The Orders Of St. John Care Trust

Shotover View

Inspection report

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Date of inspection visit:
02 February 2017

Date of publication:
24 February 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We undertook an announced inspection of OSJCT Shotover View on 2 February 2017.

OSJCT Shotover View provides extra care housing for up to 55 older people. The office of the domiciliary care agency OSJCT Shotover View is based within the building. The agency provides 24 hour person centred care and support to people living within OSJCT Shotover View, who have been assessed as requiring extra care or support in their lives. On the day of our inspection 32 people were receiving a personal care 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.

We were greeted warmly by staff at the service who seemed genuinely pleased to see us. Throughout the day we saw visitors to the service being greeted by staff in the same welcoming fashion. The atmosphere was open and friendly.

People told us they benefitted from caring relationships with the staff. There were sufficient staff to meet people's needs and people received their care when they expected. Staffing levels and visit schedules were consistently maintained. The service had safe, robust recruitment processes.

People told us safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

Where risks to people had been identified risk assessments were in place and action had been taken to manage the risks. Staff were aware of people's needs and followed guidance to keep them safe. People received their medicine as prescribed.

Staff had a good understanding of the Mental Capacity Act (MCA) and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected.

People told us they were confident they would be listened to and action would be taken if they raised a concern. We saw complaints were dealt with in a compassionate and timely fashion. The service had systems to assess the quality of the service provided. Learning was identified and action taken to make improvements which improved people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

Staff spoke positively about the support they received from the registered manager. Staff supervision and meetings were scheduled as were annual appraisals. Staff told us the registered manager was approachable and there was a good level of communication within the service.

People told us the service was friendly, responsive and well managed. People knew the managers and staff and spoke positively about them. The service sought people's views and opinions and acted upon them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staff deployed to meet people's needs.

People told us they felt safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place to manage the risk and keep people safe. People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff on how to support people.

People knew how to raise concerns and were confident action would be taken.

People's needs were assessed prior to receiving any care to make sure their needs could be met.

Is the service well-led?

Good

The service was well led.

The service had systems in place to monitor the quality of service.

The service shared learning and looked for continuous improvement.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

Shotover View

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 the 2 February 2017. It was an announced inspection. We told the provider two days before our visit that we would be coming. We did this because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be in.

This inspection was carried out by one inspector.

We spoke with three people, three care staff, the domiciliary care trust manager and the registered manager. We looked at four people's care records, four staff files and medicine administration records. We also looked at a range of records relating to the management of the service. 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 their care.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

In addition we contacted the local authority commissioner of services to obtain their views on the service.

Good

Is the service safe?

Our findings

People told us they felt safe. Comments included; "Yes I am safe. I know the staff and I know they will come. They will do anything for me", "I feel safe and secure, I know the staff and trust them" and "Oh yes I know I am safe".

People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to their line manager or the senior person on duty. Staff were also aware they could report externally if needed. Comments included; "I'd go to my manager or I can whistle blow", "I would tell my team leader and manager. I could whistle blow and call the local authorities" and "I'd whistle blow and report to the manager". Guidance for staff on how to raise a concern was displayed in the staff room and on notice boards in the buildings corridors. The service had systems in place to report concerns to the appropriate authorities.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, one person was at risk of falls. The person was unable to transfer independently and used a wheelchair to mobilise. The care plan highlighted that two staff were required to safely transfer this person and records confirmed two staff were consistently deployed.

Another person was at risk of developing a pressure ulcer. The risk assessment guided staff to monitor this person's skin every day and to apply prescribed creams. A body map was used to inform staff where the cream should be applied. Records confirmed this guidance was being followed and that the person did not have a pressure ulcer.

People told us staff were punctual and visits were never missed. One person said, "They are very punctual and they have never missed a visit". Another person said, "Always on time, no problems".

People told us there were sufficient staff to meet their needs. One person said, "Staff come straight to me if I need them so I think there is enough". Another person said, "Oh yes there's enough".

