Orders of St John Care Trust

OSJCT Henlow Court

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This unannounced inspection took place on 11 and 12 December 2014.

Henlow court provides nursing, residential and respite care for up to 40 people, some of whom have a diagnosis of dementia. At the time of our inspection 37 people were living there. The home is purpose built over two floors and has lounge and dining rooms on both floors.

There was a registered 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.

All staff had received safeguarding training and knew how to recognise abuse and what action to take to protect people from harm. Risk assessments were completed to minimise risks to people's health and welfare. People were supported by sufficient staff with the appropriate skills, experience and knowledge to meet their needs. Recruitment procedures used ensured suitable staff were

Summary of findings

appointed. Not all accidents were recorded so that preventative measures for people were looked into. We made a recommendation for the service to take appropriate steps to ensure that people are not put at unnecessary risk.

People were cared for by appropriately trained and supported staff. People had a choice of food and their dietary needs were met. Where people were at risk of malnutrition steps were taken to monitor and improve nutrition to meet their requirements. Arrangements were in place for people to see their GP regularly and other healthcare professionals when they needed them. People were supported to make decisions. There was insufficient information to ensure the MCA regulations had been met. As a result people's rights may not always be protected. We made a recommendation for the service to regard best practice to protect people in respect of the Mental Capacity Act 2005. (MCA).

People told us they were well cared for and enjoyed the company of the staff. People were treated with dignity and respect and their privacy was protected. We observed staff offering people choices and gaining their consent for care. People's needs were met because the staff treated them as individuals and knew what they liked.

People were asked their views about their care and how the home was run. Concerns were listened to at residents meetings, where all aspects of the service was discussed. People told us staff listened to what they had to say and improvements were made. Regular checks were made to ensure the service was safe and well maintained.

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?

Requires Improvement

The service was not always safe.

People were safeguarded from harm because staff were aware of their responsibilities and would report any concerns.

People were supported by sufficient staff with the appropriate skills, experience and knowledge to meet their needs.

Records of accidents and incidents were incomplete so preventative measures may not be thoroughly explored.

People's medicines were given and managed safely and kept under review to ensure people were receiving appropriate medicines.

People were protected by thorough recruitment practices.

Is the service effective?

Good

The service was not always effective.

The staff were well trained and were able to look after people effectively.

People had access to healthcare professionals.

People were supported to make decisions. There was insufficient information to ensure the MCA regulations had been met. As a result people's rights may not always be protected

People were supported to have a choice of meals and their individual requirements were met. Risk of malnutrition was monitored and people had professional support when required.

Is the service caring?

Good

The service was caring.

People were treated with compassion, dignity and respect.

Staff treated people as individuals and interacted with them positively.

People were involved in making decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

People received the care and support they needed and were involved in decisions about their care when possible.

Staff knew people well and how they liked to be cared for. People were confident that staff would respond to their needs on time.

Summary of findings

People took part in many activities and went out in the community. They were able to make suggestions for new activities at regular resident meetings. Staff engaged with people individually.

Comments or complaints were listened to and responded to respectfully and changes made where required.

Is the service well-led?

Good

The service was well led.

The home was managed well and regular quality checks ensured that people were safe and improvements were made.

The registered manager was accessible and supported staff, people and their relatives through effective communication.

Regular resident and staff meetings enabled everyone to have their say about how the home was run.

OSJCT Henlow Court

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 11 and 12 December 2014 and was unannounced. The inspection team consisted of an adult social care inspector 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 service.

Prior to the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information 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 used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with the registered manager, the deputy manager, five care staff and a chef. We spoke with five people who use the service and two relatives. We looked at seven care records, three recruitment records, the staff duty roster, quality assurance information and maintenance records. We asked the registered manager to send us a copy of the duty rota and an overview record of all staff training.

We contacted two GP's, a social worker, Gloucestershire County Council Quality Review Team, an associate practitioner for the Community Dementia Nursing Services, a tissue viability nurse and a nurse assessor for Continuing Health Care. We asked them for some feedback about the service.

Is the service safe?

Our findings

Recording of accidents and incidents was incomplete. One person had an accident recorded in their daily records but no specific accident form for this accident. There was no known cause recorded for the finger damage or action to prevent the accident happening again. Staff had recorded other accidents. The accident forms used did not have learning from the event or preventative measures recorded. An operations manager completed a monthly review, which included a record of all accidents. The registered manager used the list to track when people had repeated accidents. There was no formal audit of the circumstances of all accidents to identify themes, for example, times when they happened. This information may prompt action to be taken to help reduce the risk of accidents.

