Care Quality Commission

Orders of St John Care Trust

OSJCT Whitefriars

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 26 January and 27 January 2015 and was unannounced.

OSJCT Whitefriars is registered to provide accommodation and personal care for up 57 older people or people living with dementia. There were 54 people living at the service on the day of our inspection. The service is divided into three areas, the main home that can accommodate 26 older people and two further areas, called Primrose and Jasmine where up to 28 people living with dementia are accommodated.

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 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.

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 themselves or others. At the time of the inspection one person had their freedom restricted lawfully.

Summary of findings

People felt safe and were cared for by kind and caring staff. 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. However, we saw that there were some areas where safety and security within the home could be improved.

People were supported to have nutritious and well-presented food. We found that there was choice and the availability of snacks and hot and cold drinks to ensure that people always had enough to eat and drink.

People were supported by designated activity coordinators to maintain their hobbies and interests. People told us that they were supported to maintain interests outside of the service and enjoyed trips out in the min-bus.

Staff were aware of people's choices and preferences and had the knowledge and skills to undertake risk assessments to provide for people's personal, physical, social and psychological care needs.

The provider had not identified that there were some weaknesses in the systems to monitor some aspects of the quality and safety of the service.

There was a positive culture in the home where staff enjoyed their work

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 not always safe.

There was not always enough staff on duty to respond to people's needs in a timely manner.

People had their medicines from skilled and competent staff.

Requires Improvement

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.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards. Staff had received appropriate training, and had an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

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

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 members respected their choices, needs and preferences.

Good

Is the service responsive?
The service was responsive.

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

People were encouraged to maintain their hobbies and interests including accessing external resources.

Good

Is the service well-led?
The service was not always well-led.

The provider had not always completed quality checks to help ensure that people received appropriate and safe care.

People and their relatives were able to give their feedback on the service they received.

Requires Improvement

OSJCT Whitefriars

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.

The inspection took place on 26 January and 27 January 2015 and was unannounced.

The inspection team was made up of three inspectors and an expert by experience that had experience of older people's care services. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection we looked at previous inspection reports and other information we held about the provider. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We used this information to help plan our inspection.

We looked at a range of records related to the running of and the quality of the service. This included staff training information, staff meeting minutes and information shared at care staff shift handovers. 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 reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. We used this information to help plan our inspection

During our inspection we spoke with the registered manager, the area operations manager, five members of care staff, the chef and two volunteers. We also spoke with 17 people who lived at the service, two visiting healthcare professionals and five visiting relatives. We also observed staff interacting with people in communal areas, providing care and support.

We looked at the care plans or daily care records for 12 people. A care plan provides staff with detailed information and guidance on how to meet a person's assessed social and health care needs. In addition, we undertook a Short Observation Framework for Inspection (SOFI) at lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Following our inspection we contacted the local authority for their views of the service.

Requires Improvement

Is the service safe?

Our findings

The provider had systems in place to manage risk but there were some shortfalls. We saw that people had risks to their wellbeing assessed before they moved into the service and these risks were regularly reviewed and any changes to their needs recorded in their care plan. For example, where a person was at risk off falls, measures were in place to keep them safe in their room. The provider had clear policies and procedures in place to guide staff in the safe management and reporting of accidents and incidents. The staff we spoke with understood their responsibilities in responding to emergency situations and managing untoward events such as a power failure. Furthermore, individual and group risk assessments had been completed for activities such as cooking and baking. However we did inform the manager that the level of risk identified was not recorded.

Although there were systems in place to ensure the security of people living at the service through shift handovers, fire door security checks and night time checks the previous four week's night time check lists were inconsistently completed. Staff had not recorded when they had checked to see if a person's sensor mat at the side of their bed was effective and one person who was present in the home that evening did not have their name on the list. This meant that there was no record that some people were checked at night. We observed shift handover from day staff to night staff and found that staff shared information verbally on the number of people living in the service, their care needs and that all fire doors had been checked.

We found that signage for one fire exit was obscured because a curtain had been drawn across. Furthermore the fire exit was inaccessible because three wheelchairs had been stored in front of it. This meant that the safe evacuation of people may be compromised in event of a fire.

