The Orders Of St. John Care Trust

OSJCT Patchett Lodge

Inspection report

Stukeley Road,
Holbeach,
Lincolnshire,
PE12 7LJ
Tel: 01406 422012
Website: www.osjct.co.uk

Date of inspection visit: 22 December 2015
Date of publication: 22/03/2016

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?	Requires improvement
Is the service well-led?	Good

Overall summary

The inspection took place on 22 December 2015 and was unannounced.

OSJCT Patchett Lodge is registered to provide accommodation and personal care for up to 30 older people. There were 27 people living at the service on the day of our inspection.

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

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

Summary of findings

them. The management and staff understood their responsibility and made appropriate referrals for assessment. No one at the time of our inspection had their freedom restricted under a DoLS authorisation.

People were kept safe because staff undertook appropriate risk assessments for all aspects of their care and care plans were developed to support people's individual needs. People were supported to make decisions about their care and treatment and staff supported people to maintain their independence.

The registered manager ensured that there were sufficient numbers of staff to support people safely. People were cared for by staff who had knowledge and skills to perform their roles and responsibilities and meet the unique needs of the people in their care. Staff received feedback on their performance through supervision and appraisal

People were not always given their medicine safely and there were errors and omissions in the medicine administration charts. People had their healthcare needs identified and were enabled to access healthcare professionals such as their GP, community nurse and hospital doctor. Staff supported people to have a balanced and nutritious diet.

People were not always treated with dignity and respect, although most staff were kind, and caring and sensitive to people's individual needs. People were not supported to follow their hobbies and past times and there was little provision of meaningful activities.

The registered provider had robust systems in place to monitor the quality of the service, including regular audits and feedback from people, their relatives and staff. The service had received recognition from the provider for areas of good practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

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

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

Staff did not follow safe procedures when administering medicine.

Requires improvement

Is the service effective?
The service was effective.

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

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

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

Good

Is the service caring?
The service was not always caring.

Staff cared for people in a person centred way.

People were not always cared for with dignity and respect.

Good

Is the service responsive?
The service was not always responsive.

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

People were not supported to maintain their hobbies and interests.

Requires improvement

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

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

There was an open and positive culture which focussed on people and staff, people and their relatives found the registered manager approachable.

Good

OSJCT Patchett Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection took place on 22 December 2015 and was unannounced.

The inspection team was made up of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

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

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the registered manager, the area operations manager, care leader, three members of care staff, the cook, a housekeeper, eight people who lived at the service and four visiting relatives and friends. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. This included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for 10 people and medicine administration records for 10 people.

Requires improvement

Is the service safe?

Our findings

Care staff who had received training in medicines management had been assessed as competent to administer them. However, we observed a senior member of care staff administer medicine to people at lunch time and found that people did not always receive their medicine safely. This was a risk to the person and to other people who were sat at the lunch table with them. For example, we observed two people who were prescribed a liquid medicine preferred to take it after their meal. Although the staff member was aware of this they left the medicine with the person and signed the Medicine Administration Record (MAR) chart to confirm that the person had taken their medicine although they had not. We also noted that the member of staff had little interaction with people. Furthermore, they did not wait with other people until they had safely swallowed their medicine in tablet form. People told us that they always received their medicine at the correct time. One person said, "I get it at the regular time. They are very good with that."

We looked at MAR charts for ten people and found that best practice guidelines were not always adhered to. Allergies and special instructions were recorded on MAR charts; however, we found that two people did not have a photograph on their MAR chart for identification purposes. In addition, there was a standard code to record the reason when a person did not receive their medicine, such as when they were asleep, but this was not always used and we found gaps on the MAR charts. Furthermore, people who received medicine through a skin patch were not protected from skin damage as staff did not record where and when patches were applied and so had no information to support correct rotation of patch sites.

All medicines were stored accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to national guidance on the safe use of medicines and the provider's medicines policy. The registered manager reported to CQC that there had been four medicine errors identified in the last 12 months and care staff had attended special meetings in response to these errors.

People told us that they felt safe, especially when they were receiving personal care from staff. One person said, "I'm alright. I feel safe when they are putting me in and out of the bath. They let me have a nice five minute soak." Another person said, "I feel safe when they hoist me as I really need their help."

