The Orders Of St. John Care Trust

OSJCT Athelstan 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

Overall summary

Athelstan House provides nursing and residential care for up to 80 people. In addition to long term care, the home offers short stays to people who require support with rehabilitation or a period of respite care. The staff provide care and treatment to people with nursing needs and to people living with dementia. We found breaches of regulations at the previous inspection which relate to medicine management Regulation 13 and quality assurance systems Regulation10. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 come into force on 1 April 2015. They replace the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010These relate to previous regulations now correspond with Regulation The provider sent an action plan telling us how they were going to achieve compliance with the regulations.

The inspection of Athelstan House was unannounced and took place on the 12 and 14 August 2015.

Summary of findings

A registered manager was in post. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Quality assurance arrangements were effective and ensured people's safety and wellbeing. Internal audits were used to assess the quality of care people received. However, medicine audits had not identified that protocols for some people with prescribed when required medicines needed reviewing. This meant people may not be having their medicines when they needed them.

Management systems in place ensured there was a supporting culture. The service benefited from strong leadership. People told us the registered manager was visible and staff said the registered manager was skilled in conflict resolution and providing the resources needed to meet people needs. However, some staff said they did not always understand each other roles and when their suggestions were rejected they were not given the reasons behind these decisions. This meant some staff may not understand the decisions reached and commit to the agreements reached.

Safe systems of medicine management were in place. However, the protocols needed reviewing for some people prescribed with when medicines required medicines. This meant staff may not be administering when required medicines when needed by the person. A medication administration record (MAR) file was in place to support staff with the safe administration of medicines. Each person had a photograph in the MAR file which helped staff identify the person and included was important information about the person. MAR charts were signed by staff to evidence the medicines administered.

People's needs were assessed before they moved into the home so that individual risk assessments and care plans could be developed. Care plans were developed to meet people's needs in their preferred manner. They gave information and directions for staff to follow and meet people's health and welfare needs. Care plans were updated when their needs changed.

Risk management systems ensured where there was potential harm to people action was taken to lower the risk. When people had support needs with moving, risk assessments were developed on safe systems of moving and handling. Procedures were in place for the reporting of incidents and accidents. These events were analysed by the registered manager to identify trends and patterns.

People's health was monitored. A record of visits from social and healthcare professionals described the nature of the visits and the actions that must be taken. Good working relationships were in place where people's care was shared with other healthcare professionals such as Occupational Therapists and Physiotherapists.

People were able to pursue their interests, hobbies and religious beliefs. There was an activity programme in place and people had an opportunity to participate in group activities or on a one to one basis.

People's views about the service were gathered through house meetings and internal questionnaires. People said their views were valued and their suggestions were acted upon. Staff respected people's rights and promoted positive relationships with people. Staff delivered care in a way that helped people to maintain a good level of independence. They were encouraged to make choices and were enabled to do as much for themselves as possible.

People were enabled to make choices about their daily lives. Where people had a cognitive impairment their capacity to make decisions was assessed. Mental Capacity Act (MCA) 2005 assessments were developed for specific decisions and where people lacked capacity best interest decisions were made on their behalf by the appropriate decision maker. Members of staff were knowledgeable about the principles of the MCA.

Members of staff received an induction when they started work at the home. They attended training which helped them to develop the skills and knowledge needed to meet people's changing needs. One to one meetings and appraisals supported staff to meet their roles and responsibilities.

The procedure for making complaints was on display which meant people were informed on how to raise concerns. Staff knew the procedure for making complaints. A record of their complaints was maintained which the manager investigated and action taken to resolve them.

Summary of findings

Procedures and processes were in place to safeguard people from abuse. The staff were able to recognise the signs of abuse and were clear on the expectations placed on them to report suspected abuse. People said they felt safe at the home.

People's needs were met by sufficient numbers of staff that had the appropriate skills and knowledge. Where agency staff was used to cover vacant hours the same staff was used to maintain consistency of care to people.

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?

Good

The service was safe.

People were protected from unsafe medicine systems but for some people the protocols for administering when required medicines needed reviewing.

People and staff told us there were enough staff to meet people's needs.

People felt safe living in the home and staff knew the procedures they must follow if there were any allegations of abuse.

Staff showed a good understanding of the actions needed to lower the level of risk to people.

Is the service effective?