Recruitment records were complete and helped to ensure people were protected from the employment of unsuitable staff. Applications detailed previous employment and any gaps in employment were explored during interviews. Disclosure and Barring Service (DBS) checks were completed and each employee had at least two references that included one from the last health and social care employer where applicable. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable people. Staff health checks had been completed. Nurse registrations and expiry dates were checked with the Nursing and Midwifery Council (NMC). These ensured nurses were legally registered to work as registered nurses. Copies of previous training certificates were available and held with all training certificates in staff files.

All staff had completed safeguarding training annually and had a good understanding about the different types of abuse and how to respond to them. They knew about 'whistle blowing' and how to raise concerns with the nurse in charge or registered manager. There was a detailed safeguarding procedure for staff to follow that included informing CQC. The registered manager told us there had been one safeguarding alert reported to the local authority safeguarding team in the previous 12 months. The records indicated the safeguarding had been well managed. A person told us; "I feel safe and treated very well".

People had risk assessments recorded in their care plans to minimise any identified risks. These, for example, included risks relating to falls, developing pressure ulcers and malnutrition. Staff told us about the people who were at risk from malnutrition. Some people were at risk of falls from their bed and were safeguarded because bedrails were used to reduce the risk of a fall where appropriate. A 'best interest' record was completed when people were unable to consent to interventions to minimise risk of accidents. There was an emergency plan that covered many areas, for example fire and power failure, which was accessible to staff. People had individual emergency evacuation plans and staff knew whom to contact at all times in an emergency.

People were supported by sufficient staff with the appropriate skills, experience and knowledge to meet their needs. We reviewed four weeks of staff rotas that told us staffing levels were maintained. The registered manager told us people's dependency determined the staffing levels. Care leaders were trained to calculate dependency scores monthly. We looked at examples where people were either high, medium or low dependency residential care or required nursing care. The manager told us that when people's dependency levels increased staffing levels increased.

Care staff were also supported by other staff, which included laundry and domestic staff. People told us; "There are plenty of staff to care for me, evenings and weekends as well. When they bath me they are careful and make sure I'm safe, they tell me what's going to happen and take their time with me"; "When I press my call bell I don't have to wait long before they come to help me, there's lots of staff to look after me during the night and at weekends, yes I'm really well cared for" and a relative said; "What I really do like is that there's always plenty of staff to care for my relative, they often stop and chat even when I'm here".

A relative told us; "Brilliant, this home is brilliant, I have no complaints just praise for everyone. They treat my relative very well, always clean and well dressed. There are never any bad smells, it's clean and tidy. Staff discuss with me my relatives care planning and it's provided just as we agreed. If I press the call button for my relative staff come straight away. When they move my relative they explain what they are doing and make sure my relative is safe and well cared for".

There were clear policies and procedures in the safe handling and administration of medicines. Medication administration records demonstrated people's medicines were being managed safely. People were identified by

Is the service safe?

photographs on their medicine administration record. Storage of all medicines was safe and the records were complete. There had been no reportable errors involving medicines in the last 12 months. People told us; "I always have my medication at the same time every day, the staff look after them for me to stop me worrying about them", "Staff make sure I take my tablets every day" and "They [staff] give them to me and wait until I have taken them" and "Staff are very good with my medication, they never miss and it's always on time too".

There were risk assessments of the environment that included a health and safety assessment completed in August 2014. Safety checks included, fire safety, water temperatures and equipment. Legionella water system risks were checked monthly. There was a record of actions required but no record of timescales and when the action had been completed. The registered manager confirmed the actions had been completed. A maintenance log recorded issues identified by the staff each week that had been dealt with immediately or planned.

We recommend that the registered manager takes the appropriate steps to ensure that people are not put at unnecessary risk.

Is the service effective?

Our findings

Staff received training about the Mental Capacity Act 2005 (MCA) and understood the need to assess people's capacity to make decisions. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make certain decisions. We observed staff seeking people's permission before helping them with their care and encouraging them to make choices. Staff told us most people consented verbally and if they were unable to consent in any other way a best interest record was completed for personal care. A GP had completed Do Not Attempt Resuscitation (DNAR) records for most people. Some records were incomplete where people did not have capacity to make the decision, although some relatives had been involved there was no best interest record. There was insufficient information to ensure the MCA regulations had been met. As a result people's rights may not be protected and staff may follow instructions that were not recorded accurately.

