The Orders Of St. John Care Trust

OSJCT Madley Park House

Inspection report

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Date of inspection visit: 16 and 20 March 2015
Date of publication: 09/06/2015

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

This inspection took place on 16 and 20 March 2015. It was an unannounced inspection. The service had met all of the outcomes we inspected against at our last inspection on 12 June 2013.

Madley Park is a care home without nursing on the outskirts of Witney. The home cares for up to 60 older people, who are physically or mentally frail. The home is run by the Orders of St. John Care Homes. On the day of our inspection 57 people were living at the service.

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

Staff and external health professionals told us there were not sufficient staff to meet people's needs. However, people told us there were enough staff, we observed staff did not appear to be rushed and attended to people promptly. Staffing levels were calculated on the number of people rather than the level of their needs.

Summary of findings

People's medicines were not always administered safely. Some people had their medicine left with them to take which meant staff could not be sure medicines had been taken. Medicines were stored securely and in line with manufacturer's guidelines.

Records relating to falls analysis were not always complete. Actions had been identified to reduce the risk of falls across the service, but these had not been followed up and progress could not be evidenced.

The registered manager was well respected by staff and created an open and supportive environment for staff to work in, which encouraged improvement. However, some staff told us that senior managers within the provider organisation where not so supportive.

People told us they felt safe. Staff received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service notified the appropriate authorities where concerns relating to abuse were identified and took action to protect people.

Risks to people were managed and reviewed. Where risks to people had been identified risk assessments were in place and action had been taken to reduce the risks. Staff were aware of people's needs and followed guidance to keep them safe while maintaining their freedom.

The service ensured staff had the necessary skills to support people through, induction training, ongoing training and regular supervision. Records confirmed staff received appropriate support.

The registered manager and staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA), which governs decision-making on behalf of adults who may not be able to make particular decisions themselves, and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Records confirmed people who lacked the capacity to consent were supported in their best interests.

People we spoke with told us that they enjoyed the meals provided. We saw the staff were kind and where appropriate, provided the support people needed with eating and drinking. People made positive comments about the care provided. People's comments included; "It's very pleasant" and "It's as nice as you'll find for anywhere similar."

People with complex needs received effective care. The service made appropriate referrals to healthcare professionals and their advice and guidance was followed. This included the district nurse and GP.

The service had systems to assess the quality of the service provided in the home. Learning was identified and action taken to make improvements. These systems ensured people were protected against the risks of unsafe or inappropriate care. This included complaints. People we spoke with knew how to complain and there was a complaints procedure in place. Records showed complaints were dealt with compassionately and in a timely fashion.

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?

Requires improvement

The service was not always safe because medicines were not always administered in line with the provider's policy.

Staffing levels were not set by people's dependency levels or needs which meant there was a risk of insufficient staff available to support people.

People told us they felt safe. Staff had been trained and knew how to raise concerns.

Is the service effective?

Good

The service was effective. Staff had the training, skills and support to care for people. Staff spoke positively of the support they received.

People had sufficient to eat and drink. People who needed support with eating and drinking were supported appropriately.

Staff sought people's consent. Staff explained things to people and offered them choices.

Is the service caring?

Good

The service was caring. Staff were kind and respectful and treated people and their relatives with dignity and respect.

People's preferences regarding their daily care and support were respected.

Staff gave people the time to express their wishes and respected the decisions they made.

Is the service responsive?

Good

The service was responsive. Complaints were dealt with in line with the services policy. Everyone we spoke with knew how to make a complaint and were confident action would be taken and they would be listened to.

There was a range of activities for people to engage in. Activities were linked to people' interests and hobbies. Community links were maintained with local groups who regularly visited the home.

Is the service well-led?

Requires improvement

The service was not always well led. Records relating to falls analysis were not always complete.

The registered manager was visible and approachable. People knew them and staff told us they were approachable and supportive. However, some staff told us that senior managers within the provider organisation where not so supportive.

Summary of findings

The registered manager conducted regular audits to monitor the quality of service. Learning from these audits was used to make improvements.

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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 16 and 20 March 2015. It was an unannounced inspection. The inspection was conducted by two inspectors.

We spoke with 16 people, nine care staff, the registered manager, the head of care and the area compliance manager. We looked at eight people's care records and five medicine and administration records for people. We also looked at a range of records relating to the management of the home. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on it, observation and Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern.

