The Orders Of St. John Care Trust

OSJCT Mayott House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 May 2016.

Mayott House provides domiciliary care and twenty four hour emergency cover for people in self-contained flats. The service is an Extra Care Housing Scheme and is run by The Order of St John Care Trust. On the day of our inspection 25 people were being supported with aspects of their personal care.

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.

There was a friendly, cheerful atmosphere throughout the day. People gathered in communal areas of the building where staff stopped to speak with them whenever they were passing.

People were complimentary about the registered manager and staff. The registered manager promoted a person-centred culture. Staff were skilled and knowledgeable about the people they supported and knew them well. Staff had regular supervision and were well supported by the registered manager.

Staff understood their responsibilities to identify and report concerns relating to abuse of vulnerable people. The provider had polices and procedures in place to ensure outside agencies were notified of concerns. Staff were trained in the management of medicines and people received their medicines as prescribed.

Care plans detailed people's needs and emphasised the importance of promoting independence. Risks to people were assessed and plans in place to manage the risks. People were supported to enjoy activities both in the service and in the community.

Staff had a clear understanding of the Mental Capacity Act (MCA) and how it impacted on their work. People were involved in decisions about their care.

People knew how to raise concerns and were confident action would be taken in a timely manner to resolve issues.

There were effective quality assurance systems in place to monitor and improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood their responsibilities to identify and report any concerns relating to abuse of vulnerable people.

Systems were in place to reduce the risk of missed and late visits.

People's care plans included risk assessments and where risks were identified there were plans in place to manage the risks.

Is the service effective?

Good

The service was effective.

The registered manager and staff had a clear understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA)

Staff felt well supported and completed training to ensure they had the skills and knowledge to meet people's needs.

People were supported to access health professionals when needed.

Is the service caring?

Good

People were supported by staff who were kind and caring.

People were treated with dignity and respect.

Staff took time to get to know people's likes. Staff went the extra mile to support people with social activities.

People were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People had person-centred care plans that detailed how they would like their needs to be met.

Staff understood the importance of promoting independence and found ways to support people to remain independent.

People enjoyed activities organised at Mayott House and in the community.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted a person-centred culture in the service and was well liked by people and staff.

Staff felt respected and were encouraged to suggest ways to improve the service.

There were effective quality assurance systems in place.

OSJCT Mayott House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 12 May 2016. The provider was given 24 hours notice of the inspection to ensure the registered manager was available.

The inspection was carried out by two inspectors.

At the time of the inspection there were 25 people being supported by the service. Prior to the inspection we reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law.

Before the inspection, 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 improvements they plan to make. We sent out questionnaires to seek feedback about the service. We received feedback from three people, two relatives and one health and social care professional. We spoke with the commissioners of the service and the local authority safeguarding team.

During the inspection we spoke with five people who were using the service and four people's relatives. We spoke with four care staff, the registered manager, the Domiciliary Care Manager and the Area Housing and Care Manager. We looked at five people's care records, four staff records and records relating to the general management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe when being supported by staff. One person told us, "They (care staff) always ask if I am all right before they leave me". Another person said, "I have slept a lot better since I have been here, I feel safe". Relatives were confident people were safe. One relative said, "(Person) has settled well and is happy and feels safe at Mayott House".

Staff had a clear knowledge of their responsibilities to identify and report any concerns in relation to safeguarding vulnerable people. Staff had completed safeguarding training and were able to describe the different types of abuse and signs that may indicate abuse. Staff told us they would report any concerns to the registered manager. Staff knew where to report concerns outside of the organisation if they felt concerns had not been taken seriously. This included reporting to the local authority safeguarding team and the Care Quality Commission (CQC). One member of staff told us, "I would speak to the registered manager or go to head office. If they didn't do anything I would come to you guys (CQC) or the county council".

People told us staff arrived on time and stayed for the allocated time. One person said, "It's (service) always run on time". A member of the care staff told us, "You get proper one to one time with them (people)".

People's daily care records showed staff arrived at the time requested by the person and stayed for the required time. The registered manager had a system in place to ensure all calls were scheduled and completed. This reduced the risk of missed and late visits.

People's care records contained risk assessments which included risks associated with mobility, moving and handling, medicines, pressure damage and nutrition. Where risks were identified there were plans in place to manage the risks. For example, one person's care plan included a risk assessment in relation to pressure damage. The care plan detailed the equipment in place to reduce the risk of pressure damage and the support the person needed to minimise the risk of developing pressure sores.