Staff were effectively deployed to meet people's needs. The registered manager told us staffing levels were set by the "Dependency needs of our clients". Staff told us there were sufficient staff to support people. Comments included; "Yes there's enough staff. I do not get pressured to cover extra shifts", "If someone goes sick we get in agency staff but that's rare. Yes there's enough staff" and "There is enough staff to meet people's needs". Staff rotas confirmed planned staffing levels were consistently maintained.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

Where people needed support with medicines, we saw that medicine records were accurately maintained and up to date. Records confirmed staff who assisted people with their medicine had been appropriately trained and their competency had been regularly checked. Staff we spoke with told us they had received medicine training and were confident supporting people with their medicines. Staff comments included; "I administer and prompt every day. I know I am up to date with my training", "The medicine training was good. I get checked quite often which is also good" and "Most client's needs some support with medication. I've had the training and my competency is regularly checked". One person told us how staff supported them with their medicine. They said, "They help me with my tablets, I take a few. No problems at all, they are very good".

Good

Is the service effective?

Our findings

People told us staff knew their needs and supported them appropriately. Comments included; "They (staff) do know what they are doing" and "Yes they know their stuff. The girls (staff) identified I had a problem and referred me to an occupational therapist and now I am waiting for my new mobility scooter, thanks to the staff".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction and completed training when they started working at the service. This training included safeguarding, moving and handling, dementia and infection control. Induction training was linked to the Care certificate, Skills for care, which is a nationally recognised program for the care sector. Staff spoke with us about their training. Staff comments included; "We get regular training and I find that useful" and "The training is good here, keeps you prepared for anything". Training records were maintained and we saw planned training was up to date. Where training was required we saw training events had been booked.

Staff told us, and records confirmed they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. For example, one staff member requested training specific to a person's condition. This training was provided.

Staff were also supported through 'observation of care practice'. Senior staff observed staff whilst they were supporting people. Observations were recorded and fedback to staff to allow them to learn and improve their practice. Observations were also fed into staff supervisions.

We spoke with staff about supervision and support. Comments included; "I get really good support from my managers, really helpful. I also get supervisions", "I do get supervisions and I feel I am supported here. I would like to see more of the manager though" and "I have supervisions and I can raise any issues at them. I once asked for extra training and I got it".

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected. Two people had appointed relatives to have lasting power of attorney allowing them to make decisions relating to the person's' property and affairs'. This had been authorised by the Court of Protection. We saw that people's mental health was assessed and regularly reviewed.

Staff demonstrated an understanding of the MCA and how they applied its principles in their work. Staff comments included; "This is protecting people's decisions. It's decision specific and we have to work in

people's best interests", "Clients here have the capacity to decide, it is decision specific. Any doubts about someone's capacity and I'd report it" and "I've been trained in this. I put myself in client's shoes and offer choices".

We asked staff about consent and how they ensured people had agreed to support being provided. One staff member said, "I ask, can I do this? I do this every time". Another said, "I just ask what they want to do and offer them choices".

People told us staff sought their consent. One person said, "Oh they always ask me first". Another said, "Staff let me know what's going on and they get my permission". We saw documents that supported people's comments. For example, care plans contained consent documents for photographs, information sharing and care provision. These had been signed and dated by the person.

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs and district nurses. Details of referrals to healthcare professionals and any advice or guidance they provided was recorded in people's care plans. For example, one person had been referred to an occupational therapist when their condition changed. Their guidance was recorded and being followed.

Most people did not need support with eating and drinking. However, some people needed support with preparing meals and these needs were met. People either bought their own food or families went shopping for them. People had stipulated what nutritional support they needed. For example, one person's care plan stated '[Person] can express to the carer what they want to eat and drink.

People told us their nutritional needs were being met. One person said, "No problems at all. They (staff) help me and are really good. My relative brings in my meals and the staff heat them up for me". Another person said, "Meals are no problem, the girls (staff) are wonderful with that".

Staff spoke with us about people's nutritional needs. Comments included; "I do food preparation and I assist one or two with eating. It's all fine", "One person requires support with eating. If people ever start to lose weight we call the GP and monitor them" and "Mainly preparation here. The clients are quite independent".

Good

Is the service caring?

Our findings

People told us they benefitted from caring relationships with the staff. Comments included; "They (staff) will do anything for you and we are always chatting", "I like it here really nice and they do look after me" and "Yes it is alright here. It suits me and the staff are helpful. They are nice, friendly and polite".

Staff spoke with us about positive relationships at the service. Comments included; "I love it here, the clients are like my family. It's such a rewarding job", "I like it here very much. The residents are great and we all work as a team, like a second family" and "I am a naturally caring person and the clients are very nice".

