The Orders Of St. John Care Trust

OSJCT Fosse 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

Overall summary

The inspection took place on 18 September 2015 and was unannounced.

OSJCT Fosse House is registered to provide accommodation and personal care for up 42 people. There were 41 older people living at the service on the day of our inspection.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect

Summary of findings

them. The management and staff understood their responsibility and made appropriate referrals for assessment, but no one at the time of our inspection had a current DoLS authorisation.

People felt safe and staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People praised the staff and staff told us that they were passionate about their roles

People were kept safe because staff undertook appropriate risk assessments and care plans were developed to support people's needs. The registered manager ensured that there were sufficient numbers of staff to keep people safe and care for their needs.

People were cared for by staff that were supported to undertake training to improve their knowledge and skills to perform their roles and responsibilities.

People had their healthcare needs identified and were able to access healthcare professionals such as their GP or district nurse. Staff knew how to access specialist professional help and emergency care when needed.

People met regularly with the head cook and had input into the menu plans. People were given a choice of nutritious and seasonal home cooked meals that were made from fresh ingredients. There were plenty of hot and cold drinks and snacks available throughout the day.

People were supported to make decisions about their care and treatment and staff supported people with disabilities to maintain their independence. People were treated with dignity and respect by kind, caring and compassionate staff and we saw that people were treated as equals.

People were treated as individuals and were enabled to follow their hobbies and pastimes. There were a wide range of activities provided both inside and outside the service. The service had formed strong links with the local community and people were involved with children and young people at all stages of their education. People told us that they looked forward to their visits.

There were systems in place to support people and their relatives to make comments about the service or raise concerns about the care they received. People and their relatives were encouraged to attend regular meetings with staff to discuss ways to improve the service. People and their families told us that the registered manager and staff were approachable.

The registered provider had robust systems in place to monitor the quality of the service. Staff received feedback on the outcomes of audits, lessons were learnt and improvements to the service were made. The service had received national accreditation for dementia care and internal accreditation for infection control and medicines.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were kept safe because they had their risk of harm assessed.

There were enough skilled and competent staff on duty to keep people safe from harm

Staff followed correct procedures when administering medicine.

Good

Is the service effective?
The service was effective.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities.

People were supported to have enough to eat and drink and have a balanced diet.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Good

Is the service caring?
The service was caring.

Staff had a good relationship with people and treated them with kindness and compassion.

People were treated with dignity and staff respected their choices, needs and preferences.

Good

Is the service responsive?
The service was responsive.

People were enabled to take part in a range of activities of their choosing that met their social needs and enhanced their wellbeing.

People's care was regularly assessed, planned and reviewed to meet their individual care needs and preferences.

People were supported to be involved with local community.

Good

Is the service well-led?
The service was well-led.

The service had developed strong links with the local community.

The provider had completed regular quality checks to help ensure that people received safe and appropriate care.

There was an open and positive culture which focussed on people and staff.

Good

OSJCT Fosse 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 checked 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 18 September 2015 and was unannounced. The inspection team was made up of one inspector.

Before the inspection we looked at previous inspection reports and other information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about We used this information to help plan our inspection.

During our inspection we spoke with the registered manager, the area operations manager, the head of care, four members of care staff and the head cook, eight people who lived at the service, six visiting relatives and one visiting healthcare professional. We also observed staff interacting with people in communal areas, providing care and support. Following our visit we spoke with the activity coordinator by telephone and asked the local authority for information in order to get their view on the quality of care provided.

During the inspection we looked at a range of records related to the running of and the quality of the service. This included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We also looked at the quality assurance audits that the registered manager and the provider completed which monitored and assessed the quality of the service provided. We also looked at care plans for four people and we undertook a Short Observation Framework for Inspection (SOFI) in the afternoon. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People and their relatives told us that they were safe living at the service. One person said, “I am all right. Quite content, no need to worry.” And another said, “Happy, safe and secure.” One person’s relative told us, “She is safe and well looked after.”

There were processes in place to provide staff with the skills, knowledge and information to keep people safe. For example, on the afternoon of our visit nine staff attended fire safety training with an accountable fire safety officer. We noted that an alert sign was prominently displayed on the front door raising awareness that oxygen was in use. In addition, each person had a personal evacuation plan.