There were times when there was enough staff; however, in the evening we observed that there were not enough staff to meet people's needs. We heard one person calling out that they were tired and wanted to be dressed for bed. Half an hour later this person had not yet been assisted and they were becoming distressed. Furthermore, we rarely saw staff in the lounge where some residents were watching television. One person was looking for a staff member and said, "I can't find anyone anywhere." Another person told us that they had been up very late because they could not get support to prepare for bed. This person said, "They might be short of staff, but that's not our problem, it's their problem." A regular visitor said, "Staff are under a lot of pressure, there are not enough of them but they do their best."

Staff told us that they felt there were generally enough staff on duty to provide the care required but they were very busy in the mornings and sometimes they could not answer call bells as promptly as they wished. This meant that staff did not always respond to a person's request for attention in a timely manner. One staff member said, "You can only do your best." However, one person told us, "When I call staff they attend promptly." We observed a senior member of care staff write up their daily care records in the lounge. They said, "I'm visible here, I can watch people, and staff know where I am and can come to me for anything."

At lunchtime we found that there were not enough staff on duty to meet the needs of people who were cared for in their bedroom. We saw that when a person needed encouragement and support to eat their meal that their meal was left aside for a long period of time until staff were free to give them the individual support they needed. We discussed staffing levels with the registered manager who informed us that they regularly completed a dependency tool that calculated how many staff they needed. They said that their staffing levels were more than adequate as they had more staffing hours than the tool recommended. However, the registered manager told us that they would revisit the deployment of staff at lunchtime.

Records showed that appropriate checks including two references and a disclosure and barring service check were completed before staff started work at the service.

People told us that they felt safe living in the service. One person said, "Oh yes, before coming here I never dreamt there was a place like this. I am well looked after." Another person told us, "I feel very safe here. Staff check on me during the night. I feel very secure here." Relatives told us they felt their loved ones were safe at the home. One relative said, "They are very careful about making sure the doors are secure so people are protected." Another relative said, "Nowhere is 100% safe, but my wife is as safe as she possibly can be expected to be."

Requires Improvement

Is the service safe?

Staff had an understanding of adult safeguarding issues and were able to identify the signs of possible abuse. They told us that they would escalate to a senior member of staff and had confidence that the manager would act on their concerns.

We looked at the safe storage of medicines and found they were stored in accordance with requirements. All medicines were stored in locked cupboards, medicines trolleys or fridges. Daily fridge temperature checks had been recorded and were found to be within acceptable limits. We saw there were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner.

We observed the morning medicines administration round in two of the areas of the home and saw staff took steps to maintain the safety of medicines in locked medicines trolleys. We observed the appropriate checks being carried out to ensure people received the medicines they had been prescribed. Staff talked to each person and explained their medicines to them, to reassure them and gain their compliance. One person using the service managed their own pain relief medicine and this was kept in a locked drawer in the person's room. Staff took responsibility for the administration of the person's other medicines. People told us that they received their medicines regularly and their medicines were never missed.

We looked at the medicines administration record (MAR) for five people and noted that they had a photograph of the person to aid identification and any known allergies were recorded. However, we found some inconsistency in the codes used to identify the reason when a medicine was not given. This meant there was a lack of clarity as to whether the medicine had been declined or was not required. We brought this to the registered manager's attention who said they would action this. As required medication is not taken routinely but only when a person has symptoms, such as taking cough mixture for a tickly cough. There were protocols in place in two of the three areas of the service to identify the reasons why a medicine was to be given only as required. We were informed that this protocol would be introduced across all areas.

Staff who administered medicines had undertaken initial medicine management training and their competency was assessed prior to the administration of medicines. We saw that staff had access to an up to date medicines policy that included guidance on the safe storage and administration of medicines, action to be taken in relation to medication errors and how to administer medicines covertly.

Good

Is the service effective?

