Orders of St John Care Trust

OSJCT Old Station House

Inspection report

Old Station Yard
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Date of inspection visit: 5 August 2014
Date of publication: 27/03/2015

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**

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service. This was an unannounced inspection which meant the staff and provider did not know we would be visiting.

Old Station House provides personal care for up to forty three older people in the Oxford area. Accommodation is provided in forty three flats arranged on 3 floors.

At our last inspection on 12 May 2013 the service met all of the outcomes we inspected against.

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 and shares the legal responsibility for meeting the requirements of the law with the provider"

Summary of findings

People told us they felt safe. One person said "Generally I feel safe here and well cared for," The provider had effective procedures for ensuring that any concerns about people's safety were appropriately reported.

Risks to people were appropriately assessed, managed and reviewed. We reviewed the history of the service in relation to risks and found no concerns. All assessments had been reviewed on a monthly basis ensuring they were up to date, and that people's needs were being met appropriately. Some people were living with dementia. Activities for these people were linked with their preferences and personal histories. All staff had received dementia training and we saw them offering people choices and giving them time to choose.

There was enough staff to keep people safe and meet their needs. People told us they felt there was enough staff. Staffing levels matched planned staffing levels and the head of care told us staffing requirements were driven by people's needs and the skills mix of the staff group. The service had a robust recruitment and selection process. Records confirmed that staff had received training appropriate to meet the needs of the people they cared for.

The home was clean and tidy and free from malodours. An infection control policy was in place and staff were aware of, and followed its guidance. People told us and we observed staff following safe routines using protective equipment such as gloves, aprons and hand gel.

At the time of our visit no one was subject to a Deprivation of Liberty Safeguards (DoLS) application. This is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests or their own safety. Staff at the home had knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and applied that knowledge appropriately.

People's care needs were accurately recorded with clear guidance for care staff to follow on how to support them. The home contacted other healthcare professionals if they had concerns over people's needs. People's choices and preferences on how they wanted to be supported were also recorded.

People told us they were happy with the care and support they received at the service and valued the relationships they had with staff. One person said "I couldn't have been looked after better even in the Ritz in London. They are all very kind and very patient." We saw people being treated with dignity and respect.

People knew how to complain and the provider's complaints policy was displayed around the home. All the complaints we saw had been dealt with appropriately, compassionately and in a timely fashion in line with the policy.

Regular "residents and relatives" meetings were held and people's opinions and suggestions were recorded and acted upon. People told us they knew the senior management of the service and they were accessible and approachable. People told us they felt listened to and could change things about the service.

The registered manager monitored the quality of the care provided by completing regular audits. Results were analysed and action plans for improvement made where necessary. People's opinions were sought and acted upon to improve the service. Regular surveys were conducted and results feedback to people via meetings and a newsletter.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were protected against the risk of abuse. People told us they felt safe. Staff had been trained and knew how to raise concerns.

There were sufficient staff on duty to provide care and support to people to meet their needs.

People's mental capacity to make decisions was assessed and where appropriate their best interests were considered. All staff had received Mental Capacity Act (MCA) training.

Good

Is the service effective?
The service was effective.

People had sufficient to eat and drink. Food looked wholesome and appetising. Those who needed support with eating and drinking were supported appropriately.

Staff received effective support through the use of supervision, appraisals and training.

People's care needs were accurately recorded with clear guidance for care staff to follow on how to support them. The home also contacted GP's, dieticians and Speech and Language Therapists (SALT) or other healthcare professionals if they had concerns over people's needs.

Good

Is the service caring?
The service was caring.

Staff displayed a positive, caring attitude whilst carrying out their duties. Staff were patient and compassionate whilst supporting people and engaged with them in a genuine, caring way.

Staff were kind and respectful and treated people and their relatives with dignity and respect.

People receiving end of life care had access to GPs and other healthcare professionals. The home also had strong ties with the local church and, if requested ministers could visit people.

Good

Is the service responsive?
The service was responsive.

Complaints were dealt with in a timely, compassionate way. People knew how to make a complaint and were confident they would be listened to and action would be taken.

People and their relative's views were sought frequently. Meetings were conducted with people to discuss changes in the home and to seek their feedback.

The service provided a range of activities both in and outside of the home. People's preferences were recorded and where possible relevant activities were organised and offered.

Good

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

Good

Summary of findings

The registered manager monitored incidents and risks to make sure the care provided was safe and effective.

People told us they knew the senior management of the service and they were accessible and approachable.

Staff knew their personal roles and responsibilities in relation to supporting people.

OSJCT Old Station House

Detailed findings

Background to this inspection

We inspected Old Station House on 5 August 2014. The inspection team consisted of an 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.

