The Orders Of St. John Care Trust

OSJCT Rodley House

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

The inspection took place over two days on 29 and 30 November 2016. The inspection was unannounced. The last inspection took place in September 2014 and no breaches of legal requirements were found at this time.

The home provides nursing care and accommodation. At the time of our inspection there were 36 people living in the home.

There was a new manager in place who had begun the registration process. 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 supported by staff who were kind and caring in their approach. We made observations throughout our inspection of people being treated with respect and kindness. People and their relatives were positive about the care provided in the home and told us they were involved in planning and reviewing their care. Comments included "Staff are very very good", "I have trouble with my mobility but staff are only too pleased to help", "I like it here", "staff are lovely" and "I think it's a happy place".

Care and support was tailored to people's individual needs. For one person we saw how the manager had sourced equipment to help them with a particular health need. Care plans required some attention in places to ensure they were accurate and up to date; however they described people's needs and provided guidance for staff in meeting their particular needs.

Care and support was effective. People's health needs were met and they were able to see healthcare professionals when they needed to. People who were at risk of pressure damage to the skin had specialist mattresses in place and we saw that these were at the correct setting. Where people had particular clinical needs, such as the use of a catheter, there were clear plans in place for how this should be managed.

People's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS). Applications had been made for a number of people in the home. For those people who lacked capacity to make their own decisions about their care and support, best interests decisions had been taken on their behalf. We did highlight with the manager that in some cases, although people's rights had been protected, the principles of the MCA had not been followed in full.

People in the home were safe because staff had received training in how to safeguard people from abuse. There were also risk assessments in place to guide staff in providing safe care and support. There were sufficient numbers of staff to ensure people were safe and their needs were met.

People were able to take part in a programme of activities if they wished to. This included activities such as knitting, holistic therapies and helping with aspects of the running of the home. For example, we saw one person being encouraged to take part in food preparation.

The home was well-led. There was a programme of quality monitoring and audits in place and this included gathering feedback from people who used the service. There was a culture of openness and transparency in the home and there were plans in place to improve the service further.

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

Staff were trained in and aware of their responsibilities to safeguard people in the home.

There were enough staff to ensure people were safe and their needs were met.

There were risk assessments in place to ensure staff received guidance in supporting people safely.

People received safe support with their medicines.

Is the service effective?

Good

People's rights were protected in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to see healthcare professionals when necessary.

People received support to maintain good nutrition.

Staff were trained appropriately and received supervision in carrying out their role.

Is the service caring?

Good

The service was caring.

People experienced kind and caring relationships with staff.

People and their relatives were involved in planning and reviewing people's care.

Is the service responsive?

Good

The service was responsive.

People were treated as individuals with their own needs.

There was a programme of activities in place for people to take part in if they wished to.

There was a procedure in place to manage formal complaints.

Is the service well-led?

Good

The service was well led.

There were plans in place to make improvements to the home.

A programme of quality monitoring was in place and this included gathering feedback from people in the home.

There was an open and transparent culture in the home.

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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 29 and 30 November and was unannounced.

The inspection was undertaken by 1 inspector. At the time of our inspection there were 36 people living in the home. Prior to the inspection we looked at all the information available to us, including notifications. Notifications are information about specific events which the manager is required to send us by law. The provider also submitted a Provider Information Return (PIR). This is a form filled out by the provider and gives information about things the service does well and improvements they plan to make.

During our inspection, we spoke with four people who use the service, four relatives, five members of staff, the manager and a peripatetic manager from the organisation. We looked at the care records for four people in the home as well as other records relating to the running of the home such quality monitoring records, complaints and medicine administration records. We made observations throughout the inspection of how people were supported and cared for.

Good

Is the service safe?

Our findings

People in the home told us they felt safe. We noted that people had access to an alarm if they needed staff support in an emergency. During our inspection we heard the emergency alarm sound and staff reacted quickly to check on the person. Staff confirmed that had received training in safeguarding vulnerable adults from abuse and told us they felt confident and able to report concerns if they had them. We saw certificates in staff files as evidence the training had been completed.

There were sufficient numbers of staff on duty to ensure people were safe and their needs met. During the day there was one nurse on duty, one care leader and six care assistants. Overnight there were three care staff and one nurse. People told us that there was usually a staff member available to help them if needed and that they didn't have to wait too long. We observed staff spending time with people outside of care tasks. The manager told us they were recruiting for more nurses but this was proving difficult despite an advert being out for some time. We were told that agency staff were used but where possible, the same staff were booked so that there was continuity of care for people in the home.

