Care Quality Commission

The Orders Of St. John Care Trust

OSJCT Buckland Court

Inspection report

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22 August 2022

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Ratings

Overall rating for this service	Inspected but not rated
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
OSJCT Buckland Court is a care home without nursing for up to 50 people. People had their own rooms and access to communal rooms such as bathrooms, dining rooms and lounges. People had access to outside space as the home had large gardens around the building. At the time of the inspection there were 34 people living at the home, some of whom had dementia.

People's experience of using this service and what we found
Improvements had been made to the management oversight of the service. The provider had developed detailed action plans to address the shortfalls identified at the last inspection. The plans included information about who was responsible for completing actions and had been regularly reviewed to ensure they were on track. Progress to complete actions was overseen by the area operations manager.

The management team had reviewed all incidents in a timely way. Records demonstrated actions had been taken to learn from incidents and reduce the risk of a similar incidents happening again.

The registered manager had reviewed the medicines administration procedures with staff and identified the reasons for errors identified at the last inspection. Changes had been made to the way staff worked, to ensure they provided the support people needed. This had resulted in a reduction in the number of medicines errors in the service. When errors had occurred, detailed reviews had been completed to understand the reason for the error and plan further actions to address the issues.

There were a series of audits, to assess how key aspects of the service were operating. These included assessments of the medicines management systems, care planning, risk assessments and observations of staff practice. Actions from the assessments had been followed through to ensure improvements were implemented by all staff.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 27 July 2022)

Why we inspected
We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted

inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?	Inspected but not rated
At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.	

Care Quality Commission

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Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was completed by two inspectors.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including action plans submitted by the provider. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service,

what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We reviewed records relating to risk management for three people, incident records and management auditing records. We spoke with the registered manager and area operations manager.

Inspected but not rated

Is the service well-led?

Our findings

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

At our last inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to have effective systems to assess, monitor and improve the quality of the service provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● The provider had developed detailed action plans to address all the shortfalls identified at the last inspection. The plans included information about who was responsible for completing actions and had been regularly reviewed to ensure they were on track. Progress to complete actions was overseen by the area operations manager.
● The registered manager, or one of the management team, had reviewed all incidents in a timely way. Records demonstrated actions had been taken following incidents to reduce the risk of a similar incident happening again. Examples included use of equipment to alert staff to people's risk of falling and more frequent wellbeing checks put in place to ensure people were safe. The area operations manager had monitored how incidents were being followed up by the management team to ensure action had been taken to keep people safe.
● The registered manager had reviewed the medicines administration procedures with staff and identified the reasons for errors identified at the last inspection. Changes had been made to the way staff worked, to ensure they provided the support people needed. Checks of the medicine management systems were being completed at the end of each medicines round. This enabled prompt action to be taken if there were any missed medicines or if staff had not completed records accurately. This had resulted in a reduction in the number of medicines errors in the service. When errors had occurred, detailed reviews had been completed to understand the reason for the error and plan further actions to address the issues. Actions included additional training for staff, assessments of staff competency, observation of staff practice and action to minimise distractions for staff supporting people with medicines.
● There were a series of audits, to assess how key aspects of the service were operating. These included

assessments of the medicines management systems, care planning, risk assessments and observations of staff practice. Records demonstrated these audits had identified shortfalls in the way some systems were working and identified how improvements could be made. Actions from the assessments had been followed through to ensure improvements were implemented by all staff.