Before our inspection, we reviewed the information we held about the home and contacted the commissioners of the service. During our inspection we spoke with the district nurse and the care home support service who provides specialist advice and guidance to improve the care people receive. We also looked at the 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 improvements they plan to make.

Requires improvement

Is the service safe?

Our findings

Staff told us there were not sufficient staff to meet people's needs. Comments included; "It's stressful for staff. We're rushing residents and not doing all we can for them," "We don't have enough staff" and "Our worst thing here is staffing levels." One care leader told us they felt people's dependency levels had increased and this was having an impact on the care delivered. We asked people if there were enough staff. One person said "I can't grumble, I think they're hard pushed sometimes." Another person who spent time in their room told us "They usually come" when they called for assistance.

We spoke with the district nurse who told us people's dependency levels had increased and they were spending more time at the home. They said "although carer's don't moan, you can see that they're stretched." We also spoke to the care home support service who told us people's dependency levels had increased. People's dependency levels were assessed and recorded in their care plans. We asked the registered manager how they calculated staffing levels and they told us a ratio of one care worker to eight people was used. We asked if staff levels were set by people's dependency and they said it was not. The registered manager told us the number of care staff had not increased to meet the increasing needs of people using the service. They had raised concerns with the provider but had not yet received authorisation to increase staffing levels.

However, during our visits we saw there were sufficient staff to meet people's needs. Staff were not rushed and had time to talk to people. Call bells were answered promptly. We also saw evidence that where people's dependency caused concern they were reassessed and, if appropriate, steps were taken to move them to a more suitable home. The staff weekly roster showed staffing levels were mostly maintained but some shortfalls did occur. On the second day of our inspection two agency staff were working at the home to cover sickness. Other care workers told us they were short staffed until the agency staff arrived the next day.

We were told some measures had been put in place to help the care staff. For example, domestic staff now made people's beds and kitchen assistants were employed to assist in the mornings, for example; with breakfast. The registered manager told us six staff had been recruited recently, including two care staff who had completed or were completing their period of shadowing an experienced staff member. They added that there were five vacancies for care staff, including one care leader's post.

People's medicines were not always administered safely in line with the provider's policy. Staff left some medicines with people to take meaning staff could not ensure the people had taken their medicine. The member of staff administering medicines signed the medicine records to confirm that people had taken their medicines and left two people before they had taken their medicine. One person had to be reminded a by a second care worker to take their medicine. This could put people at risk if they forgot to take their medicine.

Medicines were stored securely and in line with manufacturer's guidelines. All care leaders were trained in medicine administration. This involved reading about medicines and the relevant policy, shadowing medication rounds and completing a thirty-five question test that included observation of practice. Staff members were then observed and signed off as competent by an experienced colleague. Competency was checked bi-annually or sooner if required.

Risks to people were managed and reviewed. Where people were identified as being at risk, risk assessments were in place and action had been taken to reduce the risks. For example, one person was at risk of developing pressure ulcers. Guidance from the district nurse was being followed which included the use of a pressure relieving mattress and regularly repositioning the person. However, records relating to repositioning were not always accurately maintained. On the 15 March 2015 we saw the records for repositioning this person were not maintained in line with the guidance between 19.00hours and 23.00 hours. This meant we could not be sure the person had been repositioned. We looked at the recommended pressures of pressure relieving mattresses and found them to be correct. However, the district nurse told us that more training for staff on this subject may be needed as they occasionally found mattresses were not maintained at recommended pressures.

Another person was at risk of malnutrition. The district nurse had visited the person and their GP had given guidance to reduce the risk. This guidance was being followed. The person's food and fluid intake was being monitored and the person was maintaining their weight.

Requires improvement

Is the service safe?

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff have a criminal record or were barred from working with children or vulnerable people.

People told us they felt safe. Comments included; "safe, yes," "safe, why not? I've had no bad reports" and "oh yes, completely." The provider had effective procedures for ensuring that any concerns about people's safety were reported. Staff we spoke with could clearly explain how they would recognise and report abuse. Staff told us, and training records confirmed that staff received regular training to make sure understood their responsibilities to report concerns. One care worker said "Any concerns and I'd inform the manager immediately." Records confirmed the service notified the appropriate authorities where concerns were identified and took appropriate action to ensure people were safe.

Good

Is the service effective?

Our findings

People told us staff knew how to support them. Comments included; "I am looked after well" and "I can't complain on that score."

Staff told us that they completed the provider's mandatory training and received training updates. The service had a training plan and newly appointed staff worked through an induction pack and had an 'induction passport' (a record of induction training). This was signed off by their supervisor (mentor) when, after a period of training and shadowing in practice, the carer was assessed as competent.

