The Orders Of St. John Care Trust

OSJCT Fosse 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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced inspection on 12 April 2018.

OSJCT Fosse House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

OSJCT Fosse House provides accommodation for up to 42 older people with care needs including physical frailty and dementia. It is situated on the outskirts of Lincoln and provides accommodation over two floors. On the day of our inspection there were 39 people staying at the home.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good overall. At this inspection our rating for the responsive domain changed to requires improvement as care records did not always reflect people's current care needs and some social activities could be improved. However, this did not affect the overall rating of good. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

There was a registered manager in place. 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.

Systems and processes were in place to keep people safe. Staff understood their responsibilities for safeguarding the people they cared for and assessed risks to their health and safety. Measures were in place to reduce these risks and people were supported to stay safe, whilst not unnecessarily restricting their freedom. However, documentation in this area was not always fully reflective of the steps being taken by staff. Recruitment processes ensured appropriate staff were recruited to work in the home. Accidents and incidents were recorded, investigated and learning identified. Safety checks of the premises and equipment were completed and processes were in place to prevent and control infection. People's medicines continued to be managed safely.

Staff received appropriate training for their role and they were supported to further develop their knowledge and skills. People's needs were assessed and care was delivered in line with national guidance. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, documentation of mental capacity assessments and decision making in people's best interests was not always fully completed. People were supported to access their GP and other healthcare professionals when it was necessary.

Staff were knowledgeable about the people they cared for and treated them with kindness. They respected

people's privacy and dignity. People were involved in planning and reviewing their care.

Care was generally responsive to people's individual needs, but care plans were not always fully updated in response to changes in people's requirements. Information about people's personal preferences in relation to their care and their life history was available. Some activities were available for people in the form of entertainment, external visits and one to one and group activities at the home. However, people we spoke with and their relatives told us they would like more activities to be provided. The service had not fully embedded the accessible information standard which ensures that provisions are made for people to have information about their care in ways which are meaningful to them.

Staff felt supported by the leadership and management team and had the opportunity to raise issues and concerns. Relatives told us that when they identified a concern, it was listened to and addressed. The provider and the registered manager monitored the quality of the services provided and action plans were completed to bring about improvements when required. The registered manager carried out their role in line with their registration with the CQC.

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 remains Good

Is the service effective?

Good

The service remains Good

Is the service caring?

Good

The service remains Good

Is the service responsive?

Requires Improvement

Care records did not always reflect the current care and support people required.

A range of activities were available but people would have liked the opportunity to participate in more activities.

Information was not consistently available in an accessible format.

Staff knew people well and care was individualised to people's needs.

Processes were in place for the management of complaints and people's relatives told us that concerns raised were addressed by staff and the management team.

Is the service well-led?

Good

The service remains Good

OSJCT Fosse 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 checked 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 comprehensive inspection took place on 12 April 2018 and was unannounced. The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was dementia care.

Before the inspection we reviewed information the provider sent us in the Provider Information Return. This is information we require providers to send to us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information we held about the home including notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted County Council commissioners of adult social care services and Healthwatch and asked them for their views of the service provided. Healthwatch is the local consumer champion for people using adult social care services

During the inspection we spoke with six people using the service and five relatives. We spoke with the area operations manager, registered manager, three care staff, an assistant cook, two housekeepers and two visiting health professionals.

We observed staff providing support to people in the communal areas of the service. This was so we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included looking at all or part of five people's care records and associated documents. We reviewed records of meetings, recruitment checks carried out for three staff, staff rotas, staff training records and maintenance and safety logs. We also reviewed the quality assurance audits the management team had completed.

Good

Is the service safe?

Our findings

People were supported by staff who understood how to protect them from avoidable harm. Records showed that staff had completed training in safeguarding vulnerable adults. Staff we spoke with were aware of the signs of abuse and what to look for, such as changes in people's behaviour that might indicate they were being abused. They told us they would report any concerns to the head of care or the registered manager and they were aware of how to escalate issues to the provider's management team if necessary. The registered manager was aware of their responsibility to make safeguarding referrals.