People and relatives were satisfied with the care and support provided. People told us; "As a home you will never find one better. They are careful around my dietary needs and discuss these with me on a regular basis", "The food is really good, hot and tasty with quite a few choices to pick from" and "The food is brilliant, lots of choices". A person who had returned for respite care told us; "I was a resident a few months ago and the care is next to none. They treated me very well making sure that all my care needs were there. Staff talked to me and kept me happy. They washed me very carefully making sure that I was well presented, clean and smelt nice".

People had risk assessments for malnutrition and weight was monitored on admission then monthly. A malnutrition universal screening tool (MUST) was used to assess people's weight. Weight loss indicated referral to a GP, weekly monitoring of weight and a food and fluid chart to be used to monitor intake. The chef ensured that food and drinks were fortified with butter and cream when people were at risk from weight loss. People that required additional snacks had access to fruit, crisps and chocolate. A full cooked breakfast was available every day and several people chose this option.

We observed during lunchtime that condiments and serviettes were in place. Staff offered hand washing to people and they were given a choice of where to sit. Consent was obtained for clothing protectors if required and each person was offered a choice of food and drink. Staff obtained consent from people before cutting their meal into bite size pieces to assist them. Meals taken to bedrooms were covered to keep them warm and placed within reach. Staff supported people to eat at their individual pace and drinks were continually offered throughout the meal. Staff engaged with people and appropriate encouragement was given.

Visiting health and social care professionals told us the care was good, the atmosphere was relaxed and people appeared well cared for. They told us staff were friendly and helpful and the care plans were good and well organised. They said a staff member attended the Tissue Viability Link group meetings and acted as a link to cascade knowledge about wound care to all healthcare professionals at the home.

People were supported by staff who had access to training and were supervised by senior staff to ensure their training requirements were met. Staff told us they had supervision every six weeks and were well supported with their training. The staff told us that the service was very good for training staff and they had completed a lot of training. Senior care staff ensured that care staff with less experience were monitored and supported to improve their practice. The provider information return told us 24 of the 37 care staff had been employed for more than two years and had an annual appraisal in the last 12 months.

Staff had completed many areas of training, for example, moving and handling, medicine administration, nutrition, pressure area skin care and dementia care. The provider information return told us that 26 permanent staff had achieved a level 2 or above NVQ or Diploma in Health and Social Care. All relevant staff had completed Mental Capacity Act 2005 (MCA) training that included the Deprivation of Liberty Safeguards (DoLS). The provider information return told us that Skills for Care Common induction standards had been completed by the care staff recruited. Regular supervision of staff was completed and the majority of care staff had a named staff member that supported them. The training record highlighted when staff required a specific training update. Staff said they felt well supported by the registered manager who was always

Is the service effective?

accessible and approachable. They felt they could discuss any problems and that improvements would be made. The staff said their meetings enabled everyone to have their say and an open agenda ensured this happened.

There were policies and procedures that staff used to ensure that people were assessed and their care and treatment was planned and reviewed regularly. People had access to healthcare professionals and their GP visited every six months or sooner when required. The handover sheets recorded between shifts informed staff a tissue viability nurse had visited and changed the type of wound for a person. The district nurse had also completed a special test to assess the blood supply in a person's legs.

Where necessary people were assessed in respect of their ability to make some decisions. When they were unable to make a decision this was made for them in their best interests involving other professionals.

The registered manager had a good awareness and understanding of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a lawful way to deprive someone of their liberty, provided it is in their best interests or is necessary to keep them from harm. There were no DoLS authorisations in place. The registered manager was in the process of applying to the local authority for a DoLS and knew the responsibility to inform CQC once it was authorised and to keep the authorisation under review.

We recommend that the service seek advice and guidance from a reputable source with regard to best practice to protect people in respect of the MCA.

Is the service caring?

Our findings

People were positive about how they were cared for. They told us; “Its ok here and the staff are wonderful and helpful to me. They always give me a wonderful bed bath, closing the doors and curtains protecting my dignity and privacy”, “I come back every week to have a bath that’s how much I value the care and compassion that staff give me. Staff often listened to what I had to say”.

People were treated with dignity and respect. We observed the registered manager talking to relatives and providing a friendly welcome and reassurance about their relative. Staff had completed customer care and dignity and respect training and gave examples to us where they ensured people’s privacy and dignity. We observed staff offering people choices and gaining their consent for care. One person told us; “It’s a good home to be in. Staff are very caring and loyal and they treat me kindly. When they wash me they make sure it’s done privately. I sometimes have a bath which they are good at doing for me, but they will only do the bits that I can’t to make sure that my independence is maintained. When they have finished they help me to choose the clothes that I want to wear that day. If during the day I change my mind and want to wear something else they take me to my room and change me again, nothing is too much trouble for them”.