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Staff were aware of what to do if they suspected that a person was at risk of harm or abuse. One member of staff said, “I would follow protocol. I would go to the care leader, head of care or the manager. We have a care plan were it is all documented.”

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such as, moving and handling and falls. Care plans were in place which enabled staff to reduce the risk and maintain a person’s safety. In addition, risk assessments had been undertaken for non- care and external events, such as crossing the road with a wheelchair, family visits with dogs and using a sewing machine.

There were systems in place to support staff when the registered manager was not on duty. Staff had access to a major incident folder that contained contingency plans to be actioned in an emergency situation such as a fire or electrical failure. There was also information on safe evacuation procedures to a nearby service registered with the provider. Staff had access to on-call senior staff out of hours for support and guidance.

The provider had a system for calculating the care dependency levels for the people who lived at the service. These dependency levels then informed the registered manager of how many staff with different skill levels were needed on each shift. The registered manager told us that people’s dependency levels were regularly reviewed. We found that there was sufficient staff on duty to meet people’s needs and call bells were answered promptly. We noted that the registered manager worked in addition to the amount of care staff needed on each shift. One person and their relative told us that staff were always popping in and out of their room to see if they were ok. Their relative said, "The housekeepers and carers are always popping in to see that she is fine.”

There was a robust recruitment processes in place that identified all the necessary safety checks to be completed to ensure that a prospective staff member was suitable before they were appointed to post. We found there were safe recruitment processes in place for volunteer staff and they had the same level of security checks as permanent staff.

Medicines had been given consistently and there were no gaps in the medication administration records (MAR). Each MAR chart had a photograph of the person and allergies and special instruction were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person was asleep. We found where a person managed some of their own medicine that a protocol was in place and this was reviewed every six months. When a person was prescribed cream to be applied to their skin a body map was in place and identified the areas where cream was to be applied, to minimise the risk of errors.

People received their medicine from staff that had received training in medicines management and have been assessed as competent to administer them. We observed the lunchtime medicines being administered and noted that appropriate checks were carried out and the MAR charts were completed.

All medicines were stored accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people’s medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned. Staff recorded on the label the date when a medicine was opened. In addition, a senior member of care staff was the nominated medicines lead and was a resource to other care staff and people.

Good

Is the service effective?

Our findings

People and their relatives spoke highly of the staff and told us that staff had the skills to look after them. A relative of a person with communication difficulties spoke on their behalf and said, "Staff are wonderful, very kind, experienced staff have the skills and the younger ones are learning, one young girl is absolutely marvellous. They are special." One relatives, said, "We have no complaints; they are very caring and know what they are doing."

We found that staff had the skills to meet people's needs and provide effective care. We observed a person being transferred by hoist from their arm chair to a wheelchair. Care staff explained each step of the procedure to the person and asked the person several times, "Do you feel safe and are you ok." Care staff supported the person throughout and praised them for their efforts.

Staff were provided with training in areas such the care of a person living with dementia, safeguarding, deprivation of liberty safeguards and dignity. In addition, several staff were supported to work towards a nationally recognised qualification in adult social care. A staff member said, "The organisation is excellent with training. They give you the opportunity to climb the ladder." Furthermore, all staff new to the service undertook a six month probationary period that included a 12 week induction programme, where they completed a 'Back to Basics' workbook with the supervision of a mentor and also shadowed experienced care staff before they worked on their own.

Staff were supported through regular supervision and they received an annual appraisal. The head cook said, "In the kitchen we have group supervision We are open and honest and everyone knows how we feel. Staff are encouraged to speak up." A member of care staff said, "Appraisals are worthwhile, good two way feedback and positive feedback. Put at ease. Don't feel threatened by it."

We observed that people's consent to care and treatment was sought by staff. People had signed their consent to have their care plans in their bedroom and to have their photograph taken for identification purposes. Where a person lacked capacity to give their consent staff acted in their best interest and a mental capacity assessment had been undertaken.

We spoke with the registered manager, head of care and care staff about their understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The MCA is used to protect people who might not be able to make informed decisions on their own about the care or treatment they receive. Where it is judged that a person lacks capacity then it requires that a person making a decision on their behalf does so in their best interests. We saw there was a policy to support the DoLS and MCA decision making processes. The registered manager and staff were aware of MCA and DoLS.

