The Orders Of St. John Care Trust

OSJCT The Paddocks

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

We undertook an announced inspection of OSJCT The Paddocks on 18 February 2016.

OSJCT The Paddocks is a new service registered with us on the 25 August 2015 and provides extra care housing for up to 44 older people. The office of the domiciliary care agency OSJCT The Paddocks is based within the building. The agency provides 24 hour person centred care and support to people living within OSJCT The Paddocks, who have been assessed as requiring extra care or support in their lives. On the day of our inspection 12 people were receiving a personal care service.

There was a registered manager in post. However, on the day of our inspection the registered manager was on annual leave. The service was being managed by the area housing and care manager. 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. The service had safe, robust recruitment processes.

People were 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 reduce 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 domiciliary care trust 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 in place to reduce the risk and keep people safe. People received their medicine 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 (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 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 well-led?

Good

The service was well led.

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

People knew the management structure of the service and spoke with managers with confidence.

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

OSJCT The Paddocks

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 18 February 2016. 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 they would be in. This inspection was carried out by two inspectors.

We spoke with five people, one relative and three care staff. We also spoke with the area housing and care manager and the domiciliary care trust manager. We looked at five people's care records 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 commissioners of services, a social worker and a healthcare professional to obtain their views on the service.

Good

Is the service safe?

Our findings

People told us they felt safe and highlighted the pendant alarms they had been issued with. Comments included; "Yes I'm safe, just press and they'll come. I don't very often call them at night" and "I've got one of those caller things". One person told us how staff cared for them when they had a fall. They said, "They stayed with me until the ambulance came".

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 manager or senior person on duty. Staff were also aware they could report externally if needed. Comments included; "I would get advice from a senior member of staff and report to the manager. I could also find the number of the local authorities and tell them as well", "I'd report concerns to the manager" and "I can whistle blow, I used it long ago. I would tell the manager immediately and I would also call CQC (Care Quality Commission)". The service had systems in place to investigated concerns and report them 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. A risk assessment was in place and staff were guided to support this person in line with their wishes. The person could walk independently for short distances with a frame. Staff ensured the frame was fit for purpose and they were guided to maintain a clean, clutter free environment to reduce trip hazards. The person had also been referred to an occupational therapist for further assessment. Staff we spoke with were aware and followed this guidance and daily notes evidenced the person was supported to remain as mobile as they could be.

Another person had difficulty mobilising. Their care had been reviewed following a fall and the risk assessment guided staff to encourage the person to 'use their wheelchair if they felt weak or tired'. Daily notes and staff evidenced this guidance was being followed. Other risks assessed included skin condition and pain. All risk assessments were regularly reviewed and updated.

Staff told us there were sufficient staff to support people. Comments included; "There is enough staff and there is more coming as we get more clients. We cover for each other and we get regular breaks", "If we need two staff for people's needs overnight we get an extra one" and "There's now plenty of staff, more than enough".

There were sufficient staff deployed to meet people's needs. The domiciliary care trust manager told us staffing levels were set by the "dependency needs of our clients". For example, where people required two staff to support them we saw two staff were consistently deployed for each visit. 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.

People received their medicine as prescribed. Where people needed support 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. We spoke with staff about medicines. Comments included; "We help people with medicine. We prompt and we give medicine from dossett boxes" and "We have all had training in medicine and we've had lots of advice and training from the district nurse".

Good

Is the service effective?

Our findings

People told us staff knew their needs and supported them appropriately. Comments included; "Yes, staff are very good and kind" and "Well trained, I should say so". One person told us how staff responded when they had a fall. They said the member of staff "Put me in the safety position".

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 fire, moving and handling and infection control. Staff comments included; "I did the induction training and shadowed an experienced member of staff for two weeks. As I was new to caring this gave me lots of confidence and it also meant I got to know staff and the clients really quickly" and "I can't fault the training, really good". We saw further training for all staff was available and training records confirmed planned training was up to date and ongoing.

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 member of staff identified a person required a specific piece of equipment to improve their care. The staff member told us, "I raised this issue and we got the equipment the next day". Another member of staff spoke with us about supervisions and support. They said, "We get regular supervisions and we can raise issues but we don't have to wait for a formal meeting. I can raise something anytime and know if I ask help will be provided". Staff also had access to further training. Records showed staff had been trained by the district nurse to support a person with a particular condition.

