The Orders Of St. John Care Trust

OSJCT Ermine House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

OSJCT Ermine 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 Ermine House accommodates up to 45 people in one adapted building. There were 39 people living in the home when we visited.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Systems and processes were in place to keep people safe from the risk of harm and abuse. People had their medicines administered safely by trained and competent staff. The service was clean and staff adhered to safe infection control practices.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People had their care needs assessed and their care was planned in line with up to date guidance and legislation. There were sufficient staff to care for a person's individual needs and staff were trained appropriately. People were provided with a balanced and nutritious diet and had access to a range of healthcare services.

People were cared for by kind, caring and compassionate staff. People and staff had a good relationship and the service had a homely atmosphere. People were cared for as unique individuals and their privacy and dignity were respected.

Staff supported people to spend their time as they wished. There was a range of internal and external activities tailored to individual needs and pastimes. People had an advanced care plan to protect their wishes at the end of their life to achieve a comfortable and pain free death.

People spoke highly of the care they received and the attitude of staff. Staff enjoyed working at the service and were proud of their achievements. The provider had a robust approach to monitoring the quality of the care people receive. The registered manager had built a good relationship with key organisations and the local community.

People who live in the service and staff have a voice and are supported to give their feedback on the service.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good	**Good**
Is the service effective? The service remains good	**Good**
Is the service caring? The service remains good	**Good**
Is the service responsive? The service remains good	**Good**
Is the service well-led? The service remains good	**Good**

OSJCT Ermine House

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 19 March 2018 and was unannounced. The inspection team consisted of one inspector. The inspector returned to the service on 5 April 2018 to provide feedback to the registered manager who was on leave on the day of the inspection.

We did not request a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed any information we held about the service. We reviewed safeguarding alerts and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with the area operations manager, the head of care, three members of care staff, the cook, two housekeepers, the activity coordinator and five people who lived at the service and two visiting relatives. We also observed staff interacting with people in communal areas, providing care and support. Following our inspection we returned to speak with the registered manager.

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

Good

Is the service safe?

Our findings

Staff had access to safeguarding and whistleblowing policies. Staff from all disciplines were aware of how to identify if a person was at risk of abuse and their responsibility to escalate their concerns through the safeguarding route or by whistleblowing. Staff had information on the local safeguarding helpline and told us that they would use it if they had to.

Systems were in place to identify and reduce the risks to people living in the service. People's care plans included detailed and informative risk assessments. These documents were individualised and provided staff with a clear description of any risks and guidance on the support people needed to manage risk. Staff understood the support people needed to promote their independence and freedom, yet minimise the risks. For example, one person was at high risk of falls, but had been assessed as safe to mobilise independently in their wheelchair.

A robust recruitment and selection process was in place and staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and helps employers to make safer recruitment decisions and prevent unsuitable staff being employed.

People told us and our observations confirmed that there was enough staff on duty to keep people safe. One person said, "The staff are busy, but I'm well looked after." The provider used a resident dependency rating tool that helped guide the registered manager to roster sufficient staff with the right skills and experience to look after people.

Robust systems were in place for the safe ordering, storage, administration and disposal of medicines. We found that people's medicines, including controlled drugs were managed consistently and safely by staff. We looked at medicine administration records (MAR) for seven people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person was asleep. Some people were prescribed as required medicine, such as pain relief, and staff had access to protocols to enable them to administer the medicine safely.

We met with the head housekeeper who was clearly proud of their role. They shared with us their team's achievements in maintaining a high standard of cleanliness. We saw that good infection control practices were adhered to and all areas of the service were clean. All staff had attended infection control training, had access to policies and procedures that reflected national guidelines and had access to personal protective equipment. Standards of cleanliness in the home were regularly assessed by a registered manager from another service provided by the parent organisation.

The provider's robust processes to investigate when things went wrong in the service ensured that the incident was shared with staff and lessons were learnt. When appropriate these lessons were shared across

the parent organisation. This process encouraged staff to openly speak out about incidents and concerns.

Good

Is the service effective?

Our findings

When a person first moved into the service staff undertook a full assessment of their physical, social and psychological needs. They used an assessment tool that was supported by current good practice guidelines and was used throughout the parent organisation.

Staff attended mandatory training such as fire safety and safe moving and handling. In addition, they were provided with training pertinent to their roles. For example, a senior member of care staff told us that they had recently attended training to help them understand the needs of a person living with dementia and said, "It was really good, it was interesting. We had a video about the experience of someone living with dementia; it was quite in-depth and has helped my understanding." The senior cooks attended an annual meeting with their peers from across the provider organisation. The head cook told us that this provided them with the opportunity to identify training needs and to share ideas about issues to improve the dining experience. Newly appointed staff undertook the Care Certificate, a 12 week national programme that covered all aspects of health and social care.