Some people had chosen to make advanced decisions about the care they did not want to receive in a medical emergency or at the end of their life. We found that they had a do not attempt cardio pulmonary resuscitation (DNACPR) order stored at the front of their care file. This ensured that their wishes were respected. A DNACPR is a decision made when it is not in a person's best interest to resuscitate them if their heart should stop beating suddenly.

People were provided with a well-balanced and nutritious diet. In addition, hot and cold drinks were available throughout the day and bowls of fruit and snacks were provided in the communal areas. One relative appreciated this and told us, "The grapes and crisps are free." People were given a choice of where they took their meals, some choose the dining room and others preferred to take their meals in the lounge or their bedroom. People told us that the food was good. One person said, "No complaints. Can have a cup of tea at any time, very good food."

We observed lunchtime and saw that people were offered a choice of main course. Overall we found that lunchtime was a positive experience. People were supported to eat their meals without being disturbed. The service had a protected mealtime policy and a sign was on the dining room door alerting visitors not to interrupt people at mealtimes. We saw that some people had requested alternatives to the daily menu. For example, one person had a fried egg. After lunch people told us that they had enjoyed their meal, had enough to eat and that the food was good.

The head cook explained that people were offered a choice of meals from a four week menu plan, and seasonal changes would be made to the menus in October. The head cook attended resident meetings, where people shared their ideas about changes to the menus. In addition, people' completed a dietary advice sheet provided by the head cook so as their likes and dislikes

Good

Is the service effective?

could be catered for. Furthermore, it identified foods that the person may react to. For example, we saw recorded on one person's dietary sheet, "Not spaghetti bolognaise – upsets stomach."

People assessed as being at risk of malnutrition or dehydration had their food and fluid intake monitored and actions were taken. For example, we saw that one person who had been referred to their GP for weight loss had been prescribed regular nutritional supplements. The head cook told us that they fortified some dishes with butter, milk and cream to support people who may be at risk of weight loss or malnutrition. Furthermore, all dishes, including cakes and puddings were homemade and made with fresh ingredients. We looked at food intake charts for six people and found that they provided an accurate record of the quantity of food offered and eaten.

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, speech and language therapist and district nurse. Staff were also aware of action to take in an emergency medical situation. We noted that a person who was unwell at lunchtime was assessed as needing medical assistance and the person's GP was contacted. Furthermore, people living with dementia and their families had support from a specialist nurse in dementia care, called an Admiral Nurse, appointed by the provider.

We spoke with a healthcare professional who regularly visited the service. They told us that information about a person's well-being was shared at each visit and recorded in their care file to ensure the person received ongoing support and treatment for their health problems. They said, "The staff are pretty good, turn charts and fluid charts are kept up to date in the person's room."

Good

Is the service caring?

Our findings

People told us that they were well cared for. One person said, "Well looked after, can have what you want, everything is good here, ever so friendly." Another person said, "We have good banter. I have a good rapport with all the staff."

A relative told us that they felt reassured that their loved one had a key worker who was very good to both of them. They said, "I can visit her at any time, we can go to her room, and they always give us a cup of tea. They are good to me too." Another relative of a person who had lived at the service for many years said, "There have been a few issues over the years, but mainly they are very good."

Care staff told us how they built good relationships with people and care staff who were key workers explained their role to us. A key worker takes overall responsibility for most aspects of a person's care. A staff member said, "I book GP appointments and liaise with their family."

We found that all staff treated people with kindness and compassion. For example, we saw when one person lost their way in the corridor that two housekeepers stopped what they were doing and supported the person to the lounge. They person was soon reassured and we heard them chat and laugh with the housekeepers. Staff supported people to do things in their own time. We saw one person sat in the dining room mid-morning, after breakfast. They told a member of care staff that they were not yet ready to get dressed. The staff member offered them another cup of tea and said to us, "I will come back to [person's name] when he has had his tea and ready to get dressed." We noted that the staff member kept their word and when the person had finished their cup of tea they assisted them to their bedroom to get dressed. At lunch time we observed that one person remained at the dining table after others had moved through to the lounge areas. We were told that this was because they did not want assistance to eat their meal and staff respected their wishes. We saw that their care plan recorded that they were a slow eater, did not want help and wanted to maintain their independence. We saw that kitchen and care staff frequently asked the person if they were ok and if they wanted anything else.