Systems in place for storing and administering medicines were safe. Medicines were stored in locked trolleys so that they weren't accessible to people who weren't authorised to do so. Medicines requiring additional security were stored appropriately. Within the medicines trollies, individual's medicines were stored in boxes with the person's photograph on the front so they were easily identifiable. Medicine Administration Record (MAR) charts were in place to record when people had been given their medicines. Of the sample of MARs we reviewed, these had been completed accurately. Any medicines that had been declined were stored securely in bins and locked away until collection from the pharmacy. Records were kept of the medicines that were returned. We checked the stock balance of two medicines and found these to be correct according to the records.

Some people in the home had medicines prescribed 'as needed'. Where this was the case, there were clear protocols in place for their use, stating the maximum dose that could be given. Some people had creams and ointments applied to their skin. Where this was the case, we saw that a form was in place so that staff confirmed when this had been done.

Risk assessments were in place to support staff in providing safe care for people. For example we saw that people were weighed and assessed monthly using a nationally recognised tool, to identify those who may be at risk of malnutrition or obesity. A tool was also used to assess the risks associated with people's skin and whether they were at risk of developing pressure sores. Where a risk had been identified, there were measures in place to minimise the risk. For example, some people had pressure relieving mattresses in place in relation to their risk of skin damage. Where people had bed rails in place, there was a 'risk balance' tool in place to identify any potential concerns with their use.

There were recruitment procedures in place to ensure that staff were safe and suitable for their role. We checked the files of four recently recruited and saw that references from past employers had been sought. There was also a Disclosure and Barring Service check (DBS) in place. A DBS check provides information

about whether a person has any convictions and whether they are barred from working with vulnerable adults and children. For the nurses employed by the service, we saw a copy of their professional registration number was kept on file.

Accidents and incidents were recorded and submitted on a computer system. The manager looked at each incident and told us they wouldn't close the incident on the system until they were satisfied that appropriate detail had been recorded. The computer system produced data that allowed the manager to identify any trends in the types of incidents that were occurring. The system had helped the manager identify particular times in the day when incidents were occurring and told us they were planning to address this with staff at the next staff meeting.

Good

Is the service effective?

Our findings

There was evidence that people's rights were protected in line with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This is legislation that protects the rights of people who are unable to make decisions independently about their own care and support. DoLS provides a framework to ensure people's rights are protected if they need to be deprived of their liberty in order to receive safe care. DoLS applications for people in the home had been made for those that required them.

When decisions were made about people's care, we saw that the principles of the MCA had been followed. For example, where bedrails were in use, the person's capacity to consent had been assessed and if necessary a best interest decision made on their behalf. In one case, it was recorded that other options had been discussed with the person but they had expressed that they felt safer with the bedrails in place. We did find occasions, however when the principles of the Act had not been followed in full. In one person's care records we saw that a sensor mat was used, however there was no records of the person having consented to this, or a best interests decision being made. The manager told us that the sensor had been used for the person's safety when they had been in a room upstairs but was no longer in use since the person had moved downstairs. The person's care plan was updated by the second day of our inspection to reflect this. We also noted that when this person had moved room, discussion had taken place with relatives and relevant professionals so that a best interests decision was reached. However, there was no mental capacity assessment in place prior to the decision being reached.

People's health needs were clearly documented and met. In the care records of one person, we saw that they had a catheter in place. It was stated in the care plan that this needed to be changed every 12 weeks and there were records to show that this had been completed. The catheter also needed to be cleaned once a week with a prescribed solution and this was recorded on the person's MAR chart. For a person that experienced epileptic seizures, there was clear guidance in place about how to manage these and when emergency help should be sought. Guidance included when and what dose of medication should be administered. Records were also kept of each incident of a seizure so that this could be monitored and any concerns relating to the seizures identified and reported. Some people were at risk of pressure damage to the skin and had specialist pressure relieving mattresses in place. We checked the mattress settings for two people and saw that these were correct.

People were supported to see other healthcare professionals when required. For example, we saw for one person that the GP had been contacted when there were concerns about an infection Another person was seen by the district nurse in relation to a skin wound.