Good

The service was responsive

People were able to make day to day decisions and where people were living with dementia the staff enabled these individuals to make choices.

Mental Capacity Act (MCA) assessments were completed for people with cognitive impairments. Where people lacked capacity MCA assessments were in place for specific decisions.

Members of staff benefited from one to one meetings and appraisals with their line manager. At the one to one meetings staff discussed their performance, concerns and training needs.

Is the service caring?

Good

The service was caring.

People received care and treatment in their preferred manner which respected their human rights.

Members of staff were respectful and consulted people before they offered support. People said their care and treatment was delivered in a dignified manner.

Staff used a calm approach to support situations where people could become demanding when feeling frustrated

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's current needs and gave the staff clear guidance on meeting people's needs.

People were able to pursue their hobbies and interests. People who chose to, participated in group activities while others preferred to remain in their rooms and read or listen to the radio.

The complaints procedure ensured people knew how to make complaints. People knew who to approach with complaints.

Summary of findings

Is the service well-led?

Good

The service was well led.

Effective systems to monitor and assess the quality of care were in place which ensured people received consistent standards of care and treatment. Internal audit systems had not identified that for some people their when required protocols needed reviewing.

Systems were in place to gather people's views. Regular meetings to discuss the running of the home and internal surveys were used to seek people's views. The registered manager considered the suggestions made and acted upon them.

Members of staff worked well together to provide a person centred approach to meeting people's needs.

People said the registered manager was visible. Their views were sought and valued. Staff said the registered manager was approachable, skilled in conflict resolutions and ensured the resources were available for staff to meet people's needs.

OSJCT Athelstan 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 inspection took place on 12 and 14 August 2015 and was unannounced. The inspection was completed by one inspector, a specialist advisor and Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with 10 people who used the service, seven relatives, 10 staff including two registered nurses, the registered manager and area manager. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for three people. We also looked at records about the management of the service.

Good

Is the service safe?

Our findings

Suitable arrangements were in place to safeguard people from the risk of abuse. People told us they felt safe living in the home. One person said “nice and safe here, secure and kind people around to look out for you.” Another person said “I feel very blessed to be here safe and sound.” A visitor said, "I visit once a month and I’ve never seen anything which would suggest that the home is anything other than safe.” Members of staff knew the signs of abuse and the actions they had to take for suspected abuse. They said safeguarding adults procedures were available and they attended refresher training to ensure they knew how to identify and report abuse. A physiotherapist working to support people with their rehabilitation said they had no concerns about people’s safety.”

Suitable arrangements to manage risk were in place. The dependency needs of people were assessed and where risks were identified action plans were developed to lower the risk. Risk assessments were developed for people assessed at risk of developing malnutrition and for people at risk of pressure damage. Staff said risk assessments were reviewed monthly or following incidents and accidents. A member of staff said risk assessments were developed for people at risk of falls and for people at risk of malnutrition.

Malnutrition Universal Screening Tool (MUST) assessments were used to assess the risk of people developing malnutrition. Action plans were developed for people assessed at risk of malnutrition to help them maintain a healthy weight. Staff said people’s weight was monitored and depending on their level of risk guidance was followed on the actions to be taken. For example, fortified drinks and enriched meals.

Risk assessments were developed for people who fell frequently or for people with a history of falls. The risk assessments included the factors that may affect the person which may cause of a fall, for example, poor vision and night time medicines. Action plans were then developed to prevent further reoccurrences.

Safe systems of moving and handling were in place. Where people had mobility needs risk assessments were developed on the support needed from the staff. Moving and handling risk assessment included the equipment and the number of staff needed for safe moving and handling techniques. Staff told us they had attended moving and handling training which ensured they knew how to safely help people to maintain their independence. We observed safe moving and handling which demonstrated that staff knew how to support people safely and appropriately.

Procedures were in place for dealing with environmental emergencies. Contingency plans and personal evacuation plans (PEP) were devised to ensure people’s safety in the event of an environmental emergency. For example gas leaks. PEP gave important informing about the person on how to support them to evacuate the building safely in the event of an emergency. Contingency plans and PEPs were held in the front office in a “grab bag” to ensure the information was available to emergency services in the event of an emergency.

The registered manager told us accidents and incidents were analysed to identify trends and patterns. They said routine checks were carried out for all falls which included observations of people’s vital signs and equipment was used to keep people safe. There was an audit of falls used to assess trends and patterns such as times of falls and staff on duty at the time of the accident.