People's dignity and privacy were respected. When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful.

People told us they were treated with dignity and respect. One person said, "Yes they do treat me with dignity and respect. I cannot fault them". Another person said, "Oh they are good with that, very respectful".

We asked staff how they promoted, dignity and respect. Comments included; "This is important. Where personal care is concerned I close doors and curtains and cover them up. I respect their dignity" and "I close curtains and doors to protect their privacy. I treat them with respect and make sure they are comfortable with what we are doing".

People were involved in their care and kept informed. Daily visits schedules and details of support provided were held in people's care plans. For example, one person's schedule stated the evening support visit would 'assist with night clothes and help to bed'. Details of other specialist support relating to a specific condition were also listed. Schedules of support were updated in line with care reviews informing both people and staff of the support needs. Daily notes evidenced visiting schedules were followed and consistently maintained.

People told us they were involved in their care. One person said, "I have been asked about my care and I have my say". Another person said, "I've had review of my care and I've been fully involved".

Staff told us they involved people in their care. Comments included; "I involve clients by choices. I show them different clothes for them to choose or offer choices at mealtimes. It involves them" and "I talk to them about what we are doing and give them choices to make".

People told us staff promoted their independence. One person said, "I can do most things myself now but they have always supported me to be independent". Staff spoke with us about promoting people's independence. Their comments included; "I get them to do what they can do", "I only help them if they cannot do it. I wouldn't take away what they can do" and "I ask them what they can do themselves and encourage them to do it".

The service ensured people's care plans and other personal information was kept confidential. People's

information was stored securely at the office and we were told copies of care plans were held in people's homes in a location of their choice. Where office staff moved away from their desks we saw computer screens were turned off to maintain information security. A confidentiality policy was in place and gave staff information about keeping people's information confidential. This policy had been discussed with staff at a team meeting.

People's diverse needs were respected. Discussion with the trust domiciliary care manager showed that they respected people's different sexual orientation so that gay and bisexual people could feel accepted and welcomed in the service. They told us, "We have an equality policy that reflects our commitment to people's diverse needs". The equality policy covered all aspects of diversity including race, sex, sexual orientation, gender re-assignment and religion.

People's care was recorded in daily notes maintained by staff. Daily notes recorded what support was provided and events noted during the visit. These provided a descriptive picture of the visit. For example, one staff member had noted in one person's care plan 'assisted [person] with jewellery and her hair' and 'chatted throughout the visit, all good'.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to accessing the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person had stated they like to go to the shops every morning. Another had stated they liked 'TV and reading'. Staff we spoke with were aware of people's preferences.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person used a mobility scooter to mobilise independently and had stated in their care plan they wanted 'carers to transfer me to my scooter in the morning'. This was to enable the person to go out. Another person had provided information for staff on how they liked their meals. Daily notes evidenced people's preferences were being followed.

People received personalised care that responded to their changing needs. For example, one person's condition had slowly improved and their support needs had reduced over time. They told us, "As I got better my care changed to suit me. I am pretty independent now but they keep an eye on me". People's requests to change support visits were respected. Where people had private or medical appointments they contacted the office and changes were made to the person's visit schedules. These changes were made in consultation with the person to reschedule visits at a convenient time for them.

People were supported by staff who understood, and were committed to delivering, personalised care. Staff explained to us how they tailored people's care to suit their personal preferences. Staff comments included; "Personalised care is caring for that person as an individual, giving options and choices", "This is about the person you are caring for. The individual" and "It's care for that person, done their way". One person spoke with us about the care they received. They said, "I am very happy with my care. This place is twice as good as where I was before. They know me and my ways".

People were supported by staff to pursue hobbies and interests. The building contained communal areas where people could meet friends and relatives in comfort. These areas were also used by people to pursue their interests. For example, during our visit we saw a religious group meeting being held in a lounge area that was well attended. Church services were also held in the lounge. One person we spoke with told us how they organised events. They said, "I run coffee mornings, cheese and wine events and a film show for other residents here. Staff support me to do this. [Staff] is brilliant. I only have to say I'm doing something and he rearranges all the furniture for me and gets things just right".

People knew how to raise concerns and were confident action would be taken. Everyone we spoke with knew how to raise a complaint and felt they were listened to. One person said, "My family would complain for me, we know what to do and I feel they would listen". Another person said, "I do know how to complain. They are mostly quick to respond but I nag them".