People received the support they required for their nutritional needs. We observed that in each of the lounges, there were snacks and drinks available including fresh fruit, biscuits and crisps. Any particular dietary needs were described in people's care plans, for example if there were any concerns about the person's weight or if they needed a soft textured diet. If necessary, we saw that specialist input was sought from the Speech and Language Therapist. We did note however in one person's plan that their diet should be fortified to add extra calories; this is usually advised when a person is at risk of malnutrition. However in

this case the person was not identified as being at risk according to their monthly assessment. We queried this with the manager who identified that there had been a period of weight loss in the past but there were no current concerns. The manager subsequently updated the care plan and spoke with the staff responsible for food preparation.

People and their relatives were generally positive about the food on offer. One person commented that their relative had put on a significant amount of weight since moving to the home.

Staff reported feeling well supported in their role and that they had received all the training they needed to carry out their role. It was difficult to obtain an overall picture of the training that staff had completed as the training matrix was not up to date due to technical difficulties with the computer system. However, we checked the files of three care staff and saw that certificates were in place as evidence that relevant courses had been completed. For example, in safeguarding vulnerable adults, MCA and DoLS, and dementia care.

Staff told us that communication was good amongst the team and they were given all the information they required at times such as handover and staff meetings. Staff showed us handover sheets that they carried with them on duty. This contained key pieces of information about the people they were supporting, such as any particular changes in need or illness they were experiencing. Staff commented this was a useful way of keeping up to date.

Good

Is the service caring?

Our findings

People and their relatives reported being very happy with the care they received at the home. Comments included "Staff are very very good", "I have trouble with my mobility but staff are only too pleased to help", "I like it here", "staff are lovely" and "I think it's a happy place".

Family and friends were able to visit at any time so that people could maintain relationships that were important to them. Relatives confirmed that they were able to visit when they wished and had never experienced any problems being able to see people in the home.

People were supported by staff who were kind and caring in their approach and who treated them with dignity and respect. We made observations throughout our inspection of staff carrying out their role with affection and care for the people they were supporting. On one occasion we saw staff support a person with moving and handling equipment. Staff spoke to the person throughout to explain what they were doing and to reassure the person. The person appeared settled and relaxed whilst they were being supported. On another occasion we saw staff supporting a person with their midday meal, and shared a joke with them, both the person and staff clearly enjoyed the exchange.

In people's care records, we saw that their preferred name was checked and made clear. We heard staff addressing people with their preferred name. We also heard staff frequently use terms of endearment such as 'darling' or 'sweetheart'. These terms were used in a caring context and for many people may be entirely appropriate; however, we discussed with the manager how it would be best practice to check whether people are happy to be addressed in this way.

People were supported to maintain their independence and daily living skills. This was detailed in care plans. For example, in one plan we saw that the person was able to wash and dry their face as part of their personal care routines. One person told us that although their relative wasn't physically able to carry out much of their own care, they were given choices when possible, for example about what to wear. We observed that when staff supported people to be seated in the lounge, people were asked where they would like to sit.

People and their relatives told us that they were asked about the preferences for the ways in which they were cared for. One person for example, told us they'd been asked about their preferred meals. A relative told us, that although they hadn't been able to attend, they had been invited in to a meeting with their relative's keyworker. A senior care assistant told us how they planned a person's care with them by sitting out in the garden with them and discussing what they would like to be in their plan. Although it was clear from our discussions that people were asked about their care and support, we did discuss with the manager how it wasn't always clear from reading people's records that this was the case.

People were given opportunity to express their views and opinions. Resident and relatives meetings took place. From the minutes of the meetings, we read that people were asked for their feedback on the menus and whether they would to take part in 'taster days', to sample future meal ideas. People were also given

opportunity to put forward suggestions and ideas. There was also a 'postcard' system for people to provide feedback. A record of these comments were kept and we noted a number of positive comments including 'The care is sensitive and very supportive. The management are happy to listen to our concerns and to act upon them, we could not ask for any more', and 'I have lived here now for six years, I really enjoy it, it's a lovely place'.

People had opportunity to express their views at review meetings where their care was discussed and any changes in need identified. We saw records of these meetings where people's views and opinions had been recorded.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. Care was person centred and people were treated as individuals with unique needs. We saw one person, who due to a particular health condition often preferred to be on the floor rather than seated in a chair. The manager told us how they had sourced and purchased a floor cushion for the person so that they could be comfortable in their preferred position. The person frequently used the cushion throughout the day. This was a clear example of the home responding to a person's particular need.

