plan, which would prevent a further similar situation, was forwarded to the inspector. Staff took an open and transparent approach to rectifying this and were keen to learn from this situation in order to make further improvements. A representative of the provider carried out a monthly review of the audits completed by the home and of previous actions. Any actions from this were added to the overall improvement plan. The provider also carried out an annual quality review assessment. This was carried out by the provider's internal quality monitoring team and assessed the service on all areas of compliance and provider performance indicators. Actions from this were added to the overall improvement plan by the registered manager. We saw evidence of these actions being worked through by the registered manager. These monitoring processes were effective because they identified areas of improvement and gave timescales for actions to be met. Actions were subsequently followed up and improvement evidenced.

The registered manager kept themselves up to date with best practice by attending all refresher training provided by the provider. They read relevant journals and attended other meetings, such as internal manager meetings where best practice was discussed and ideas were exchanged. The staffs' and registered manager's involvement with numerous health and social care professionals also helped to keep the staff teams knowledge up to date.