Details of how to complain were contained in handbooks given to people when they joined the service. The service had received very few complaints. Four complaints were recorded for 2016 and all had been dealt with compassionately, in line with the provider's policy on complaints. Staff told us they would assist people to complain. One member of staff said, "I would write things down for them and report it to the manager".

The service sought people's opinions. 'Client care quality visits' were conducted every month. A senior member of staff visited people in their homes to obtain their views on the service. People could also raise issues or concerns at these visits. For example, at one visit a person raised an issue about some mobility equipment. The provider referred the person to an occupational therapist and the person was reassessed. A summary sheet of all visits for the month was compiled to allow the registered manager to analyse the information and look for patterns and trends. Records confirmed all people were visited on a regular basis.

Quality assurance surveys were regularly sent to people and their families. Results of the surveys were analysed to look for continuous improvement. The latest results we saw were very positive about the service. However, the trust domiciliary care manager told us, "Response rates across the trust have been very low recently. We are looking at ways to try to improve people's response rates.

People could nominate staff for the 'shining star' award as part of the provider's recognition and reward scheme. People could nominate and vote for staff under various categories which included, 'carer of the year' and 'unsung hero'. Details of how to nominate staff were readily available.

Good

Is the service well-led?

Our findings

People we spoke with knew the registered manager. Comments included; "I think I know the manager quite well, he does come to see me occasionally. He is alright" and "The manager is friendly and approachable but not here enough of the time. He can sometimes be difficult to get hold of". The registered manager at this service also managed two other services for the provider.

We saw the registered manager and the trust domiciliary care manager talking to people and their visitors during our inspection. People clearly knew the management team and spoke with them with confidence in a relaxed and familiar manner. Both the registered manager and the trust domiciliary care manager knew people's names and spoke to them respectfully, with genuine affection. These interactions produced lots of smiles, laughter and appropriate humour.

Staff told us they had confidence in the service and felt it was well managed. Comments included; "The manager is ok, doing a good job. It's an open and honest service with a really good team", "The manager is nice, approachable and they listen" and "[Registered manager] is very approachable, understanding and supportive. It's well managed here, they make sure we do a great job. They are very visible to".

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the domiciliary care trust manager and the registered manager spoke openly and honestly about the service and the challenges they faced. Staff told us they felt the service was open and honest. One staff member said, "There's no secrets here and I don't think there is a culture of blame either". One person said, "Yes, I do think this is an honest service".

Accidents and incidents were recorded and investigated. The results of investigations were analysed by the provider to look for patterns and trends. They were also analysed to see if people's care needed to be reviewed. For example, one person had a fall and was treated in hospital. The service referred the person to the GP and district nurse and their care was reviewed. Falls were also recorded on a monthly report which was analysed collectively by the provider to look for patterns and trends across all services. Any actions arising from this analysis was forwarded to the registered manager to action. For example, we saw people who suffered a fall were referred to the GP.

Learning from accidents and incidents was shared through a 'serious incident learning' notice circulated to all services by the provider. A summary of incidents was highlighted and learning from the incident shared. For example, at another provider location it was discovered a packet of fluid thickener had been contaminated. The batch number for this particular thickener was circulated to all provider locations and staff were guided to check stocks for the batch number and remove these sachets. Staff were also guided to check for any signs of contamination amongst other sachets. This had been reported to the supplier and manufacturer who were investigating.

Staff told us learning was shared at staff meetings and briefings. Comments included; "We have a handover

book and we raise issues at meetings. We also have notices that inform us" and "We share learning at staff meetings and through the information notice board. We also get updates given to us. Communication is really good here". Records confirmed staff meetings were held regularly and learning was shared at these meetings. Policies were discussed at meetings and staff signed to evidence they had read the discussed policy and attended the meeting.

The registered manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care and were modelled on the five domains used in CQC inspections. This allowed the service to match the audit results against our inspection criteria. Audit results were analysed and resulted in identified actions to improve the service. For example, one audit identified improvements were required relating to medicine records. We saw action had been taken and the improvements made. Another audit identified a person's care plan needed a review. We saw this review had taken place.

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Details of how to whistle blow were displayed in staff areas and on notice boards around the building.

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 was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.