We spoke with ten people who used the service, one relative and eight members of staff. 43 people were living at the service. The registered manager was on annual leave. We looked at a range of records about people's care and how the home was managed.

We reviewed previous inspection reports and other information we held about the home including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

Before our inspection, we reviewed the information we held about the home and contacted the commissioners of the service to obtain their views. We also looked at the 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.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People told us they felt safe. Comments included; "Staff are kind and friendly but they do seem to be busy," "I think I do feel safe in my room and around the home," "Generally I feel safe here and well cared for," "I feel very safe and content with care and staff contact." The provider had effective procedures for ensuring that any concerns about people's safety were appropriately reported. Staff we spoke with could clearly explain how they would recognise and report abuse. Staff told us, and training records confirmed, staff received regular training to make sure they stayed up to date with the process for reporting safety concerns. One member of staff said "If I had concerns I would see the head of care or manager. I could also call the number on the poster in the staff room for the council and Care Quality Commission (CQC)."

Risks to people were appropriately assessed, managed and reviewed. We reviewed the history of the service in relation to risks and found no concerns. We also contacted community healthcare professionals and asked about risks at the home. Comments we received included; "we have no concerns with this service," "we visit this service every other week. I think the service manages risk well." Six people's care plans had appropriate risk assessments in place. One person's care plan showed they had difficulty mobilising. The risk assessment highlighted the hazards and gave clear guidance for staff to follow to reduce the risk. Staff were aware of the risks and followed the guidance. The assessment had been reviewed on a monthly basis ensuring it was up to date.

Other risks assessments we saw included risks to tissue viability (where people are at risk of pressure sores), eating and drinking and weight loss. One person was identified as being at risk of choking. The person's GP had assessed them and their recommendations were being followed. The district Nurse visited every week and the person had been referred to a Speech and Language Therapist (SALT). Their recommendations were to have thickened fluids to a "syrup consistency." However the person did not like to have their fluids thickened. The SALT team was contacted again and the issues discussed with the person who had agreed a compromise. This protected the person but respected their freedom to choose. The risk assessment was updated to reflect the changes made.

Where risks to weight loss were identified Malnutrition Universal Screening Tool (MUST) charts were used to monitor and manage the risk. MUST is an assessment tool, used to determine the risk that someone may be at risk of malnutrition and recommends actions that need to be taken to manage the identified risk. Frequent and regular weighing regimes were in place to ensure weights were monitored closely. Staff were following recommendations and those identified as at risk of weight loss were all maintaining their weight.

There were sufficient staff on duty to provide care and support to people to meet their needs. The head of care told us staffing levels were based on people's needs and the skills of the staff group. We were told the service had not used agency staff for over two years. Comments from staff included; "there's enough staff here, but sometimes it can be difficult to get a day off," "occasionally tight depending on what we are doing," and "only if there are people off sick do we sometimes struggle." When asked, none of the staff we spoke with told us they felt they were working excessively long hours.

Call bells were answered promptly and staff did not appear rushed in their duties and had time to chat with people and join in activities. One person said "if I need to use a call bell for help it is always answered promptly." We looked at the staff rota and saw actual staff levels consistently matched planned levels.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were suitable. We looked at six care staff files and saw the provider followed a consistent and robust recruitment and selection process.

The home was clean and tidy and free from malodours. An infection control policy was in place and staff were aware of, and followed its guidance. We observed staff following safe routines using protective equipment such as gloves, aprons and hand gel. People told us staff used protective equipment. One said, "Staff are very particular about gloves and that sort of thing." Staff we spoke with told us personal protective equipment (PPE) was available. One said, "The cleaning schedules are good and there is plenty of PPE ." Another said, "There are soap and towels and plenty of aprons though occasionally we run short of gloves." Only one member of staff mentioned shortages of

Good

Is the service safe?

gloves. We saw an ample supply of gloves of various sizes in the store room and around the home. All the bathrooms and toilets contained notices regarding hand washing procedures and had bars of soap and towels available. These measures promoted a clean environment for people and reduced the risk of the spread of infection.

At the time of our visit no one was subject to a Deprivation of Liberty Safeguards (DoLS) application. This is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests for their own safety. We spoke to the head of care who told us the registered manager was considering the new guidance in relation to DoLS. Care staff had been trained in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and we saw they applied that knowledge appropriately. For example, people's mental capacity to make decisions was assessed and where appropriate their best interests were considered. We saw staff offering choices to people and taking time to explain what was happening and why. Staff respected people's decisions.