Risks to people's health and safety were assessed and reviewed so they were supported to stay safe, whilst not unnecessarily restricting their freedom. For example, when people needed support to move around the home, the equipment and support they needed was recorded. However, we found one instance when a person's falls risk was incorrectly calculated, which suggested they were at lower risk of falls than they actually were. When we spoke with staff and the registered manager, we found all the necessary actions were in place to minimise the person's risk of falling and therefore there was no impact on the person. The registered manager agreed to review the person's risk assessment and care plan to ensure it correctly reflected the person's care needs and the care provided. Equipment was in place to reduce risks to people, including pressure relieving mattresses and sensor mats to alert staff when people were at risk of falling.

People were supported by staff who were aware of their responsibility to report any accidents or incidents. When accidents and incidents occurred they were reported and investigated. The registered manager showed us evidence of the monthly review of falls to identify themes and additional measures to reduce risks to people.

We received mixed feedback from people, their relatives, staff and visiting professionals as to whether there were sufficient staff available to meet peoples' care and support needs. During the inspection we noted staff were not always present in communal areas when people were calling for assistance. We noted a person's legs were inflamed and badly scratched which staff had not noticed until we brought it to their attention. People commented on how busy staff were and a relative said, "They (the staff) are ever so busy all the time when we visit and it's difficult to get anyone to have any time to spend to catch up regarding [family member's] care." Prior to the inspection we were contacted with a concern about staffing levels at night. We checked staff rotas and saw the number of staff on duty generally matched the planned number. The registered manager told us that the head of care did night shifts regularly and they carried out spot checks at night. They felt the number of staff was sufficient for people's needs. The provider used a recognised tool to determine staffing requirements on an annual basis and the registered manager could ask for additional staff if they felt they were required. However, the area operations manager said they would review staffing levels, particularly at night.

People could be assured that required recruitment checks were completed to ensure staff were suitable to work with them. However, recruitment files did not always contain evidence of a reference from the person's previous employer. The registered manager told us a verbal reference was obtained but was not recorded in one case we reviewed

People told us they received their medicines regularly and staff explained their medicines to them. Processes were in place for the timely ordering and supply of people's medicines. They were stored and managed safely in line with requirements. Staff completed records of administration of medicines accurately and consistently. Staff received training and competency assessments to ensure they maintained safe medicines practices and regular audits were completed to monitor compliance with medicines requirements.

The premises and equipment were managed safely. The required safety checks including fire safety, water safety and other checks of the premises were completed. Equipment was serviced regularly and the required safety checks of the premises were completed. The décor was in need of updating, however, the provider told us they were planning a new build in the ground of Fosse House in the near future. On the day of the inspection, contractors were re-decorating all the corridors of the home and there was a high level of dust. Housekeeping staff and the contractors were working to address this and individual rooms were not affected. The provider had measures in place to prevent and control infection. Staff were aware of the steps required to reduce the risk of infection and completed infection control training. They spoke about a recent outbreak of infection at the home, the precautions they used to reduce the spread of infection, advice they obtained from external specialists and said, "Teamwork was the key."

Good

Is the service effective?

Our findings

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. Records showed that DoLS applications were completed when required and there was a systematic approach to the assessment of people's capacity and best interest decision making in relation to these decisions.

People were supported with their behaviour in the least restrictive way. We spoke with the registered manager and reviewed the records of two people who were living with dementia and showing distressed behaviours, which presented a risk to themselves and others. We found staff had met with and involved the families and other professionals in determining the way they could be care for in the least restrictive way and which kept them safe. The discussions we had showed that all possible factors were considered in order to promote people's well-being.

A person had a Lasting Power of Attorney in place for their health and welfare. The attorney had signed their care plans to show they had been consulted and agreed to the person's care plans. We spoke with the relatives who had the power of attorney and they confirmed they were fully involved in decisions about their family members care.