People who were supported with their medicines had clear care plans in place, detailing the medicines they were taking. All medicine administration was recorded on a medicines administration record (MAR). The provider worked to the Oxfordshire shared care protocols which required all care staff completing delegated health tasks to be trained and signed as competent by a health professional. Staff we spoke with knew their responsibilities relating to the administration of medicines and worked to the provider's medicines policy. Staff had received training in medicine administration and were signed as competent before administering medicines unsupervised. Where there were specific needs relating to the administration of medicines this was detailed in the person's care record. For example, one person had difficulty swallowing. The person's medicines were put into food to make it easier for the person to swallow them. This had been discussed with the person and health professionals. Staff we spoke with knew about this person's needs and how to administer their medicines.

Records relating to recruitment of new staff contained relevant checks that had been completed before staff worked unsupervised in people's homes to ensure they

were of good character. These included employment references and disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment
decisions and prevent unsuitable people from working with vulnerable people.

People's care records included personal emergency evacuation plans to ensure people were supported appropriately in the event of an emergency.

Staff were aware of their responsibilities in relation to infection control. One member of care staff was the infection control lead and promoted good practice in infection control. The staff member had received additional training to ensure they had the knowledge to undertake the infection control lead role.

Good

Is the service effective?

Our findings

People told us staff had the skills and knowledge to meet their needs. One person told us, "The staff are aware of my needs and know how to support me".
Staff told us they were supported in their role to ensure they had the skills and knowledge to meet people's needs. Staff had regular supervision in line with the organisations policy. Staff told us supervision was a positive experience and was an opportunity to discuss issues. One member of staff told us, "(Registered manager) lets me say what I want to say. It's (supervision) my space. I like to be told what's going right and what's not. (Registered manager) is a good listener who says it how it is".

Through supervision staff identified development needs and were encouraged to enrol for national qualifications in social and health care. One member of staff had requested additional training in medicine administration to improve their confidence. Training had been arranged. The member of staff had developed their skills and knowledge and had become the medicines lead for the service.

New staff completed an induction programme which included training in moving and handling, infection control, safeguarding and fire safety. Staff told us they had shadowed more experienced staff until they felt confident to work alone.

Staff completed regular training which was either e-learning or face to face. A training matrix enabled the registered manager to ensure staff completed training in line with the organisations policy. Where staff required updates these were arranged in a timely manner. We saw that several training sessions were arranged to ensure staff skills and knowledge were kept up to date.

We saw that several staff had signed up as 'Dementia friends'. Dementia Friends is an Alzheimer's Society initiative that enables people to learn about what it's like to live with dementia and then turn that understanding into action. Staff had completed training in dementia care and were positive about the impact the training had on their understanding of how to support people living with dementia.

The registered manager had a clear understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA). 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.

Staff had completed training in MCA and understood their responsibilities to support people in line with the principles of the Act. Staff comments included: "Just because someone lacks cap city in one thing, it doesn't mean they lack capacity in everything"; "To make sure people have the right to make their own decisions and that we support them to make decisions independently and if they can't then decisions are made in their best interest" and "We all have a right to live our lives as we want to. If someone doesn't have capacity we have to make sure decisions are in the best interest of the person".

Care plans contained information relating to people's capacity where there was reason to believe the person lacked capacity to make a specific decision. For example, a capacity assessment had been carried out following an incident with medicines prescribed to a person living with dementia. The capacity assessment was to determine whether the person could consent to steps being taken to reduce the risk of further incidents. The capacity assessment determined the person did have capacity to consent to the decision.

People were supported to meet their nutritional needs. For example, one person had difficulty eating. The person's care plan identified that food needed to be cut up and the person preferred to eat with a spoon. Staff were aware of the support this person required. People were able to choose what they wanted to eat and were supported to prepare their own meals where required.

There was a restaurant available in the scheme. Care plans identified where people required support to visit the restaurant and the days they wished to eat there. During our inspection we saw people being supported to visit the restaurant. There was a cheerful atmosphere and people were enjoying the food. One relative told us "[Person] is eating so much better because they are eating with other people".