People told us; “Staff are very kind and meet all my care needs that’s in my care plan in the office. I also can discuss anything with my key worker. When staff provide my personal care they respect my dignity and privacy only doing the things that I’m unable to do. They tell me what they would like to do and is that ok. When they come to my room they knock on the door”, “It’s wonderful here the staff are very kind and compassionate. I have a key worker to chat to. We talk about my care and it’s written down for me and it’s kept in the office” and “When I press my call button staff come more or less straight away. The home has a loving warm caring atmosphere”.

People chose what to do and were encouraged to be independent, for example people told us they could get up and go to bed when they liked. Some people had pictures on their bedroom door with memory prompts about their life to recognise their own room. We observed people relaxed and communicating with other people and the staff in a friendly and supportive atmosphere. Other staff for example domestic staff chatted with people and helped people who wanted to buy sweets from the portable sweet shop.

Care staff told us they always help with activities and engage with people one to one in the afternoons. Staff said they played board games or gave people hand massages. The home’s monthly newsletter for December 2014, Henlow Herald, had news, views and pictures of a recent trip to a shopping centre at Cribbs Causeway near Bristol. People said; ”There are things to do that keep me active and I like going out too”, “Staff sometimes sit and chat to me, I do like that” and “I’m very happy for what they do for me and I feel very well treated and wouldn’t want to be anywhere else”.

Letters to compliment the service were seen. Relatives had written; ‘mum became frail and needed palliative care and the staff provided professional, competent and compassionate care’. Another relative said; ‘There is a genuine culture of listening to residents and valuing them as individuals’.

Is the service responsive?

Our findings

Individual care was well planned. One care plan for a person living with dementia advised staff to refer to the admiral nurse, if there were any concerns. An admiral nurse is a dementia care specialist. A member of staff told us they were supported to attend dementia link meetings with the admiral nurse and met with all staff to feed back information from the meetings.

People's daily records told about their activities, diet and the mood they were in, where relevant. Risk assessments were clear about the risk and kept under review. Nutrition and diet were assessed and monitored. People were referred to a specialist when required. The chef knew people's dietary needs and food allergies to ensure they had the correct consistency meals to prevent choking and did not have an allergic reaction to their food. People told us they visited the dentist and other healthcare professionals visited them. People said; "If I need to see my doctor staff arrange for this to happen", "If I need to see my GP or chiropodist staff will call them for me", I think I have my care written down with my key worker, and if I press my call button staff come right away. All care plans had hospital transfer information to go with the person should they require a hospital admission. The detailed six monthly care plan reviews included comments from the person about their care and if their needs were met adequately.

A relative said; "If there are concerns and I'm not here staff will call me at home. I know when I'm not here they care for my relative and I can relax knowing the care my relative is getting". Staff carried pocket alerts so that they knew when people needed assistance.

Handover information between staff at the start of each shift ensured that important information about people was known, acted upon where necessary and recorded to ensure people's progress was monitored. An example was when one person next required medicine for pain and another person with fragile skin was to be checked again later. The handover record also had information about how to evacuate each person in an emergency and whether all fire exits had been checked as cleared.

Wound care plans had photographs and clear records of action to take and healing progress. Advice from the tissue viability nurse was sought to ensure that wound care practice was complete and up-to-date. People had advanced directive care plans where they decided their future care should they become unable to tell staff what they wanted, for example, to remain at the home should they suffer from a stroke. There were spiritual care plans where people had planned the support they wanted; for example support to follow a preferred religion.

The care staff were knowledgeable about people and how they liked to be cared for. The three people who required support to change position to prevent pressure ulcers, had their position changed at correct intervals. Information to help people living with dementia was constantly being updated, for example the use of coloured beakers and plates to help people see them more easily. Staff were updating people's life stories to enable staff to engage with them effectively about the past.

We looked at the activities plan for November and December 2014 where regular and new activities were planned. People could choose from 'pamper sessions', chair exercises, 'pat dog' therapy, cooking, jewellery making, ten pin bowling, musical entertainment, a shoe shop visit, church services and many special Christmas themes. The home had entered the provider's competition 'How Christmassy is the home' and people had joined in with decorating the home.