Our findings

People and their relatives told us that they were confident that staff had the knowledge and skills to carry out their roles effectively

We found that staff had completed their mandatory training within the previous 18 months. In addition most staff had undertaken training in looking after the needs of a person living with dementia. A member of staff told us that they had undertaken a two day course in dementia, provided by a national charity for Alzheimer's disease and had found this very useful to their role. Staff had access to further specialist training, such as caring for the needs of a person living with diabetes. We found that staff training requests were met. For example, we read in recent staff meeting minutes that staff had requested training in the management of special mechanical mattresses and the registered manager had arranged for this training. Care staff were knowledgeable about the support and care that people needed and were able to describe people's care preferences. These measures ensured that only suitable staff were employed by the service. We observed staff supported people's care needs in a knowledgeable and confident manner.

A visiting healthcare professional told us that some staff new to the service lacked the knowledge on issues such as pressure ulcer prevention and that they had been approached by the registered manager to provide some future training on this subject. We found that staff were supported in their roles through supervision sessions and an annual appraisal.

Staff told us they would always seek consent from a person before they gave them care. We found that people had given their consent to have their photograph taken for identification purposes, to share their personal information with other agencies and for the safe use of bedrails. We saw where one person lacked capacity to consent to their care their next of kin who was also their lasting power of attorney signed consent on their behalf. A lasting power of attorney is someone registered with the Court of Protection to make decisions on behalf of a person who is unable to do so themselves.

We spoke with the registered manager 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 a person is assessed as lacking 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 guide staff in the MCA decision making process, including undertaking capacity assessments and leading best interest meetings. We found evidence that capacity assessments, best interest checklists and best interest meetings had been undertaken and records were kept in people's care files. This meant that the provider followed current legislation.

Some people had a valid do not attempt cardio pulmonary resuscitation (DNACPR) order stored at the front of their care file. 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. We saw when people had been admitted to the service from hospital with a DNACPR that care staff had requested a review from their GP in case the person's overall health had improved and they no longer needed a DNACPR order.

People told us that the food was good. One person said, "We have very good food'. Another person said, "The food and care is very, very good."

We observed lunchtime in two dining rooms. People were able to make their choice from both written and pictorial menus. Pictorial menus helped people living with a dementia or who had communication difficulties make their choice. We observed a staff member enable a person to make a choice who could not make up their mind what to have for lunch; they brought the choice of meals to the person to help them decide. Staff were very supportive and encouraged people to eat their lunch. Where a person required assistance to eat their meal staff enabled them to eat at their own pace and lunch was not rushed.

People had access to hot and cold drinks throughout the day. For example, in the evening we overheard one person say to staff, "I could do with another cup of tea before bed." A freshly made cup of tea was brought to them. The main lounge and dining rooms had bowls of fruit, crisps and biscuits for people to help themselves.

We spoke with the chef who kept an account of the special diets and food preferences of people using the service. They told us they were trying out new meals to assess people's responses to them and gathering their feedback.

Good

Is the service effective?

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, district nurse, dentist and optician. We saw people and their relatives had access to a range of information leaflets on health related issues such as 'living well with dementia'. One person told us, "GP comes to us if we need him, or we can see the optician if we need our eyes tested." Another person said, "They arrange the GP for you. The doctor comes in when needed." Relatives spoke positively about the way care staff supported their loved ones to access care from external healthcare professionals. For example, a relative told us that staff had kept them informed when their relative's condition had changed and had arranged for their GP to visit them. A record was kept of when a referral was made to a person's GP or other healthcare professionals.

We were told that people living with dementia and their families had support from a specialist nurse, called an Admiral Nurse, appointed by the provider. We saw that they had organised awareness sessions for relatives of people living with dementia.

We spoke with a visiting healthcare professional who was a regular visitor to the service. They told us that a member of care staff always accompanied them on their visits. This meant that staff were aware of a person's changing healthcare needs and care plans were amended to reflect this change and maintain continuity of care between their visits.

Good

Is the service caring?

Our findings

We found that people were given a choice of who delivered their personal care and their families could be involved if they wished. For example, one person's visitor told us that sometimes they helped with their relative's care and their relative appreciated this. Care staff described the ways in which they gave people choices in their personal care. For example in deciding when they wanted to get up and what they wanted to wear. People confirmed that they were given a choice in the care they received. One said, "I have my bath sometimes in the bathroom and some times in the bed. I get a choice."