Leaflets on the role of the local advocacy service were on display and accessible to people and their relatives. These provided care staff and people and their relatives with information on how to access an advocate to support a person through complex decision making. For example when a person permanently moved into the service. We found that one person had an advocate appointed. In addition, people and their relatives had access to information leaflets issued by national charities that provided them with guidance on how to live well with dementia.

We saw that small gestures of kindness and respect helped to maintain a person's privacy and dignity. For example, at lunchtime staff offered people a choice of tabard or napkin to protect their clothes from spills. Furthermore, when staff interacted with people they spoke with them appropriately and treated them with dignity and respect at all times. We observed that before staff entered a person's bedroom they knocked on their door and called out hello. In addition, bedroom doors were closed when a person was receiving personal care.

Staff had access to a designated dignity champion who provided staff with up to date guidance on how to respect a person's privacy and dignity. In addition, there was up to date dignity information near the main entrance accessible to staff, people and their visitors.

Good

Is the service responsive?

Our findings

We found that people were encouraged to spend their time how and where they wished. Some people choose to sit in their bedroom listening to music and reading. A person who chose to spend their time in their bedroom told us, "I have my meals in my room, I don't like being downstairs. I'm not lonely, I just don't like crowds." Other people returned to their bedroom from the lounge when their visitors arrived so as they could spend time together.

People told us that they could personalise their bedroom and one person told us, "My room is comfortable." Another person's relative said of their room, "Perfectly acceptable." Some people invited us to look at their bedroom and we found that most bedrooms had personal possessions such as small pieces of furniture, photographs and keepsakes.

Different resources were used by care staff to learn about people's likes and dislikes and care needs. Most people had a chart on display in their bedroom called, "All about me" that was used as a quick guide to their preferences. We saw that one person liked to listen to light music, but not too loud. However, when they felt unwell, they requested that they relax in bed where it is nice and quiet. More detailed preferences were recorded in a people's care files and their life histories had also been recorded.

People had care plans tailored to meet their individual needs and they were encouraged to take part in reviews of their care plans. However, if a person was unable or did not want to be involved their relatives were invited to the reviews. One person's relative told us that their loved one was no longer able to contribute to their care plans, so they attended regular care reviews on their behalf. We saw that when changes to a person's care needs were identified at their review that actions followed. For example, we saw where a person's ability to mobilise had deteriorated and that a new wheelchair had been ordered.

There was a shift handover system in place where staff exchanged information about people and the environment. One staff member said, "Handover is important. We need to know what is going on, any changes with care or mobility, any safety issues with equipment." Another said, "Every day is different and they change on a daily basis." We looked at the previous week's handover sheets and noted that they recorded when a person was in hospital, on a family outing or if care and treatment had been declined and action taken.

We found that people were supported to maintain their hobbies and interests and also develop new skills. For example, one person shared how they had found a new interest in drawing and were supported in this by visiting school children. They said, "Children from school come in and talk to me two or three times a week. I get help with my painting and drawing." The person was proud of their achievements and added, "When I first came in I couldn't draw a straight line." In addition to visiting schoolchildren, other supporters were involved with people. For example, one volunteer led a painting and colouring class, and a group from the local football club led an exercise class and armchair games.

We spoke with one of the activity coordinators who was enthusiastic about their role and how they enabled people to maintain their interests and pastimes and develop new skills. They said, "It's about doing something they [people] enjoy." They told us about the Friday knitting group, who have sold their creations at craft fayres, and the sports group led by one person's relative where they talk about football. They also told us about how talking with a person about their life story had led to the person meeting up for the first time in many years with an old wartime friend.

People participated in external activities and events organised by the provider's activity lead. Five people had recently attended a harvest festival, where scarecrows that they had made were on display. These events had led to good rapport between different services and people had made new friends through this. Regular themed fun evenings were organised and people, their relatives and staff dressed up. We saw that the corridor walls were decorated with tactile and pictorial decorations such as music and travel, reflecting different events that people, their families and staff had been involved in.

We found that people were supported to celebrate special occasions. One person had a birthday the previous weekend and had gone out to lunch with their family. When they returned to the service at tea time staff had a birthday cake with candles and people sang to them. Furthermore, one person was unable to leave the service to celebrate a family member's birthday, so to enable them to be involved, the family member's party was held in the service.