Further training was also available to staff. Two care leaders had completed National Vocational Qualifications (NVQ) in Health and Social care at level three. One care leader said "there is very good training and development." All care staff received dementia training. Staff were knowledgeable and confident about supporting people living with dementia. One care worker said, "I know it is not for everyone but I find working with these people so rewarding." The registered manager told us further dementia training was planned for staff in light of plans to open a dedicated dementia unit.

Staff told us, and records confirmed they had effective support. Staff said they had appraisals and received supervision meetings. One care worker told us in the past they had raised concerns that the supervision was not very personalised and at that time the "concerns were addressed" and they received a second supervision meeting and record.

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. The MCA governs decision-making on behalf of adults who may not be able to make particular decisions themselves. They were knowledgeable about how to ensure the rights of people who lacked capacity were protected. Care records showed the principles of the Mental Capacity Act 2005 Code of Practice had been followed when assessing an individual's ability to make a specific decision.

At the time of our visit no one was subject to a Deprivation of Liberty Safeguards (DoLS) application. These safeguards protect the rights of people by ensuring that if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm in the least restrictive way.

The registered manager told us they were aware of the supreme court judgement. Care and nursing staff had knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). One person had been subject to a DoLS application but it had not been renewed. We discussed this with the registered manager who told us as this person's condition had deteriorated and they were less mobile. They had been reassessed by the GP and it was decided the DoLS was no longer applicable.

We looked at the care plan for one person who did not have capacity to make certain decisions. Their relative had Lasting Power of Attorney (LPA). This meant the relative was authorised to make decisions on the person's behalf for their care and welfare. Best interest guidance had been followed and as far as was practicable the person had been involved in the process. We saw a MCA assessment that had been completed by their GP.

Where DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) forms were in place we saw they had been completed fully with the signed consent of the person.

Throughout our visit we saw staff sought people's consent. Staff explained things to people and offered them choices. Where people expressed a preference this was respected. For example, a person was offered a choice of two fruit juices "Would you like orange or blackcurrant?" and was shown the items. The person replied "both". This choice was respected.

People we spoke with told us that they enjoyed the meals provided. We saw the staff were kind and provided the support people needed with eating and drinking. We asked people about the meals at the home. Comments included; "It's very nice. It's a good meal" and "The flavour's right."

We spoke with kitchen staff who showed us a list of dietary requirements. We saw some people received a fortified diet. This included eight people whose nutritional intake was monitored to reduce the risk of weight loss. We looked at the care plans for those at risk and saw people were gaining or maintaining their weight.

The registered manager told us that further training had been given because staff in the service had not always carried out a malnutrition universal screening tool (MUST) assessment accurately. MUST is a tool used to assess and manage the risk of weight loss. The manager said the situation had now been resolved with accurate MUST scores in place. They also told us they had increased snacks

Good

Is the service effective?

and finger foods for people around the home. Where people were at risk of choking, they had been referred to a Speech and Language Therapist (SALT). Assessments had been made and we saw SALT guidance was being followed.

We observed the lunchtime meal. The food looked wholesome and appetising and the mealtime was a relaxed and enjoyable experience. We looked in people's rooms and saw fresh water or juice was available to them. These were in easy reach of the person. However, one person said the juice was "not always" replaced daily. Nobody else we spoke with raised this concern.

People were supported to maintain good health and had access to healthcare services. People had received support from a range of specialist services such as SALT, district nurse's, the care home support service and occupational therapy teams. GP and specialist professional visits were recorded in people's care plans. For example, where people were at risk of weight loss the care home support service and district nurse had been contacted and we saw their guidance was being followed.

Good

Is the service caring?

Our findings

People made positive comments about the care provided. People's comments included; "I've been very lucky," "I'm quite happy," "It's very pleasant" and "It's as nice as you'll find for anywhere similar." People also told us that staff were kind and caring. Comments included; "The girls are lovely," "They are very good, nothing I could fault about it."

Throughout our visit we saw people were treated with respect and in a caring and kind way. The staff were friendly, patient and discreet when providing support to people. Staff took the time to speak with people as they supported them. We observed many positive interactions. For example, one person became agitated whilst waiting for lunch to arrive and was walking away from the dining area. A staff member said "would you like to come and sit down with me." They walked with the person and sat down at the table with them and engaged them in a conversation about food, their likes and dislikes. This person then stayed more settled at the table and ate dinner when it arrived.