One person was reluctant to be supported to receive personal care. We saw a mental capacity assessment in the care plan in relation to personal care and noted the person had also been assessed by their GP. A best interest document had been completed. This is where the person's best interests are discussed and recorded. This included their personal health needs, preferences, privacy and dignity. We saw that care workers had supported this person and were aware of their needs and preferences and the person was now accepting personal care. Progress had been documented in the daily notes and showed a clear, positive improvement in this person's well-being. Staff used the least restrictive practices to ensure this person received appropriate care.

Good

Is the service effective?

Our findings

We asked people about staff. Comments included; "The majority of staff are very good," "I never have any problems with staff, everything is done for me," and a relative said "They all seem very good and well trained to look after them. They are well cared for and always very clean and tidy whenever I visit." Staff told us they had the training they needed to meet people's needs. One care worker said "We are well trained here and can access further training if it is needed." Records showed that all staff received appropriate induction training to enable them to support people and staff told us further training was available. For example, staff had been trained in dementia awareness. Throughout the day we saw staff apply this knowledge appropriately. Staff took time to explain and offer choices to people living with dementia. For example, staff offered a choice of meal at lunchtime by showing the person two plates of food. People indicated what they wanted and this choice was respected.

Staff told us they had effective support, induction, supervision (one to one meetings with line managers) and training. Staff said they all had an annual appraisal and received regular supervision meetings with their line manager. One said, "I have regular meetings and I do feel supported. I believe I can change things if I ask." Another said "The manager is very approachable, I do think they listen. I feel supported and I can have my say in supervision meetings." Staff records confirmed they received appropriate support to care for people effectively.

People's care needs were accurately recorded with clear guidance for care staff to follow on how to support them. The home also contacted GP's, dieticians and Speech and Language Therapists (SALT) or other healthcare professionals if they had concerns about people. People's choices and preferences on how they wanted to be supported were also recorded. For example, one person used a wheelchair and needed assistance with transfers, however they had asked they be allowed to do as much for themselves as possible to remain independent. Staff were aware of this person's preferences and told us they only assisted the person when necessary. Records of GPs visits, advice and recommendations were recorded in people's care plans and staff appeared knowledgeable regarding people's care needs.

We asked people if they had enough to eat and drink. One person said "Generally, it's very nice." Another said "everything is fine except for the food." Some residents had said the meals needed to be improved. We spoke to the head of care about this who told us the registered manager was following this up. People's preferences were recorded in care plans but occasionally the service did not provide their first choice. There was a newly formed residents catering committee that met regularly with the management to address issues around food. Most people however felt the food was fine and they were "content" with the meals. The meals we saw at lunchtime looked wholesome and appetising. Drinks were available at mealtimes and throughout the day. Each person's flat also had a small kitchen area where they could make their own drink. People told us night staff would also make drinks for them on request. The service contacted specialists for advice if they had concerns over people's nutrition. We saw where people needed assistance with their meals staff provided appropriate support. The kitchen maintained records of people's preferences and dietary needs, for example; people needing special or pureed diets. These records were reviewed and updated every month.

One person was at risk of pressure sores and had been assessed by staff. The district nurse also visited this person. Following the assessment appropriate guidance was put in place which included monitoring the person's skin condition regularly and the installation of pressure relieving equipment. Care records showed the guidance was being followed and we saw the person did not have a pressure sore. We visited this person's room and saw appropriate equipment had been installed to reduce the risk.

The home was decorated in a way that helped people orientate their way around. The doors were different colours to the walls with clear, large door numbers. Each floor was named, Daffodil, Snowdrop and Bluebell, and a picture of the relevant flower was on each door along with a photograph of the person. This made it easier for people to identify their rooms. One person was blind and on their door was a notice stating "please introduce yourself." This person was assisted by staff when they moved around the home. Another person liked flowers and their room contained vases of flowers and paintings of flowers were hung on the walls. Their balcony had been turned into a flower garden. This person told us their relative regularly brought them flowers. People could also furnish their

Good

Is the service effective?

rooms to personalise their environment. In all the rooms we visited we saw chairs, tables and sideboards that individualised each room. Personal bedcoverings and soft furnishings were also popular.

Good

Is the service caring?

Our findings

People told us they were happy with the care and support they received at the service and valued the relationships they had with staff. One person said "I couldn't have been looked after better even in the Ritz in London. They are all very kind and very patient." Another said ""I feel very content with care and staff contact. Staff are very caring for personal care." A relative told us "Very pleased with the room in general and the overall care provided." One care worker we spoke with told us how they loved their job. They said "It is the best job ever. I love the residents, every day is different and a new challenge. If I can make someone smile I am happy." All throughout our visit we observed positive interactions between people and staff demonstrating a genuine caring attitude.