We noted at the midday meal, people were served their meals on a plate size of their choosing as for some people a large portion discouraged them from eating. Staff also told us about how there were people that they encouraged to sit near to each other as they encouraged each other to eat. For one person, we were told this had proved particular helpful in supporting them to eat more.

One person told us about how the home understood their relative's preferences and needs. For example there was a particular type of clothing that they liked to wear and the home had bought them this for their birthday. The person told us that staff understood how their relative liked to be dressed.

People's had care plans in place that covered various aspects of their support, for example their mobility needs, communication and emotional needs. These gave clear information about the ways in which the person should be supported. For example, in one person's plan it stated that staff needed to support the person with their verbal communication and this could be done with the use of pictures. We did find examples however of areas of care that would benefit from further detail. For example, we found one person who presented with behaviour that was potentially difficult to manage. There was a standard document in place that guided staff in managing behaviour and recordings made of any incidents. However, the plan wasn't individualised to include the specific strategies for the person concerned. On the second day of our inspection, we saw that the manager had added more detail in to the person's file.

There was a document in place in people's files entitled 'all about me', this contained information about the person's individual preferences, for example their preferred routines, what they like to read and what they liked to watch on TV. There were notes on the document to show that it had been completed in discussion with the person concerned and their relatives if appropriate.

There was a programme of activities in place for people to engage in if they wished to. We spoke with the activities coordinator who was clearly enthusiastic and passionate about their role and was in the process of gaining further qualifications in dementia care. They told us about how they incorporated the work of experts in the field of dementia in to their work. During our inspection we saw that people were encouraged in a knitting activity. People were also encouraged to take part in aspects of the running of the home, for example one person was asked to help with peeling carrots. We also saw the activity coordinator spending time with people outside of organised activities. For one person in the home, we read in their care plan that 1-1 time was important for their wellbeing as they weren't always physically able to attend formal activities. The activity coordinator told us about how they supported this person by taking other residents to their

room for a 'coffee morning', spending time talking with them about their favourite films and carrying out 'holistic treatments', such as reiki.

People felt confident and able to raise concerns and complaints. One person told us they would "talk to one of the bosses". Relatives told us about minor issues they had raised and felt that staff were approachable with any issues. There was a procedure in place for formal complaints. There was a complaints policy in place which outlined the timescales that should be adhered to in responding to complaints. There had been one complaint in the last 12 months and this had been responded to. As part of the process, the person who had complained had been invited in to speak with the manager to discuss their concern in more detail. This reflected an open and transparent approach to dealing with complaints.

Good

Is the service well-led?

Our findings

There were systems in place to monitor the quality and safety of the service provided. There were audits taking place on a regular basis that looked at specific areas of the service such as infection control, care plans and catering. These audits produced action plans that were then monitored by the manager. For example we saw that latest infection control audit had produced an action plan with a number of points to complete. This included cleaning of particular areas of the home and some items that needed replacing. There were notes on the audit to say when the action points were completed.

There was also a quality monitoring tool in place that looked at the home's performance against the areas that are covered at CQC inspections. For example, we saw that this included information about resident involvement, whether call bells were at hand for people and visitors were welcomed. Feedback from people was gathered through the use of an annual survey. The results of the survey were managed centrally by the organisation before being sent to the home. At the time of our inspection, the most recent results had not been published.

Regular team meetings took place with care staff and nurses. This was an opportunity to discuss important developments in the home and to discuss any issues or concerns. We saw from the latest meeting minutes that positive feedback was given to staff as well as areas of performance that required attention. We also noted that supervision had been discussed and the need to book in dates for all members of staff. This demonstrated an open and transparent approach to the running of the home.

The manager told us about the plans for improving the building they had recently had agreed. We were told that the outside garden were going to be made more user friendly with better pathways so that they were more easily accessible. On the upstairs floor, a patio was going to be built to give easier access to the outdoors for people on that floor. This reflected a culture of continual improvement in the home.

Staff and relatives told us they felt senior staff were approachable and supportive. One relative commented that they had frequently seen the new manager around the home and felt reassured by this. There was also support for staff from other senior staff within the organisation. For example, the manager told us that since arriving at the home, they had received support from a peripatetic manager within the organisation. Staff felt that the organisation as a whole was positive about providing good care. One member of staff commented about the organisation that "the residents are their priority".