However, mental capacity assessments were not always documented when people could not make a decision about their care. When bed rails were used to prevent people from falling out of bed, mental capacity assessments and best interest decisions were documented when people did not have the capacity to consent to their use. A systematic approach was used to assessing risk when staff considered using bed rails to prevent a person falling out of bed. However, mental capacity assessments and decision making in relation to decisions about the use of sensor mats, medicines administration and the provision of personal care when this caused the person distress, were not always documented. The manager agreed to review this further and address this.

People's needs were assessed and care was provided in line with current guidance. For example nationally recognised tools were used to assess people's risk of developing pressure ulcers and their nutritional risk. When people required assistance to prevent the development of pressure ulcers, care was provided in line with best practice. People's diverse needs and characteristics were recognised and accommodated to ensure people were not subject to discrimination. Staff we spoke with and the care plans we reviewed,

showed these characteristics had been considered when providing care for people.

People were supported with their day to day healthcare. We saw people were supported to access their GP when they were unwell and we saw evidence of the involvement of other professionals such as chiropodists and opticians.

People and their relatives felt staff were competent and well trained. Staff were knowledgeable about people's care needs and supported them safely and effectively. Staff received a full induction when they commenced employment and the provider ensured they maintained their skills and competency through training updates. Staff were positive about the training provided and felt it equipped them with the skills they required to provide effective care. One member of staff said, "It's a good home, the training and support is brilliant – outstanding." They told us and records confirmed, they received supervision and an annual appraisal to identify their goals and development needs.

People were provided with a varied and balanced diet based on their individual preferences. People told us they enjoyed their meals and had plenty to drink. Catering staff were knowledgeable about people's needs and monitored the amount they ate. We observed staff encouraged to people to eat and drink when they required some assistance and prompting. However, we observed a member of staff supporting three people who required assistance at lunchtime at the same time which did not provide an optimum mealtime experience. The registered manager agreed to monitor this to ensure it did not occur in the future.

Good

Is the service caring?

Our findings

All the people we spoke with said they felt staff were kind, courteous and polite and they treated them with respect and dignity. One person said, "They (staff) are all very kind and friendly. I feel very safe here." The relatives we spoke with also said they felt the staff were kind and caring. A relative told us of the steps staff had taken to identify reasons why their family member was unsettled and showing signs of distress. They said staff consulted other professionals, tried different environments to find where they were most comfortable, and spent time with their family member. They said this had had a positive effect and their family member was now more settled.

People were supported to maintain their privacy and dignity. We saw staff knocking on people's doors before entering and speaking sensitively to people when they needed assistance. We observed staff providing explanations to people and reassurance when they moved them using a hoist. They ensured the person was covered appropriately to protect their dignity. A member of staff said, "I always knock before entering someone's room. Their room is their little home and we have to respect that; the same with their belongings."

We observed staff supporting people at their lunchtime meal. Staff interacted well with people and we observed that when they provided assistance, they allowed the person to eat at their own pace and treated them with dignity and respect.

People were involved in the development and review of their care on a regular basis and this was documented in their care records. A relative told us they had lasting power of attorney for their family member and they were invited to a meeting with the manager and other professionals to discuss their family member's care. They said, "They (staff) went through everything with us, they are so good. We are really impressed." They went on to say, "If staff have any concerns they take us into the office to discuss things with us."

People confirmed they were offered choices and we observed staff offering choices in relation to where they wanted to spend their time and choice of food and drink.

People's relatives told us there were no restrictions on visiting and people told us they were able to go out with their relatives whenever they wished.

Requires Improvement

Is the service responsive?

Our findings

People's care needs were assessed and care plans developed to meet their individual needs. They contained information about people's individual preferences and wishes in relation to their care. However, they did not always fully reflect changes to their care needs and the actions needed to keep them safe. For example, a person's eating and drinking care plan stated they were able to eat a normal diet, but when we reviewed all the monthly evaluations of care we found they had been assessed by a speech and language therapist and they required a soft diet. This meant the changes would not be immediately apparent to staff on reading the care plans. During the inspection we observed a member of staff giving the person biscuits whilst another member of staff was aware of the person's needs and ensured the food was soft prior to giving it to the person. The registered manager said the person was a new member of staff and they would ensure the person's needs were communicated to the member of staff. This meant that improvements were required to ensure that people's care records clearly recorded any changes in people's care needs and that changes were communicated to all staff.