People were supported to access health professionals where needed. Records showed people had seen GP, district nurse, falls service, occupational therapist and dentist. During our visit staff contacted health professionals on behalf of people. For example, one member of the care team called the district nurse as a person had injured their leg. Another member of staff was arranging transport for a person to enable them to attend a hospital appointment.

Good

Is the service caring?

Our findings

People were complimentary about the caring approach of care staff. Comments included: "The staff are good. They look after me. I can't fault the care"; "The staff are nice, absolutely wonderful"; "I like the staff, they are really nice"; "I could not wish for better care. I feel like the Queen. The staff are wonderful and I'm not just saying that" and "The staff are very friendly". Relatives were equally complimentary about the staff. One relative told us, "Staff are lovely, really friendly and caring".

Visiting health professionals told us that they had seen positive interactions between people and care staff. One social and health care professional told us, "The service users enjoy working with staff. Staff are service user led".

Staff spoke with compassion and kindness when speaking with and about people. Comments from care staff included; "I love it here. I love working with the clients. They are just the best. I get satisfaction from helping them" and "I always think about the person. You would expect it for yourself".

We saw many kind and caring interactions. For example, staff were supporting people to prepare for a garden party in the scheme during the afternoon of our visit. One person came out of the hairdressers after having their hair done. One of the care staff stopped to compliment the person on their hair. The staff member bent down to the person's level, touched their arm and made eye contact. The person smiled in response and thanked the member of staff.

We saw examples of staff going the extra mile for people. One staff member had come into work on their day off to take a person shopping. Another member of staff had bought an ornament of a person's favourite bird and given them as a gift. The person showed us the ornament and was clearly delighted that the member of staff had bought it for them.

Staff had received training in equality and human rights and understood how to protect people's rights. For example, people were treated with dignity and respect. One person told us, "They are always conscious of my dignity and privacy". Staff explained how they protected people's dignity. Examples included; "I make sure the door is closed and locked if I am supporting someone with personal care so that no one can come in" and "I make sure doors and curtains are closed. During transfers I make sure people are covered with towels to maintain their dignity".

Staff were discreet when speaking to people in communal areas of the scheme. One person was in the restaurant when a health professional visited. A member of the care staff approached the person and knelt down beside them. The staff member spoke quietly in the person's ear and pointed out the health professional to the person. The staff member then offered to support the person back to their flat so they could see the health professional in private.

People were included in the development of their care plans and felt involved in decisions about their care. One person told us, "They always involve me and ask me how things should be done". We heard staff asking

people's permission before providing support and giving detailed explanations before any support was given.

Good

Is the service responsive?

Our findings

People were assessed prior to using the service. Assessments were used to develop personalised care plans that identified the support people required to meet their needs. Care plans contained details of each care visit and the support the person needed at each visit.

People's personal preferences were detailed in their care plans. For example, one person's care plan identified they did not wish to be supported by male carers. The person told us, "They don't send a male worker because I have asked them not to". People's care plans included people's full names and preferred names. People were called by their preferred name.

Where people had specific needs in relation to health conditions care plans detailed how needs should be met and actions staff should take if they observed the person's condition had deteriorated. For example, one person's care plan identified the person experienced seizures. The care plan detailed what staff needed to do in the event of a seizure and at what stage emergency services should be called.

People's care plans detailed what people could do independently and the importance of supporting the person to maintain their independence. For example, one person's care plan stated, '[Person] can carry out some personal care tasks independently with guidance and support. Regaining dignity and independence is very important to (person)'.

Where people wished to remain independent care plans detailed any risk associated with the activity and how risks could be mitigated to support the person to maintain independence. For example, one person wished to use a piece of kitchen equipment. The care plan detailed how staff should set up the equipment and the care visit time had been adjusted to enable staff to return once the equipment had been used.

Staff understood the importance of promoting people's independence. One member of staff said, "For me it's all about independence. I always remind them [people] use it or lose it". One person who was living with dementia had a cup tea made for them at each care visit. However, one member of care staff had supported the person to make themselves a cup of tea. The staff member told us how pleased the person was that they had achieved this. It was clear that the staff member had been equally pleased at the achievement.

Care plans detailed people's histories, likes and dislikes and the activities that interested them. Care plans showed that this information had been used to ensure support was person centred. For example, one person had enjoyed a profession where they worked outside. The person was living with dementia and still enjoyed walking outside. To enable them to continue to do this and to ensure they did not get lost a GPS tracking system had been added to the person's mobile phone. We saw the person walking freely outside.