We saw that staff respected people's individual likes and preferences. For example, during the morning a member staff helped a person with verbal communication difficulties choose a television channel to watch. The person said they wanted to watch a programme that was familiar to them and they flicked through the channels until the person found something they liked. At lunchtime the television was switched off and soft music was played. A member of staff told us that this was because one person who took their meals in the dining room at lunchtime did not like noise and they respected their wishes.

Staff interacted with people in a caring and compassionate way. There was a good rapport between people and staff and people were treated with dignity and respect and made to feel that they mattered. People spoke in a positive way about the staff that cared for them. For example, one person told us, "The people who work here are very nice. We are looked after very, very, well. I am quite contented." Another person said, "I am happy, well looked after and staff are cheerful."

We spoke with relatives who told us they were happy with the care their loved ones received. One person's relative said, "My parent is so well looked after here. They are wonderful staff, they never rush them." Another relative said, "Staff are very kind, they have got to know my parent very well and the senior carer's are fantastic."

A visiting healthcare professional said "They (staff) obviously care. If staff have any concerns about a person, they ask you and always ask for a handover before you leave."

We saw where one person who lived with dementia could easily become anxious. Their care plan recorded that staff should use terms of endearment when speaking with them such as 'love' and 'darling' as this helped to reassure the person. We saw a staff member sit down beside the person and put an arm around their shoulder and speak to them in this way. The person responded well to the staff member and was at ease in their company.

We found where a person was unable to make decisions about their care and treatment that care staff involved their family. A relative of a person living with dementia said staff discussed their parent's care with them regularly and they were involved when their care plans were updated

The hairdresser was visiting the service. One person who wanted their hair done did not like water and had a fear of the hairdressing salon. We observed the hairdresser and a member of care staff who the person trusted support her to have her hair done in a quiet corner of the lounge. The person was treated with dignity and compassion and remained calm throughout the process. We later saw the pleasure the person had when other staff members complimented them on their hair do.

Staff were able to describe the steps they took to maintain a person's privacy and dignity, such as closing their curtains when they were getting dressed. We observed that staff treated people with dignity and noted when staff spoke with people they knelt down or sat beside them so maintain eye contact at the same level rather than stand over them. When staff walked into the lounge or dining room they acknowledged they people who were already sat there.

The registered manager told us dignity had a high profile in the service and was discussed at team meetings and staff had taken part in the last year's national dignity awareness day. We saw that there was an information board guiding staff on the key aspects of dignified care. We saw that people's care plans included reference on how to support them to maintain their privacy and dignity with aspects of personal care.

Good

Is the service responsive?

Our findings

People had their care needs assessed and personalised care plans were introduced to outline the care they received. For example, where one person had recently had a fall, their care needs were reassessed and a standing hoist was introduced to help them transfer safely from their arm chair to their wheelchair. Their care file recorded the revised risk assessment and action staff would take to support their care needs. We looked at the care file for a person living with chronic rheumatoid arthritis. We saw that their care plan identified the actions staff would take to relieve the person's painful hands and lower limbs.

Care staff told us that they understood how to use care plans to meet people's needs. One senior member of care staff said, "We give person centred care. We know them because their care plans tell us what they like and don't like, we talk to them." Another carer added, "And we keep a record of what they do."

People took part in a range of group and individual activities and pastimes and were given a choice of how and where to spend their time. Some people chose to sit in one of the quiet areas of the service or in their bedroom. One person said, "I like to read books and there is a library. My daughter also brings me books to read." Another person said, "My friends can come and visit at any time." We saw from one person's records that they liked staff to read to them.

People were supported to maintain contact with the local community. They told us how they enjoyed trips out. One person said, "I go shopping with the carer in my wheelchair." Another person told us, "In summer time they take me out in the wheelchair." One visitor told us their relative had the opportunity to go outside the home from time to time to visit the local shops. The service had its own mini bus for trips out into the local community.

A weekly activity programme was displayed in each unit and was the focus for basic daily activities which all care staff would initiate when they had the opportunity. There were two part time activities coordinators in post who were dedicated to providing additional activities for people. We talked with the coordinator who worked in the units for people living with advanced dementia and they told us of the ways they engaged people with activities suitable for their individual interests and abilities. For example, one person was partially sighted and would put the paint brush in their mouth but enjoyed painting. They had therefore found they could use an "aqua painting" system which enabled them to join in the activity and maintained their safety. The coordinator told us that some people enjoyed doing domestic activities such as dusting and folding linen and special equipment had been purchased to enable them to participate in this. This meant that people were engaged in useful occupations and maintained a level of independence.