Staff told us that they had received training on how to keep people safe and how to recognise signs of abuse. In addition, staff knew how to share their concerns with their senior managers and the local safeguarding authority. One staff member explained what they would do if they suspected abuse, "There could be a change in the way they are, they could be outgoing and then quiet, I would speak to them and tell the manager or whistle blow and make the council aware." We found that the provider had policies, procedures and a safeguarding resource folder in place to support staff to prevent people from avoidable harm and help keep them safe.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such as, moving and handling and falls. Care plans were in place which enabled staff to reduce the risk and maintain a person's safety

A staff member told us that they tried to give person centred care, but it was difficult in the evening and added, "We could use more staff after tea and before the night staff come on duty. Everyone wants to go to bed at that time." The provider had a system for calculating the care dependency levels for the people who lived at the service. These dependency levels then informed the registered manager of how many staff with different skill levels were needed on each shift. However, the registered manager told us that they were reviewing staffing levels for certain times of day. The registered manager told us that people's dependency levels were reviewed once a month. People told us that staff responded to their calls bells. We received comment such as, "When I use my call bell they are not far behind," and "They come quickly when I ring." We found that there were sufficient staff on duty to meet people's needs and call bells were answered promptly.

We looked at two staff files and saw that there was a robust recruitment processes in place that identified all the necessary safety checks to be completed to ensure that a prospective staff member was suitable before they were appointed to post.

Good

Is the service effective?

Our findings

People told us that they were happy with their care and staff had the skills to do their job and support them to maintain their independence. One person said, "The staff seem capable and very helpful." Another person said, "They help me wash and dress in the morning and then I can do what I want."

Staff were provided with training in areas such the care of a person living with dementia, safeguarding, deprivation of liberty safeguards and dignity. In addition, several staff were supported to work towards a nationally recognised qualification in adult social care. Staff spoke with enthusiasm about the training they received. For example, a member of kitchen staff said, "They try to involve us in all types of training." A member of care staff told us, "All the training is fantastic. Never worked in a place like it. This goes above and beyond." All new staff undertook a six month probationary period that included a 12 week induction programme, where they completed a workbook with the supervision of a mentor. New staff also shadowed experienced care staff before they worked on their own. Furthermore, the registered manager explained that there would be changes to the induction programme and new starters would undertake the new care certificate. This is a new training scheme supported by the government to give staff the skills needed to care for people.

Staff received supervision and appraisals from their head of department or the registered manager. A senior member of care staff told us that they provided supervision to care staff every couple of months and added, "We're told we are doing a good job at our appraisals."

We observed that people's consent to care and treatment was sought by staff. For example, we saw that people had signed consent to reside at the service. Staff were aware that some people were unable to sign or give verbal consent and described the signs of agreement that they look for. One staff member said, "You look for body gestures, they will nod, grin or give the "thumbs up" sign." And another member of staff said, "I always ask for their consent, you don't do things against their will. There are capacity issues."

Where a person lacked capacity to give their consent staff followed the principles of the Mental Capacity Act 2005 (MCA). The 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.

We saw where a person had lacked capacity to consent to their care that they had appointed a member of their family to act as their Lasting Power of Attorney (LPA). A LPA is someone registered with the Office of the Public Guardian to make decisions on behalf of a person who is unable to do so themselves.

Care staff understood the principles of MCA. One staff member said, "You assume people have capacity. A lot of people are forgetful, but you can't actually say they lack capacity. Some people have fluctuating capacity. They'll not take their tablets and you go back in half an hour and they will." Another staff member told us, "A person can be confused, but it could be that have a urine infection or a mini stroke. You have to look for triggers first."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There was no one currently living at the service being cared for under a DoLS authorisation. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

People were provided with a well-balanced and nutritious diet and offered a choice of meals from a four week menu plan. We found that if a person did not want the choices on offer that alternatives to the menu were available, such as omelettes and baked potatoes. Most people told us that the food was good. One person said, "The food is alright. There is usually a choice or I'll have a salad." Another person said, "The food is good. It shows good foresight the way they arrange the meals." A sign in the dining room informed people that hot and cold snacks were available at any time. Furthermore, the registered manger told us that crisps and fruit were available with morning and afternoon drinks but no one wanted them.

Good

Is the service effective?

We spoke with the cook who told us that they catered for people with special dietary needs and food allergies. We saw that they maintained a record of people's dietary needs and food likes and dislikes. Some dishes were fortified to support people who may be at risk of weight loss. For example, we found that butter and milk was added to mashed potatoes and homemade cakes and full fat milk to custards. We noted that all dishes were homemade and made with fresh ingredients.