Records showed what was important to each person. For example, staff had recorded information about people's family life, employment and religious beliefs. People's preferences regarding their daily care and support were recorded. For example, one person wanted to care for themselves but could not always do so. Staff were instructed to let the person try and only assist if asked or if needed. Staff were aware of this person's preference and followed the instructions. We saw people being offered choices and staff respecting people's decisions. We also saw staff giving people information so they could make an informed choice. For example, one person who was diabetic wanted some sweet sugary food. The care worker explained the implications of this and offered a suitable alternative which the person chose.

We saw people being treated with dignity and respect. Staff used people's preferred names and when they spoke about people to us or amongst themselves they were very respectful. We saw staff knocking on people's doors and wait to be invited into their rooms helping to promote their privacy. A group of staff had been appointed dignity champions for the home. They were a point of reference for other staff regarding issues or questions about dignity and respect. One dignity champion we spoke with said "I tell new staff to treat people how you would want your grandmother to be treated." Care plans we looked at reflected how people were treated with respect. Appropriate language was used throughout and people's choices were emphasised. One noted the person liked craftwork and enjoyed staff involvement in the activity. Staff were aware of this and we saw people were engaged in this activity during the day. Two care workers sat with people and took part in the activity. People chatted and laughed with the staff clearly enjoying the event.

The home ran a dementia café and people, relatives and staff were invited to visit. One to one activities with people were offered by staff at events in order to engage people. For example, jigsaw puzzles. Staff told us they tried to involve those people who did not usually take part in events. One care worker said "it works well but ultimately it is their choice to join in or not."

People were involved in decisions about their end of life care. For example we saw one person had a do not attempt cardio pulmonary resuscitation (DNCAPR) order in place. This was signed by both the person and their GP. We saw that some care plans contained people's wishes for their end of life care. One person had stated their priority was "to be treated with dignity and respect." They had also stated if possible they did not want to die in hospital but at the home. Some people had listed their funeral preferences and had chosen favourite hymns or readings. All the end of life plans we saw were signed by the person demonstrating their involvement in recording their choices.

People receiving end of life care had access to GPs and other healthcare professionals to assist and advise. The home also had strong ties with the local church and, if requested ministers could visit and attend people.

Good

Is the service responsive?

Our findings

People were assessed prior to any care being given, reducing the risk of inappropriate care. The assessments covered their medical condition and history, and included tissue viability (skin condition), mobility and eating. Care plans were made from these assessments and where risks or issues were identified, referrals were made and specialist advice sought. Staff were aware of changes made to people's care plans and knew how to support them. One person told us their care needs were changing due to a change in their health. They said "Up to now I have been able to be very independent but I feel my need for support will increase." We spoke with the head of care who had put plans in place to provide extra support to the person when they needed it

People told us how the service responded to their needs. One person said "I had very good input into my care plan when I arrived and it is followed." Another said "Being here suits me very well. Dignity is very good and I'm very strict on my medication. I ask to see my new prescriptions and make sure I'm getting everything properly."

People's needs were regularly reviewed and care plans updated accordingly. Information about changes to care was shared with staff at handover and staff meetings. One care worker said "Communication is good and I attend the meetings. We all get to see the minutes of meetings too."

People knew how to complain and the provider's complaints policy was displayed around the home. All the complaints we saw had been dealt with appropriately, compassionately and in a timely fashion in line with the policy.

Regular "residents and relatives" meetings were held and people's opinions and suggestions were recorded and acted upon. For example, at the last meeting it was suggested that a "Residents Catering Committee" should be formed to discuss catering at the home. We saw this suggestion had been carried forward and the committee was in place and scheduled to meet every month. Minutes of meetings were circulated around the home.

The home had two activities co-ordinators who provided a range of activities in the home. These included communal activities in the dining area such as craft work or games along with regular trips out of the home. These included trips to a tea dance, river cruises and a visit to a local wildlife park. Outside trips were usually limited to 12 to15 people but they made sure that everyone had an opportunity to attend by rotating names if trips were over booked. The home also maintained a good relationship with the local church. People could attend services at the church or, when the local vicar visited, in the home. The woman's church group also regularly visited the home. One person said "Entertainment is really good and there is always something to do." Another person said "We have enough to do here with what is offered. One member of staff is helping me try to write my life story." An activities co-ordinator told us that maintaining community links was important. They said "We try to provide as much activity outside the home as we can. It is so good for our residents to get out and about." Many of the people at the service were mobile and independent and we saw these people going out throughout the day, either on their own or with family or friends.