Good

Is the service responsive?

We saw a copy of the complaints and concerns policy was accessible to people and their visitors at the main entrance. In addition, each person had the provider's handbook in their bedroom that also contained useful information about the service including how to make a complaint. Furthermore, there was also a comments and suggestion box for people to give their thoughts on the service. People and their relatives that we spoke with said that they had no cause to complain. One person said, "No complaints. They are all nice to me." One relative said, "If mum had a problem she would tell me and I would deal with it."

Good

Is the service well-led?

Our findings

There was a positive culture of openness and equality and a sense of community. A sign on the front door read, "Welcome to our family." People and their relatives had access to a copy of the quality statement that focussed on the corporate values and behaviours of the provider.

We found several examples of practice where strong links had been forged with the local community to bridge the generation gap and for people to feel that they were part of the local community. For example, there were regular visits from work experience students from a local school and students working towards a national community award that chatted with people, read to them and supported them in their hobbies. In addition, young people with a learning disability and children from a local nursery school visited the service several times a year to entertain. Furthermore, people had taken part in an election campaign and had set up a mock polling station in their garden. Three local electoral candidates visited the service and shared their vision for the local community. On election day, the candidates had arranged transport for people to go to the local polling station to cast their vote. People told us that they enjoyed the voting experience and were given a cup of tea.

There was a regular programme of team and departmental meetings and staff spoke positively about the benefits of attending these meetings. We found that they could air their views and were listened to. One said, "I feel they [registered manager] care, makes you feel valued. Shift times have changed as a result and that is better for the residents."

A newsletter was issued every two months and people were invited to contribute to it. It provided information on recent and future events, shared birthdays best wishes and welcomed people and staff new to the service. People and their relatives were invited to have their say at a regular resident and relatives meetings and any changes or improvements identified were actioned.

Staff told us that the registered manager was approachable and they would go to them with a problem. One said, "I can go to [registered manager] and talk with them confidentially." A visiting healthcare professional told us the registered manager and head of care were approachable.

One staff member who was developing their role, said, "Very approachable, has helped me develop my confidence. Is good with ideas and lets me put them in place."

The registered manager was on a part time secondment, working with other senior staff from the provider organisation on a programme to drive improvements throughout the service. The registered manager told us that they were well supported by their area operations manager, other registered managers, their head of care and senior carers to maintain visible leadership and quality of care in the service during their absence.

The provider had an electronic process in place for staff to record accidents and incidents such as slips trips and falls and medicine errors. We found that incidents were investigated and lessons were learnt and shared through reflective practice meetings. For example, a recent incident led to the implementation of photographic guidance on the safe use of bed rails and bed bumpers. The registered manager and care staff told us what incidents were notifiable to CQC as part of the provider's registration requirements, for example when a person had a Deprivation of Liberty Safeguards (DoLS) authorised.

There was a programme of regular audits that covered key areas such as health and safety, medicines and infection control. Audits were delegated to different heads of department. For example, the head cook told us that they were responsible for undertaking a kitchen audit once a month. An annual care quality audit was undertaken on behalf of the provider. In addition, the area operations manager undertook monthly quality assurance visits and the registered manager completed a monthly report that included medicine incidents, falls and DoLS authorisations. The registered manager told us that the outcome of the quality audits and reports were shared with all the team, lessons were learnt and action plans were put in place.

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and reporting incidents and guidance on delivering personal care . Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager, local authority and CQC. One staff

Good

Is the service well-led?

member said, “I would follow protocol, I have previous experience.” We found that previous safeguarding concerns had been investigated by the registered manager and appropriate actions had been taken.

We found that the provider worked collaboratively with other agencies to implement new standards of care. For example, a senior member of care staff explained to us that they were trialling a new dispensing system in partnership with their local pharmacy. They had replaced pre-dispensed medicine packs with individual medicine boxes where each box has recorded the person’s name, prescribed medicine, dose and frequency on the label. At the time of our inspection no medicine errors had been identified.

The service had received accreditation for dementia care from a national charity that supports improving the life of people living with dementia. In addition, they have received internal accreditation for infection control and medicines. One staff member summed up what made them a good team. They said, “We are passionate about what we do.”