People were given a choice of where they took their meals, some choose the dining room and others preferred to take their meals in the lounge or their bedroom. We saw that people were offered a choice of drink with their meal and these were regularly topped up.

People assessed as being at risk of malnutrition or dehydration had their food and fluid intake monitored and their weight recorded and actions were taken. Staff told us that some people had been referred to their GP for weight loss and had been prescribed regular nutritional supplements and referred to the dietitian.

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, speech and language therapist and district nurse. When a person needed a specialist medical assessment care staff liaised with the persons' GP to ensure that they received it.

People and their relatives had access to information leaflets on how to keep well in later life provided by national charities. They also received support from a dementia champion and an Admiral nurse. Admiral nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia to help them cope.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. One person told us, "They are very good in a kind and polite way." Another person said, "They've been very good. I can't complain. They're all very friendly." One person's relative said, "It's one of the best places round here. She seems a lot happier than when at home."

We found that staff were sensitive to the change people experienced when they first moved into the service from their own home. One staff member said, "They are unsettled and can get depressed leaving home. It's a big change, a new environment and they are living with and being cared for by lots of strangers. We take it in small stages; they need time to settle in." One person who had moved into the service a few days before our visit told us how staff had made them feel welcome and said, "They came and asked me about what I liked and disliked and what I liked to be called."

We found that people were supported to celebrate special occasions. For example, a couple celebrated their sixty-fifty wedding anniversary together. They celebrate with a special cake and their photograph and message of congratulations was posted in the December newsletter.

Leaflets on the role of the local advocacy service were available. These provided care staff and people with information on how to access an advocate to support a person through complex decision making, such as permanently moving into the care home. Advocates are people who are independent of the service and who support people to make their own decisions and communicate their wishes.

There were measures in place to enable people to be familiar with their surroundings. For example, the signage throughout the service was in word and pictorial format.

We saw that people's right to their privacy and personal space was respected. For example, we noted that staff always knocked on a person's bedroom door before entering and doors and curtains were closed when a person was receiving personal care. On staff member said, "I knock on the door, you don't just walk in." The people we spoke with confirmed this. Furthermore, relatives told us that they were able to visit at any time and could use one of the quiet lounges or the person's bedroom so as they were undisturbed.

We observed that a dignified approach was taken at lunchtime and people were offered cleansing wipes to clean their hands before lunch and gravy and parsley sauce were served in gravy boats so as people could help themselves. Some people were offered the choice of a protective tabards so as their clothing would not get soiled from spills. Most people sat in friendship groups and people who were assisted to walk to the dining room were asked where they would like to sit. One member of staff said, "The residents like to sit with the same people they know." Some people were assisted to eat their lunch by care staff that sat beside them and supported them to eat their meal at their own pace. Throughout the meal staff treated people with dignity and respect and acknowledged their achievements.

Staff told us how they treated people with the same respect that they would give a member of their family. However, we found at times staff focussed on the task and not the person. For example, before lunch we observed two incidents where care staff were assisting people to transfer from their armchair to a wheelchair using a special transfer aid and were interrupted by other staff for non-urgent matters. The people at the centre of the procedures were ignored, and talked over. When staff finally acknowledged the person they spoke to them in a way that they would not speak to their colleagues and addressed them as "my lovie" and "sweetheart".

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

Requires improvement

Is the service responsive?

Our findings

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. Furthermore, people's care files and risk assessments were reviewed each month and changes to their care needs were recorded. We saw that the format of the care plans was easy to follow and we could access the information we needed. We saw where one person was at risk of falls that they had a sensor mat at the side of their bed and an alarm alerted staff when the person got out of bed unaided. A senior member of care staff said, "Our care plans are more person-centred now. The [provider] is really into person-centred care. It does work. They are individual. If I was here I would want to do as I want."

Different resources were used by care staff to learn about people's likes and dislikes and care needs. Most people had a booklet called "All about me" that recorded the person's life story and was a resource to enable staff to get to know the person's history. One staff member told us, "I know them, know their likes and dislikes. I do the best I can for them." However, there was no recorded information of how people liked to spend their time or how to maintain a person's interest in their in hobbies and pastimes.

We found that the activity coordinator was on leave and there was not an activity programme in place. In addition, there was a wall mounted activity planner in the dining room which was blank. A staff member said, "There isn't enough for people to do. We don't do enough with them. They've got bingo today, but usually they just pass their time reading and watching television." We saw that the bingo session was well attended and organised by one person's relatives.