People told us; "There are some activities that keep me occupied, we go out in the mini bus sometimes doing things in the community but not now it's too cold. The staff often stop and chat to me and they care, they know what I need" and "There are some activities and we go to the pub for lunch and those kind of things, I like skittles the best. I feel treated with dignity and respect and when I'm talking to the carers they listen to me which is very nice".

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The complaints policy was displayed in the entrance to the service. We looked at a recent complaint record where a relative was responded to respectfully. The response included other health and social care professionals and improvements to practice were made. People said; "If I have concerns or a complaint I talk to my key worker who helps us put it right, she also talks to me about my care and any needs that I have".

A relative told us; "If I had any concerns or complaints I would speak to the manager, she would respect what I was saying and together we would put things right. She is very

Is the service responsive?

good at her job. Staff always make me feel welcome and discuss anything that has happened since my last visit. If my relative has had an appointment staff feedback to me what had happened".

Is the service well-led?

Our findings

People told us about how they have their say about the service, one person said; "I'm happy to raise any concerns that I have at residents meetings and feel listened to. Sometimes I fill in a form about what I think of the home. Staff told us the manager was visible and always available to discuss concerns with and communicated well with all staff so they understood what needs to improve.

The provider information return stated the registered manager attends staff handovers and works with care staff regularly. We observed the registered manager was accessible and engaged throughout the day with people, their relatives and the staff. Staff said they felt well supported by the registered manager who was always accessible and approachable. They felt they could discuss any problems and that improvements would be made. The staff said their meetings enabled everyone to have their say and an open agenda ensured this happened.

There were links with the local community. A display of information in the entrance hall regarding local support groups, for example Dementia Good Practice, Advocacy Trust, and the local authority safeguarding team.

The service encouraged an open communication with people their relatives and staff. There was a suggestion box for people and their relatives to use to make comments about the service. Resident/relative meetings were held every three months. We looked at the minutes from two meetings where 10 to 15 people attended. Information about new staff appointed and new people accommodated was provided and some dates of special events were given. People were able to make comments and suggestions for improvements and there were many suggestions about meals and requests for certain activities. One person had commented 'complaints were addressed well and they were very happy with the previous residents meetings'. A person told us; "We have residents meetings where we talk about the things around the home and what we would like to do".

Multiple choice questionnaires were available in the hall for people to complete about the service and post in the box provided. The registered manager told us that few were completed but they had been positive about the service. The last annual resident's survey was completed near the end of 2013, we were unable to see the results this time. However, people's comments about their care had been recorded by staff in the six monthly care plan reviews. We found positive comments about the care and staff.

Staff were aware of the need to provide a quality service at all times and offered suggestions for improvement. Staff meetings were held regularly, we looked at minutes from August 2014 and November 2014 meetings for day staff and a night staff meeting in October 2014. Staff were reminded about the provider's core values that had been discussed at individual personal development reviews. Information about the provider's 'mystery shoppers' was discussed. This was where staff were judged how people were welcomed to the home. The result recorded from the last 'mystery shopper' was "an overall big improvement". The support for new inexperienced care staff was discussed so that all staff knew who may require additional support. Results from a recent infection control audit was 95% correct and was shared with staff who were congratulated during the meeting. Information about food allergies was also discussed to ensure people were not given food that they were allergic too. Staff were able to offer suggestions for improvements and the registered manager addressed them during the meeting. Housekeeping meetings were held three monthly to help provide information and improve practice. Staff were made aware of and put forward for the providers awards and successful staff have their achievements displayed in the hall.

Monthly operational reviews were completed where operation managers from the provider visited the home and looked at the quality of service provided. We looked at the records of the October, November and December 2014 reviews. Many issues were looked at by the operations manager. These included when people had fallen, significant weight loss, wound care and what action had been taken. A selection of care plans were monitored and staff were alerted to incomplete records. There was evidence that action had been taken when shortfalls in practice were identified. Examples seen were improvement of medicine records and most staff had now completed competency in applying creams for people.

The registered manager had notified CQC about events and we used the information to monitor the service and ensure they respond appropriately to keep people safe.

Policies and procedures had been reviewed to ensure that recent best practice was included. An example seen was

Is the service well-led?

the End of Life policy. Staff had access to all policy and procedures on computer. There was a programme of audits completed to include health and safety and infection control. All care plans were audited over a three month period. We checked a care plan audit for one person and there was a lot of detailed information where the plan had been improved. All audits had action plans with timescales which were signed when completed. The operations manager reviewed the audit actions monthly to assess progress. The service had a major incident plan for emergency actions to ensure staff effectively supported people at all times.