People's diverse needs were catered for. The manager told us that a local church visited once a week and led a multi-denominational service that was open to people of all faiths and beliefs.

People and their relatives were provided with information on how to make a comment or complaint when they first moved in to the service. People and their relatives told us they did not feel the need to complain but if they did they would speak to the staff. One person said, "I know who to complain to, but there is no need." We saw that there was a comments and suggestion box accessible near the main entrance. We saw that a suggestion had been made for coat hooks to be positioned on the back of bedroom doors and this had been acknowledged and actioned.

Complaints were responded to in a timely manner. We found that lessons were learnt, external healthcare professionals were involved to prevent a repeat of an incident if it was health related and changes were made to a person's care plan and treatment regime. We saw that the family of one person had written to the manager and thanked them for taking their complaint seriously and for their help and kindness.

Requires Improvement

Is the service well-led?

Our findings

Owing to a previous incident which had resulted in the prosecution of the provider by the Health and Safety Executive, we asked what arrangements were in place to ensure the safety of people who used the service if they chose to go outside unsupervised. We were informed that the provider had put systems in place such as nightly security and fire door checks to ensure that these could not be opened without the knowledge of staff. Technology had been put in place to alert staff if doors were opened and the system would direct staff as to which door. Staff would then ensure that the outside area was checked. The provider had also secured the garden and sectioned it into smaller areas so that if someone chose to go out at night they could not go far or get lost. However, we saw that although systems were being adhered to by staff, these checks were not being properly recorded in line with the provider's systems. For example, staff did not always sign their name or record the date and time when checks were carried out. The provider's audit systems had not identified these inconsistencies. This meant that the provider had no way of assuring themselves that the systems were being used correctly.

We discussed with the registered manager how they had promoted a positive culture within the service and develop links with the local community. They told us that young volunteers participating in a national citizenship scheme visited the service and they also took students on placement from the local further education college. This helped to bridge the generation gap. Furthermore the service had a dementia café that people and their families could visit.

The provider had corporate values that demonstrated the open culture of the service and these were on display for staff, people, and visitors to the home to read. However, we found that the registered manager spent most of their time in the office during our visit and was seldom visible to people, their visitors and staff. We asked a regular visitor to the home if they saw the registered manager regularly they said they did not know who the registered manager was. We asked people the same question and one person said, "I do not know."

Staff told us they received regular supervision from a more senior member of staff and that these were a two way exchange whereby they were given time to identify their progress and development needs and they received positive feedback on their performance and areas for improvement.

Staff attended regular staff meetings and told us that they had attended a meeting the previous week. They said the meetings were used to talk to them about plans for the home and issues which needed to be addressed. They said they were encouraged to contribute their views and raise issues that were important to them. Some staff told us that the registered manager was supportive and one staff member said, "This is a good place to work and all [senior staff] are approachable." We read the minutes from staff meetings and found that a range of appropriate topics such as communication and training were discussed and action taken where needed.

We saw that policies and procedures were referenced to national guidance and current research evidence for best practice. Staff were aware of the whistle blowing policy and said they would use this if they needed to raise a concern. Staff told us that the manager and their deputy were approachable and were confident that they would act on their concerns.

A programme of regular audit was in place that covered key areas such as health and safety, medicines and infection control. We looked at recent monthly medicine audits and found that there was evidence of ongoing improvements. For example, where incorrect coding on MAR charts had been identified on a previous audit there was an action plan to rectify this.

We reviewed the results of a quality survey called 'Your Care' that 18 people had responded to. People had provided feedback on a range of areas relevant to their experience such as home comforts, choice, having a say and 'quality of fife'. The service scored highly and above the average of all participating homes in all categories. In addition, face to face feedback from people and their relatives about the culture of the service was positive. For example, one person said, "Everyone is good, you're looked after."

People and their relatives were invited to attend meetings to discuss the service. We saw the dates for future meetings on display in the main reception area.