Information about people's personal preferences and life stories was available in their care plans and in "This is me" booklets. Staff generally knew people's preferences, but continued to give them choices rather than making assumptions.

The service employed activities coordinators and staff were exploring ways to tailor the activities provision to the needs of people using the service. For example, staff were provided with training on the use of music to improve the well-being of older people through an initiative called, 'Live music now'. There was a knitting group and gardening activities had recently been introduced. On one day each week, the activities coordinator worked in the evening to encourage people to participate in activities prior to them going to bed. The registered manager said they had observed people asking to go to bed early and thought this might be due to a lack of activities in the evening. However, the overall hours of the activities coordinator were not increased and as a result there were no activities during the day on these days. This was the case on the day of the inspection, when we did not see any activities to occupy people. Some people and relatives told us they would like to see more activities for people. A person said, "My [relative] comes to take me out, but for some other people there isn't much for them to do." Another person said, "There are times when it would be nice to be doing more things, but I am lucky that my family come and visit such a lot."

The registered manager explained there had been a significant number of new people admitted to the home over the previous month and this had changed the types of activities people would like to participate in. They were currently looking at changes to the activities schedule to take account of these changes.

People's communication needs were recorded in communication care plans. They identified when people required hearing aids or glasses and when people's understanding and communication was affected by dementia, this was recorded. However, there was little information about how to aid people's understanding and enable them to make choices. There was no information in easy read or pictorial format. Staff showed us photographs they had taken in preparation for developing a pictorial menu, but they did not currently show people the food options at the mealtime or make any adaptations to aid choice. A

resident's handbook which provided information about the services provided and was in a large print format was stored in each person's room.

People's relatives said that if they had any concerns or issues they raised them with a senior carer or the head of care and they were addressed. Information about how to raise a complaint was available in the resident's handbook. One relative spoke about the input of the registered manager and head of care in resolving issues related to their family member.

Records indicated that no formal complaints were received by the service since the beginning of 2017. The registered manager told us the complaints policy was normally displayed in the entrance to the home, however had been removed during the re-decoration.

Advance care plans were in place which identified people's wishes when they reached the end of their life. Staff had received training in end of life care.

Good

Is the service well-led?

Our findings

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.

The registered manager was aware of their responsibilities and made the required notifications to the CQC. The CQC ratings from the last inspection in 2015 were displayed on the website for the home. At the time of the inspection, all information had been removed at the entrance to the home to enable re-decoration to take place, therefore information was not displayed about the CQC ratings, but we saw the information was available.

There was a clear organisational structure in place and care staff said they would normally discuss any concerns with the senior carers initially. They felt supported by the senior carers and the head of care. One member of staff said, "The seniors always take the staff seriously and deal with any concerns, whatever they are. They listen and respond, whatever the concern, and they make you feel really supported. Then there is the manager and head of care too." Another member of staff said, "The leadership here is excellent. I've worked in four other homes and this is the best. The staff are well looked after– encouraged – motivated. There's lots of support."

The registered manager and the provider completed quality monitoring audits that looked at different aspects of the service using the CQC key lines of enquiry and completed infection control audits. We reviewed the results of the audits and saw that when improvements were required, action plans were developed and completed to address the issues. Some of the provider's policies were overdue for review, however the review process was underway and we were assured the new policies would be available imminently.

There were a small number of records which the registered manager had difficulty in locating or were missing during the inspection. For example, records of bacterial water testing and shower head cleaning, pre-employment references for staff, safeguarding records and copies of lasting power of attorney documentation. Following the inspection we were given reassurance that the necessary checks were completed and documentation to confirm this was provided.

Regular meetings were held for people using the service and for staff. We reviewed the minutes of the meetings and saw a range of topics were discussed relevant to the service and improvements which were planned.

The provider commissioned an independent residents and relatives feedback survey which was completed in October 2017. However, they had not received the report from the survey at the time of the inspection.