Staff were knowledgeable about the care people required and the things that were important to them in their lives. We saw they conversed with people about their career, family and where they had lived. One care worker said "building a good relationship with people and relatives is most important when developing a care plan. Every time I see relatives I check with them and ask if they have any concerns about their relatives care. Then I can take action before anything becomes an issue."

Staff treated people with dignity and respect. We saw how staff spoke to people with respect using Mr or Mrs or the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. Records used respectful language. Where staff were providing personal care doors were closed. All rooms had ensuite bathroom facilities. These facilities helped to support people's privacy and dignity.

People were supported to be independent. One person said "I look after myself completely." The person said they needed to live in a supported setting due to a risk of falls when they had been in their own home. Another person told us they tried to keep mobile "I like to do a little bit of walking with my frame." We observed this person walk from the lounge to the dining room. The care worker stood by ready to assist the person who was able to stand and walk with the aid of their frame. The care worker encouraged the person and chatted to them as they made their way to the dining room.

We observed the lunchtime meal and saw where people needed support with eating, staff supported them appropriately. They sat at eye level with the person and encouraged them, supporting at the person's pace. We saw examples of caring support. One care worker immediately noticed when one person needed discrete assistance with wiping their mouth and offered them this support. Staff gave people the time to express their wishes and respected the decisions they made. For example, one person had requested gravy with their meal but asked "only over the potatoes and meat," not over the vegetables. We saw the care worker explain this to the member of staff preparing this person's meal and noted they carefully applied the gravy as requested. We observed staff communicating with people in a patient and caring way, offering choices and involving people in the decisions about their care. For example, at lunchtime we saw people's preferences of what to eat and drink were respected.

People's preferences were documented in their care plans. One person had stated, "I like to take my medicine so put my tablets in my hand at mealtimes." We spoke with a care leader who administered medicines. They were aware of, and able to tell us about this person's preference. They said "That's the way they like it so that's how I do it."

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission to the service to make sure the service could meet their needs. However, one person was admitted to the home who the district nurse described as requiring nursing needs. This person was then admitted to hospital and from there to a nursing home. We spoke to the registered manager who told us this person had complex needs and should not have been admitted to the home. They said they had reviewed the assessment process to prevent a reoccurrence. Two people had since been moved from the home when their assessed dependency levels had increased. One member of staff said the service had "admitted people with too high needs."

People had contributed to assessments. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, previous occupations, interests, hobbies and religious needs. For example, one person had stated they were deeply religious and we saw from the daily notes the person regularly attended the Sunday services.

Care plans contained a "significant life events" page. People had listed important events in their lives such as married life, children, work and occupations. Staff told us they used this information to engage people in conversation. People had also listed personal preferences with regard to daily care. For example, one person had stated they liked their breakfast in their room. A kitchen assistant told us this preference was always respected. They said. "People can choose when they want breakfast between about 8am and 9.30am. They can eat in their bedrooms if they prefer." We observed people making personalised choices about their care and support. One person wanted to be assisted with their meal in the lounge. This preference was respected.

A range of published activities were available including trips out of the home. Religious services were regularly held and people could attend the local church. The home employed a full time activities coordinator who told us they tried to provide activities that related to people's lives and interests. For example, gardening activities were organised for people who enjoyed gardening. The registered manager told us they had just completed a survey asking people what activities they wanted and what hobbies and interests they had. They said the results would be used to review the activities and tailor them to reflect people's interests.

Group activities were held including days out using the homes mini bus. Canal cruises, trips to the seaside, garden centres and local places of interest were organised and photographs of these events were displayed in the lounge. The home had a bar, shop and hairdressers available to people and activities were planned throughout the week. We observed that some people were taking part in group activities on the ground floor during the morning. We spoke with a person who told us they enjoyed this and found it stimulating. When we asked if they had played bingo, they replied "No, it's where you have to find your name" and pointed to describe the activity (word search).

The home maintained links with the local community. The local resident's association held their meetings in the home and people were encouraged to attend and take part in these meetings. "PAT (pets as therapy) Dogs" visited the home every week and people had taken part in a "litter pick" with local residents. A dementia café was held every week where families and people could gather and the home held a fete, open days and BBQs where local residents and relatives could attend.

People had access to a large, secure garden area. Pathways and paved area were level and safe for people who used wheelchairs and benches were arranged to allow people to sit in the garden. Equipment was available for people to engage in gardening activities. Borders were tidy and maintained.