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. For example, one member of staff was reminded to 'wear gloves when administering medicine".

We discussed the Mental Capacity Act (MCA) 2005 with the domiciliary care trust manager. The MCA protects the rights of people who may not be able to make particular decisions themselves. The domiciliary care manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected.

Staff demonstrated an understanding of the MCA and how they applied its principles in their work. Staff comments included; "This is about decisions and where people struggle to make certain decisions for themselves. I always give people a choice. I ask them or I show them and check they understand", "It is about people's decisions and being able to choose. We always assume they have capacity" and "It's all to do with choices and offering clients options. It's not all decisions but specific ones at that time".

We asked staff about consent and how they ensured people had agreed to support being provided. One staff member said, "I ask them first and repeat the offer if they refuse. In the end it is their choice", "They have their own mind. I always ask and go with their decision. If they say no I'll ask later but it's up to them. I show

them what they have to wear and they choose" and "I ask and I check, I always ensure I have their permission". All the care plans we saw were signed by the person evidencing they had consented to the support plan.

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. We spoke with a healthcare professional prior to the inspection. They said "The carers all seem fine, very diligent. The service is very accommodating and I get good timely referrals. I have no problems with them following guidance and I feel we have good communication with the service".

Most people did not need support with eating and drinking. However, some people needed support with preparing meals. People either bought their own food or families went shopping for them. For example, one person could eat independently but could not prepare their meals. Staff were guided to offer choices to the person and follow 'good food hygiene' practices. Staff were also guided to leave snacks for the person. Staff told us and daily notes evidenced this guidance was followed.

People told us staff supported and encouraged them to eat and drink. We saw people we visited had drinks available. One person we met had a glass of milk and two glasses of fruit juices in reach. They said "I drink a lot of milk". Another person told how staff prepared meals for them. They said "I always have two cooked meals".

People received effective care. For example, one person was at risk of developing pressure ulcers. The person had been referred to the district nurse who had assessed the person and provided guidance for staff on how to support this person effectively. This included monitoring the person's skin condition and the use of pressure relieving equipment. We saw this guidance was being followed and the person did not have a pressure ulcer.

Good

Is the service caring?

Our findings

People told us they benefitted from caring relationships with the staff. Comments included; "There's nothing at all wrong with the carers. They're very good. I'm very pleased", "I'm pleased with what they're doing. There's about seven of them. They're lovely girls", "They're very good. I've been used to working with people" and "They're more than willing to help". One person made a remark, referring to the carer who had introduced us and then left the apartment, "As you see, ones like [staff's name] are very sweet".

Staff told us they enjoyed working at the service. Comments included; "I like all the girls and I definitely love the clients. I am a people person", "It is lovely and quiet here. The people are lovely and we have such a good team" and "We have really caring relationships here. We make friends. I was invited to lunch by one client so I came in on my day off. It was lovely".

We observed staff communicating with people in a very patient and caring way, offering choices and involving people in the decisions about their care. People were given options and the time to consider and choose.

People's dignity and privacy were respected. We saw staff knocked on doors before entering people's flats. Where they were providing personal care people's doors were closed and curtains drawn. This promoted their dignity. We saw how staff spoke to people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. Language used in care plans was respectful.

We asked staff how they promoted, dignity and respect. Comments included; "I always knock on doors before I go in and I close the doors and draw the curtains. I use their preferred name and with personal care I cover them up as much as I can. I respect their wishes", "I talk to them respectfully, cover them with towels which promotes their dignity and I don't make a fuss" and "We are a good team and we know these people. I'm polite, respectful and I always close doors and curtains to keep things private".

People's independence was promoted. For example, one person could sometimes get up out of bed independently but sometimes needed staff support. The person's care plan noted staff were to 'prompt and supervise' the person and to only assist them where necessary. Staff spoke with us about promoting independence. Comments included; "I treat them how I would want to be treated, with encouragement and kindness. Clients respond to this and many can do lots for themselves if encouraged" and "I think we try to get them to do what they can. Clean their teeth or wash their face. I always encourage them and it gives them some dignity".