An activities questionnaire was used to find out what activities people wanted to do. People who could not fill the form out by themselves were helped by staff. People were also asked what their interests and hobbies were and what they did before they retired. The information was collated by the activities co-ordinator who told us they tried to match people's preferences. Activities were provided throughout the week and advertised in the lounge. One person had asked to do craft work and we saw this activity taking place. The person was engaged with the activity and was being supported to do so by a care worker.

Relatives were encouraged to visit the home. One person, who was active liked to go out to lunch with their relatives. Daily notes in their care plan showed this was encouraged and a regular occurrence.

Good

Is the service well-led?

Our findings

People told us they knew the senior management of the service and they were accessible and approachable. Comments included; "I get on well with all of the key staff and managers," "We have regular meetings with the manager and we are able to challenge anything that needs attention," and "all my requests are dealt with effectively." People told us they felt listened to and could change things about the service.

The management structure for the home was displayed in the reception area. It identified who was who and what role they played in the organisation. It also identified who were "Dignity Champions" and those staff who took a lead role, for example; in dementia care. Staff knew their personal roles and responsibilities. They told us they felt motivated and supported to do this by the registered manager. Staff records contained clear job descriptions that detailed their role and responsibilities. Staff were also supported by regular supervision meetings and appraisals where roles and responsibilities could be discussed. Staff told us they felt supported and the registered manager was approachable. One care worker said "The manager is very good, approachable and quite laid back. Communication is good and I do feel confident I can raise issues." Another care worker said "The manager is always available, I think they listen. Support is good here."

The lead staff had been trained in these areas to be a point of contact and reference for other staff with queries or questions relating to the subject. The service was also piloting the Trust's new "Apprentice Scheme" for staff. This is a scheme run by The Orders of St John Care Trust to train young people to become carers. Two staff at the home were on the scheme. One we spoke with said "It is a good scheme and I am loving it. I get lots of help and support and I can always talk to the manager."

During our visit, senior staff and care staff were visible and seen to be interacting with people throughout the home and speaking to people by their names in a friendly way. People clearly knew them and spoke with them openly in a familiar fashion. They told us this was normal practice. Regular meetings were held for staff, people and their relatives and minutes of these meetings were published and displayed. A monthly newsletter was published that highlighted activities people had enjoyed and gave information about the service. Notice boards displaying information for people were sited around the home to help promote a culture of open communication.

The registered manager carried out regular audits to monitor the service. We saw the results were analysed and discussed at meetings. This allowed any identified patterns and trends to be addressed and the service improved. Information from these audits was reported to the services head office and the results analysed collectively with other service audit results. From this analysis improvements to the service were made. For example, two other homes had changed the main meal of the day from lunchtime to the evening, serving a light lunch at midday. It was seen people were more alert and active in the afternoons and it was noticed that falls in these homes had reduced. This practice was being planned, in consultation with people and their relatives, and the operations manager told us they intended to introduce this practice in the home in October 2014.

The service had a whistleblowing policy that was available to all staff. Staff we spoke with were aware of the policy and we saw notices and posters displayed giving information and guidance to staff on how to whistle blow. Contact details for the Care Quality Commission (CQC) and Oxfordshire County Council (OCC) were included in the information.

Accidents and incidents were recorded and investigated and the results were fed to head office for analysis. Any patterns and trends were identified and this information was fed back to the service. For example, falls monitoring forms were used to map falls and learning from the information was shared at the "falls lead" meeting. This meeting was held to specifically discuss falls. We saw guidance from GPs was discussed along with guidance from the Care Home Support Service who specialise in falls prevention. Learning from these meetings was published and displayed around the home.

Regular surveys were conducted to seek people's opinion of the service. The surveys covered the full range of services provided, including care, communication and catering. We saw the results were recorded, analysed and published with the majority of people rating the home as good or excellent. Comments on the survey included, "I can speak to senior members of staff if I need to," and "I have a real say in how staff provide my care." Any issues arising from

Good

Is the service well-led?

the survey were carried forward to an action plan. For example, it was identified people wanted more flowers around the home. From the action plan we saw vases had been purchased and flowers ordered on a weekly basis. We saw flowers displayed around the home. A suggestion box was also available for people and relatives to use in the main foyer.

Staff at the service worked with other organisations to make sure that local and national best practice standards were met. We saw the service worked with the local safeguarding team, OCC, the Care Home Support Service and other professionals. We spoke with a visiting physiotherapist who told us they maintain good relations with the home. They said they felt this was one of the better homes with prompt referrals. The service notified the appropriate authorities when incidents or occurrences happened. These included notifications to CQC, the local authorities and the police.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.