People told us that there was little for them to do, that they would like more activities and outings. One person said, "[Activity coordinator's name] is ok, but when she is not here nothing happens. I don't know why they don't have regular dominoes or cards or something we can play. There are so many that just sit all day and are more than capable of doing something." Another person said, "They do things up to a point, but not every day. There are no films, just day time TV." A third person told us, "I like to read and not watch TV. And they said they didn't have any outings planned. I was surprised that they don't do something to mark Sunday. It would be good idea to do something like play a few hymns."

We found that people were enabled to keep up to date with news about the local community through the "parish" newsletters. However, few people had maintained contact with the local community and there had been no visits from local organisations or schools in the previous year. With the exception of one person who attended a special interest club for people who were registered blind and another person who regularly went to lunch with their family people seldom went out.

Staff told us that they knew what to do if a person raised concerns and said that they would talk with the person but would also share it with the member of staff in charge. Another staff member said, "If I had a complaint I would go to [registered manager's name], we would speak with the family. There is a process to go through they are all recorded."

We saw a copy of the complaints and concerns policy was accessible to people and their visitors at the main entrance. In addition, each person had a copy of the provider's handbook that contained useful information about the service including how to make a complaint. We looked at the complaints, compliments and comments folder and read several cards and letters thanking staff for the care they had given a loved one.

Good

Is the service well-led?

Our findings

The registered provider's values were on display in the main reception area for people and their relatives to read. We saw that the principal values reflected the standard and quality of care people should expect to receive. However, not all values were reflected in the daily life of the service, such as providing people with the opportunity and encouragement to do and experience the things that they wish to do in order to continue a normal and fulfilling life.

We saw that the registered manager was accessible to staff, people and their families. They had recently moved their office from upstairs to a room near the front door where they could see and be seen by people, staff and visitors. Staff told us that the registered manager was approachable and a good leader. One staff member said, "I can go to her, no problem." Another said, "Very approachable, she is good. Knows what she is doing and always answers my questions." People and their relatives knew the registered manager and found them approachable. One person said, "[Registered manager's name] is everywhere. I can talk to her." A relative said, "I like [registered manager's name], she is very approachable." The registered manager had been in post for less than a year and told us that they were well supported by their area operations manager and received monthly quality visits from them.

Staff told us that it was a good place to work and they were part of a good team. One member of care staff said, "We work as a team and all pull together as a team. This is the best home I have ever worked in"

People were invited to "residents" meetings and there was a regular monthly newsletter. We read the minutes from the meeting held in October 2015. We found that the agenda raised topics that were important to people, such as Halloween, Christmas, changes to the menus and fish and chip nights. We saw that there were no attendees at the last relatives meeting and the registered manager said that relatives came and spoke with them individually.

People were asked for their feedback on the standard of service that they received through an annual quality survey. We looked at the results for 2015 and saw that people responded positively to the standards of care they received and felt safe and secure. However, we noted that people made comments about the lack of activities and outings.

We saw that staff were supported to attend team meetings. A member of care staff told us, "We have a seniors meeting next month and that will be followed by a carers meeting." A member of kitchen staff said, "We have meetings just for the kitchen staff, they are good. We are a small team." We looked at the minutes from five recent meetings and saw that the topics discussed were relevant to staff roles and responsibilities. For example, medicine administration and care plan audits were discussed with senior care staff and mattress cleaning with housekeeping staff.

The provider held an annual award ceremony to acknowledge outstanding performance and length of service. The service had received accreditation for dementia care from a national charity for their input into improving the life of people living with dementia. Furthermore, we saw that a member of care staff had recently received an award for 40 years service.

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control and guidance on delivering personal care. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager, provided national care organisations and charities for older people.

There was a programme of regular audits that covered key areas such as the kitchen, medicines and infection control. We noted that action plans were developed in response to areas of improvement identified in audits and staff learnt lessons from these. The infection control lead told us that they undertook a monthly audit on the standards of cleanliness and had recently seen improvements. In addition, the service achieved a score of 94.6 per cent in a recent internal audit, the area operations manager informed us that this was the highest score achieved in the region.

The provider had an electronic process in place for staff to record accidents and incidents such as slips trips and falls and medicine errors. We found that incidents were investigated and lessons were learnt and shared with staff. The registered manager told us what incidents were notifiable to CQC as part of the provider's registration requirements, for example when a person had a serious injury following a fall.

Good

Is the service well-led?

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