People were involved in their care. We saw people were involved in reviews of their care and had signed reviews and changes to their care. People were also informed about who was visiting them and when. Visiting schedules were provided to people and gave information about dates and times of the visit. They also stated what support the staff would be providing. For example, one person's schedule stated the evening support visit would 'assist with nightwear, medicine 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'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 'made a drink but (person) wanted to stay up so instead of helping them into bed I stayed for a lovely chat'. One member of staff told us "You build a rapport with people as you get to know them. It's not just about clinical care, they are people".

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. Staff were aware of this information. For example, one person had previously been a lorry driver and often chatted with staff about their past career. Staff were aware of this person's history and enthusiasm and on their birthday the person received a birthday card depicting a (brand name) lorry the person was familiar with. All the staff had signed this person's card wishing them a happy birthday. The person was keen to show us this and the card was proudly displayed in their home.

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 had a urinary catheter bag. The district nurse has visited and assessed this person and provided staff with training and guidance on how to support this person. Further guidance in relation to cleaning and maintaining the catheter was also provided.

People received personalised care. For example, one person was at risk of experiencing pain due to their condition. The care plan stated the person was independent but may 'need assistance at times'. Staff were prompted to ask the person at each visit if they were in pain and, if so, support them to take pain relief. The care plan also highlighted a protocol staff should follow when entering the person's home. The protocol was in place to allow staff to enter the home using a master key which meant the person did not have to get up and answer the door. Staff were aware of and followed this protocol. The person's condition was regularly reviewed and the service and healthcare professionals responded to changes to the level of their condition. For example, we saw at the last review of care the person was referred to the GP and as a result their medicine was changed.

People's preferences were recorded and respected. For example, one person had stated they 'hate showers and preferred a strip wash'. They went on to state they would 'love a bath once a week'. Daily notes evidenced this person's wishes were respected and they had a bath at least once a week.

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 about people's preferences and how they want their care provided. Each person is different and so the care varies", "It's down to the individual how they want the care. We provide support the way they want it" and "I know their routines and how they like things done so that's how we do it".

People knew how to raise concerns and were confident action would be taken. Comments included; "If there were any problems you can nip it in the bud" and "I'd tell them if an issue arose or report them if necessary. It's no use putting up with it".

Details of how to complain were contained in handbooks given to people when they joined the service. The

service had received very few complaints. Historical complaints had been dealt with compassionately in line with the provider's policy. Staff told us they would assist people to complain. One member of staff said "Yes I would help someone complain if they wanted. There are details in the plans. I would also inform the manager for them".

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. 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.

Good

Is the service well-led?

Our findings

People we spoke with knew the registered manager. Comments included; "I know the manager, they are very good", "I don't really know the manager that well but I have met them" and "They do an amazing job. They are really good".

Staff told us they had confidence in the service and felt it was well managed. Comments included; "I find the manager to be supportive, approachable and helpful. I can go to her with any problem and she will deal with it", "The manager is really lovely and very supportive" and "She is definitely approachable. She sees the clients all the time, she gets on well with them and If we need help she will roll up her sleeves and join in".

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 area housing and care 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 "I think we are honest here, nothing gets swept under the carpet. If a mistake was made I think we'd all feel confident enough to own up and feel safe and supported. There is not a culture of blame here".

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, a series of near misses at other locations raised an issue relating to sensor mats moving when people walked on them. Services were reminded all sensor mats should have 'anti slip backing' and be fit for purpose. Another notice gave details of a fire and listed preventative measures to reduce further fire risk. These notices were on display in the staff room.

Staff told us learning was shared at staff meetings and briefings. Comments included; "Yes we do share learning here. We have a handover book and a diary where we share information and learning. Also staff meetings", "We all share learning. We have our meetings and we can look in the care diary so we can write notes so staff on the next shift get the information" and "We have a big white board where information from the district nurse is written. This is very helpful. We also ring each other frequently".

Team meetings were regularly held where staff could raise concerns and discuss issues. For example, staff had requested a care diary to compliment the handover book used to share information from one shift to the next. We saw this request had been actioned and a diary was in place and in use.

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, a medicine audit identified some staff were not signing MAR where people declined their medication. Action was taken and we confirmed MAR were now completed correctly. The provider's quality team also conducted audits within the service and their latest audit rated the service at 100%. The provider had celebrated this success by accrediting the service in infection control, medicine management and care. Certificates to this effect were displayed on a notice board.

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.

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.