Regular surveys were conducted where the service sought the views of people and their relative's. Feedback from the surveys was used to improve the service. For example; the service highlighted people wanted more seafood on menus. Seafood and fish was now regularly on the menu and we were told people could have seafood on request.

The service conducted a range of meetings to obtain people's opinions. Relatives, people and staff meetings were regularly held and actions from these meetings carried forward. For example, at one meeting people made several suggestions regarding meals. We saw these suggestions were taken forward to the chef and actioned. At a staff meeting staff raised the issue of covering the duties of key workers if they were sick or on leave. A key

Good

Is the service responsive?

worker is a named member of care staff who is the main point of reference for individual people. This issue related to people having baths. We saw a new system was put in place to address the issue and allow people the opportunity to bath when they wanted too.

A complaints policy and procedure was in place and displayed in the home and held in the service users guide given to all people and their relatives. People told us they knew how to complain and were confident action would be taken. Comments included; “I’ve done so before and it was dealt with,” “yes I can but don’t need to” and “it depends what it was. I have in the past but that was a one off.” All the complaints we looked at had been dealt with compassionately in line with the policy. Staff were aware of the policy and knew how to assist people to complain if they so wished.

Requires improvement

Is the service well-led?

Our findings

Accidents and incidents were investigated to identify patterns and trends across the service. Where issues were highlighted action plans were created with the intention of improving the service. For example, reducing falls in the home. The registered manager, head of care and falls lead (a care leader given the role of being a point of reference for staff relating to falls) met monthly to discuss and analyse data relating to falls. Actions had been identified but there was no evidence these actions had been completed to reduce the risk of falls across the service. The registered manager told us they were planning to review this process involving GPs, district nurses and the care home support service with the "intention of meeting monthly to discuss all aspects of risk prevention."

There were systems in place to assess the quality of the service. Regular audits were conducted to monitor the quality of service and learning from these audits was fedback to staff to make improvements. For example, an audit identified care leaders required further training in relation to the use of weight loss assessment calculators used to manage the risk of people losing weight. Care leaders, and records confirmed the training had taken place and accurate assessments were in place.

The registered manager empowered and motivated staff. Care leaders had been appointed to "lead roles". For example in dementia, medication, infection control, nutrition and falls. They received extra training and became a point of reference for other staff and provided training and guidance within the role. One care leader we spoke with said "I said I would like a new challenge. I've just been appointed as the falls lead. I will receive training to be the moving and handling trainer for the home. I will have a carer who will support me in this lead role." They said it was a positive step to have a lead responsibility.

Staff knew their roles and responsibilities and understood what was expected of them. Job descriptions held in staff records detailed their roles and responsibilities and staff told us they could discuss these at supervision meetings with their line manager.

All the people we spoke with knew who the registered manager was and told us they were approachable. Comments included; "she is very nice" and "I always get to say hello and pass the time of day." Staff told us the registered manager was supportive and approachable. Staff's comments included; "If I raise a concern they will follow it through and try and identify what the cause is," "the door's always open downstairs. They're very supportive. I always know who to contact out of hours," "I'm confident they will do their best for us" and "We've had so many managers since we've been here (over 10 years). I like the current manager." The registered manager told us they operated an open door policy so staff and people could have access to them.

Staff commented senior managers, within the provider organisation, were not as well received as the registered manager. One told us communications with senior managers was sometimes poor. They said "sometimes there was a lack of communication between those in the home and those who weren't." Another said senior managers would "sometimes shout at staff in front of residents."

The services values were displayed around the home and staff received a copy when they started working at the home. The values included caring, empowering and respecting. The registered manager told us the provider was considering a review of the services values and how they would be promoted within the service. One member of staff, when asked about the registered manager's vision for the service, said there was a clear vision where "residents come first."

Regular meetings were held with people and staff and their opinions and suggestions improved and developed the service. For example, following a meeting where mealtimes were discussed dining room assistants were employed to assist staff at busy meal times.

There was a whistle blowing policy in place that was available to staff around the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. This included the Care Quality Commission (CQC). Staff were aware of the policy.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the home had informed the CQC of reportable events.

We spoke with the registered manager about their vision and plans for a dedicated dementia unit. They told us they were seeking advice from dementia specialists relating to

Requires improvement

Is the service well-led?

decoration, activities and current best practice to ensure a high level of quality care. Additional training was planned for staff and their vision was for a well trained, dedicated team to work on the unit. We were told plans were in place and work would start later in the year.