Staff supported people to eat a healthy, nutritious and balanced diet. Mealtimes were a social occasion; most people took their meals in the dining room and were encouraged to sit in friendship groups. People were given their choice of meal and those who required assistance to eat their meal were supported by members of care staff. We saw that the atmosphere in the dining room was light hearted and the meal service was not rushed. Staff asked people if they enjoyed their meal and if they had enough to eat and drink. The people we spoke with told us the food was good.

People told us that they had a say about the food they wanted to eat and their special dietary needs were respected. One person told us, "I have difficulty eating meat, but staff help with this and I have the food I like." People who were assessed as capable and visitors had access to a kitchen where they could make hot drinks and snacks.

Staff in the service held lead roles for an aspect of care they have shown a special interest in. These included medicine management, pressure area care and safe moving and handling. The leads attended regular updates, both within the organisation and with external agencies and were responsible for cascading information and new knowledge within the team.

People were supported to maintain good health and had access to healthcare services such as their GP, speech and language therapist, dentist and district nurse. We found that staff responded to any health concerns in a timely manner. For example, we observed the head of care contact the local GP to request visits for people that day; one person was feeling nauseous and was unable to take their medicines. We read in another person's care file that they had regular contact from their district nurse to monitor the function of their indwelling urinary catheter.

People had a say in the decoration of the service and were encouraged to personalise their bedrooms to make them homely. One person who had recently moved into the service told us, "I came in at Christmas;

I've quickly settled in and have my own bits from home." We found that small touches added to the homeliness of the service. For example there was an old fashioned sweet trolley with traditional sweets in glass jars. We noted that this was popular with people and their visitors.

People and staff told us of the improvements made to the service in the previous 12 months. These included decorations to some public areas and some toilets were upgraded.

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. Staff understood the principles of MCA and sought consent from people for aspects of their care. For example, one person who was admitted to the service as an emergency social admission gave their signed consent to live in the home. Where a person had appointed a lasting Power of Attorney (LPA) to act on their behalf when they were no longer able to make decisions for themselves a copy was kept with the person's care file.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). No one living in the service at the time of our inspection had a DoLS authorisation granted.

Good

Is the service caring?

Our findings

We spoke to the relative of a person who recently moved into the service. The person had a short stay in the home in 2017 for respite care. Their relative told us, "[name of person] was becoming forgetful and having frequent falls at home. I'm very happy to have [name of person] here. She has settled in well and joins in all the activities. I wanted this home for her, as it is a good home."

People were looked after by kind, caring and compassionate staff. We observed two staff assisting a person into their armchair. Staff supported the person at their own pace, offered words of encouragement, asked them if they were comfortable and thanked them for their cooperation. One person told us how staff enabled them to maintain their independence. They were sat in a recliner chair with their feet elevated. "I have the remote control for my chair. I can change my position at any time. That makes me happy."

People had a say in the running of the service and were invited to attend regular resident meetings and we saw that the minutes of these meetings were made available. However, one person we spoke with suggested that perhaps an action plan could be shared after each meeting, so as people who lived in the service were aware of progress made with their suggestions. We shared our conversation with the registered manager who showed us a copy of actions taken following feedback from a resident meeting held in January 2018. The registered manager accepted the person's comment and said that from now on people who raised an issue would receive feedback of the actions taken.

Several people had their own mobile phone or laptop and were able to maintain contact with family and friends through various forms of social media whenever they wanted to. Staff supported other people to use communication equipment owned by the service to keep in touch with family and friends

We saw that people who lived at the service were treated with dignity and respect and had a good relationship with staff and were at ease with each other. A member of care staff told us, "We treat them like they were our own family. I'd have my family stay here. They can have all their nick knacks and furniture."

Staff were aware of how to ensure a person's dignity was maintained and respected their right to privacy and their personal space. There were quiet seating areas in the service where people could have a private chat with their family or friends. People could also entertain their family and friends in the privacy of their own bedroom.

Good

Is the service responsive?

Our findings

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. We saw that individual care plans focussed on supporting a people to live well and maintain their optimum level of independence and well-being.

Care plans and other documents were written in a user-friendly way according to the Accessible Information Standard so that information was presented to people in an accessible manner. For example where a person used an alternative name we saw the care record was written using that.

We saw that staff exchanged information about a person's care needs and wellbeing at shift handover to maintain continuity of person- centred care. Care staff told us that every day is different for people who lived in the service and they needed to be aware of any changes in their care needs or well-being. One member of care staff said, "I like to take the time to get to know them, especially if they are new. I read their care files, but you can learn so much by just talking with them." Another member of care staff said, "We give person-centred care here. There is no rigid routine. I'm a key worker for some residents, but I help look after others."

The service has recently introduced interactive and creative music sessions. Regardless of ability, people were invited to sing, hum or play an instrument. The registered manager told us this had given people a sense of purpose. Care staff told us that some of their performances were very moving. For example, one person who had a stroke in the past and was unable to speak and had little movement was seen tapping their hand and smiling to the music. Another person revealed their singing talent and sang to the other people taking part. The head of care told us that the creative music programme had been a great success and hoped it would be repeated.