During the afternoon a garden party, with entertainers took place. The event was enjoyed by people, their relatives and friends. Several people from the local community were invited and attended. Staff supported people to attend and there was a lively cheerful atmosphere.

People were encouraged to suggest activities they would like to take place at Mayott House. Suggestions made by people had included: carpet bowls, arts and crafts, movie nights and bingo. The registered manager was planning a calendar of activities.

People were supported to attend activities in the local community. People told us they were supported to go shopping and to attend local support groups. A local charity group had been approached to provide links with the local community. The local fire service and police community support officers had attended coffee mornings and talked to people about keeping themselves safe.

There was a complaint policy and procedure in place. Copies were displayed in the communal areas of the scheme. Complaints were recorded and responded to in line with the provider's policy. People told us they knew how to make a complaint and they were confident that any concerns would be dealt with promptly. The provider was currently designing a quality questionnaire to be sent out to people and their relatives to seek feedback about the service. The registered manager visited people to carry out quality checks. Any feedback in relation to the service was recorded and action taken. For example, one person's care visit time had been adjusted at the request of the person.

Good

Is the service well-led?

Our findings

People were positive about the registered manager. One person said, "[Registered manager] is lovely. He always asks if I am alright and settled". Relatives were equally complimentary. One relative told us, "[Registered manager] will always make sure they (people) have everything".

Staff told us the registered manager was supportive and approachable. Comments included: "[Registered manager] is awesome. He has such a caring side. I can tell him anything"; "[Registered manager] listens and he is easy to talk to"; "[Registered manager] is really supportive. He makes sure I'm feeling confident" and "[Registered manager] is brilliant, he's spot on". Staff told us of examples where the registered manager had supported them during difficult personal circumstances. This was much appreciated by staff and made them feel valued and respected.

Staff enjoyed their job. One member of care staff said, "I enjoy working here. It's a good place to work".

Social and health care professionals were positive about the service. One professional told us, "I have absolutely no concerns about the service. They are helpful at sourcing resources for individuals and are good at contacting me if there are any concerns".

The registered manager promoted a caring, person-centred culture in the service that supported the values of the organisation. The values were displayed in the staff area of the scheme and included, Dedicated to Caring, Empowering Individuals, Respecting Each Other and Promoting Communities.

The registered manager knew people well and spent time speaking with people as he walked around. People clearly knew him and enjoyed speaking with him. One person enjoyed an interaction with the registered manager, talking with him about the person's war time memories.

The Domiciliary Care Manager told us the registered manager was passionate about his job and spent many additional hours of his own time planning activities for people and looking for ways to improve community involvement. For example, the registered manager had planned and organised the garden party which had been advertised in the local community.

There were regular staff meetings to enable the registered manager to give feedback to staff and discuss any issues. Records showed that staff were encouraged to participate in problem solving and suggesting ways to improve the service. Each month the provider promoted a 'policy of the month'. Staff were given a copy of the policy and signed to say they had read it. For example, in April staff had been given a copy of the 'social media policy'. Staff had discussed the policy at a team meeting and signed to confirm they had read and understood their responsibilities.

The registered manager managed two additional locations providing support to people in their own homes. There was no team leader in post to support the registered manager at Mayott House. This meant there was not always management cover at the service. Nobody we spoke with told us this situation impacted on their

care and we could not find any evidence of negative impact on this service.

There were quality assurance systems in place. The organisation carried out a quality compliance audit, which audited the service against the domains used by CQC during inspections. Where issues were identified an action plan was developed which showed the actions taken to address the issues. For example, issues were identified in relation to records related to people's capacity to make specific decisions. These were now in place.

Care plans were audited monthly. However, we found that an audit on the 10 May 2016 had not picked up two missing entries on one persons' daily record. Systems in place to monitor calls showed the person had received their visit. We spoke with the Domiciliary Care Manager and the registered manager about this issue. The audit tool was immediately amended to ensure daily entries were checked for each visit in all future audits.

Accidents and incidents were reported and recorded. There were systems in place to look for trends and patterns in relation to accidents and incidents. For example, the provider monitored all falls. This included looking at falls for individual people and across the service in relation to times of falls.