People told us that they were supported to take part in a range of activities that were in response to their needs. One person spoke with enthusiasm about their recent trip to a well know supermarket and said, "It was good to buy my own treats. I love chocolate rolls." They added, "I can choose what I want to do. I take part in bingo and the exercise classes."

We spoke with the activity coordinator who told us that they tried to find a balance for group and individual activities and said, "Wednesday evening we have a fish tea from the chippie, followed by live entertainment. This is very popular." We observed eight people participating in a game of indoor curling. They had a good rapport with each other and with staff and the activity coordinator praised people for their efforts and made them feel valued.

There was a comment and suggestion box for people and their relatives to give their thoughts on the service and people were invited to take part in an annual questionnaire about the quality of the service they received.

People had access to information on how to make a complaint, and told us that they had no reason to

complain and could talk with staff at any time. Staff told us that if a person complained to them they would escalate the concern to the registered manager or the deputy manager. Low level complaints were dealt with at home level. More serious complaints were investigated down a formal route and were escalated to the provider's head office. There have been no serious complaints in the last 12 months.

Staff understood the importance of supporting people and helping them prepare for care at the end of their life according to their wishes. People were supported to record their final wishes on an advanced care plan, such as where they wanted to have their funeral, any preferred readings or hymns and if they had a Do Not Attempt Cardio Pulmonary Resuscitation order.

We spoke with staff about the emotional impact it had on them and people who lived in the service when a person died. One staff member said, "We can go to the care leader or head of care when someone dies, we're all there for each other and support each other." Another member of staff said, "We give their family support too, the family stay over, [we provide them with food and drink]. They don't pay; it's all part of the service."

The registered manager told us that they had worked to improve relationships with other professionals when a person was near the end of their life. GPs now prescribed anticipatory medicines to ensure a person was comfortable and pain free at the end of their life. District nurses have changed their referral process for end of life care and have asked care staff to ring them directly so as they can input support in a timely way.

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.

Records showed that the registered persons had correctly told us about significant events that had occurred in the service, such as accidents and injuries. The registered persons had suitably displayed the quality ratings we gave to the service at our last inspection.

The registered manager told us that they were supported by their area operations manager (AOM), who visited the service at least once a month. We saw that the AOM spoke with all the staff on duty and the people who lived in the service on their visits. The head of care was in charge of the service during our inspection. We observed and staff and people told us that they could turn to the head of care at any time, that they were resourceful and nothing was too much trouble.

The provider had introduced a new framework for supervision and appraisal for all staff called, "Trust in Conversation." We looked at the records from three recent supervisions and saw that staff were totally involved in identifying their achievements and development needs and objectives were set relevant to those needs. Staff on their probationary period had their objectives set against the provider's values and policies. The registered manager gave staff positive feedback; a head of department was told that they were a good team leader. Appraisals had been devolved to heads of department to give them a sense of leadership and responsibility. In addition staff attended regular team meetings and spoke of the benefits. One member of staff said, "I have a say, and feel better for having it."

A programme of regular audit was in place that covered key areas such as health and safety, medicines and infection control. Action plans with realistic time scales were produced to address any areas in need of improvement. The audit outcomes and required actions were shared with staff at team meetings and daily handovers. In addition, the registered manager undertook an annual quality assurance audit on behalf of the provider that covered all aspects of standards of care in the service.

Staff were positive about their experience of working in OSJCT Ermine House and said that they were well supported in their roles. Care staff told us that during a recent period of heavy snowfall, that the Head of Care made their way into work and stayed over for two days to support staff and people who lived in the service. We received comments such as, "I'm proud of my job", and "we have a good bunch of residents." The service also has the support from eight volunteers who give their time to support people through exercise and art classes.

The regional director chaired monthly meetings with the registered managers from the parent organisation to address operational issues, such as the incidence of falls and medicine errors. The registered managers then work together as an organisation to drive forward improvements. The provider's policies and

procedures are evidenced based and planned around the CQC key line of enquiries (KLOES) with particular emphasis on safety, person centred-care and clinical governance.

The registered manager worked in partnership with other organisations and had built a strong relationship with the local community. A group had been formed called "Oaks and Acorns". People who lived in the service and a local parent and toddler group met once a week. The benefits of this were two fold. Residents passed on their skills and shared memories and the parent and toddlers learnt from them. We saw photos taken of people who lived in the service and toddlers baking cakes together and painting. Feedback from the parent and toddler group has been positive and it had changed their perception of care homes. The service is also a member of several national and local organisations that helped them to deliver good practice. These include National Activities Providers Association (NAPA), Dementia UK, Lincoln Care Association (local branches of national supermarket chains had "adopted" the service as part of their community role and helped out at their fundraising events and provided donations for raffles.