Staffing levels were monitored to ensure sufficient numbers of staff were on duty at all times. Relatives told us the staff were working very hard but they felt that there were a realistic number of staff on duty most of the time. A relative said, ‘Recently there have been days when there were not enough staff. Over the years the staff have got less.” Members of staff said there was a recent recruitment of staff and their induction was in progress. A member of staff said the staffing levels were good.

Safe systems of medicine management were in place but protocols needed reviewing for some people prescribed with when required medicines. The registered manager told us protocols were to be reviewed. They said where possible people were going to self-administer their when required medicines such as angina sprays. People told us they had their medication given to them by the nurse and that they were given it on time.

Medicines were administered from a monitored dosage system and the staff signed the medicine administration (MAR) charts to indicate they had administered the medicine. Each person had an identification photograph in the MAR folder along with essential information such as allergies and anticoagulants prescribed.

Good

Is the service safe?

We were reassured medicines administration was safe when we observed a medication round on the nursing unit.

A record of medicines no longer required was maintained. Staff recorded the reasons for the disposal of the medicine and signed the record which the person acting on behalf of the disposal company also signed.

Good

Is the service effective?

Our findings

New staff received an induction when they started work. A recently employed registered nurse confirmed they had received an induction which included moving and handling, medicines management, pressure ulcer management and nutrition. The registered manager told us new staff had to undertake the induction programme before they started work at the home. They said the aim was for new staff to have some understanding of people's needs.

Staff were supported to develop their skills and increase their knowledge of people's health and welfare. Staff told us the training was good and ongoing. They said there were opportunities for vocational qualifications. A member of staff told us refresher training was provided and this ensured their working practices were in line with good practice. For example moving and handling. One person said "the staff here do a good job when it comes to it." Another person said "my carers know me well, the things I like and need and they go out of their way to help me." Another person said "the care is very good here- staff take time to learn about you." Catering staff told us they had access to training which helped them to maintain their skills.

The training matrix included the essential training staff must attend to meet the needs of people. This training included infection control, safeguarding and food hygiene. Staff also attended a two day course on dementia.

Staff were supported to meet the expectations of their roles and responsibilities. There were opportunities for staff to discuss issues of concern, personal development and performance during one to one meetings with their line manager. Staff said they had two one to one meetings and two appraisals per year. They said at their one to one meetings procedures and training needs were discussed. A member of staff said their supervision was not rushed and "it takes as long as it takes." A matrix of supervision was maintained and staff which showed staff had regular one to one meetings and appraisals.

Procedures were in place to assess people's capacity to make decisions. Mental Capacity Act (MCA) 2005 processes were followed for people with cognitive impairments such as dementia. With the exception of one incomplete MCA assessment, the principles of the Act were followed. There were mental capacity assessments regarding the use of bedrails, crash mat, high - low bed and the use of slide sheets in order to prevent falls.

People were enabled to make decisions. One person said "I can choose to stay in my room or sometimes I like to go in to the garden. If that's what I want to do people [staff] will listen to me and take me. We can do the things that we want to do here." Staff told us people were able to make day to day decisions. They said people made decisions about their clothing, meals and activities. A member of staff said "we understand people and their interests, likes and dislikes. Good communication is needed. We ask people its trial and error." They said where appropriate the staff act in people's best interest.

People had access to all parts of the property. There were no restrictions on people who wanted to move around the property. People and visitors were not provided with the access coded needed to gain access or leave the property. Applications for Deprivation of liberty safeguards (DoLS) were made for people who required support from staff to leave the building.

During the lunchtime meal we observed staff maintaining clear pathways by seeking consent to move walking aids from where people, using them, were sitting. People who lacked capacity may have been deprived of their liberty because they were not able to leave the table without their walking aids. One person said they were encouraged to eat their meal in the dining room which they were willing to do as "long as their zimmer was not moved." The registered manager will be discussing with people the table arrangement. They said the aim was to ensure people's liberty was not restricted and were able to continue sitting where they liked.

People were supported to make decisions about the medical treatment to be provided in the event of cardiac pulmonary attack. Where people lacked capacity the appointed power of attorney made these decisions with the GP on their behalf. Do not attempt resuscitation (DNAR) orders were in place where the decision not to resuscitate in the event of a cardiac arrest was reached. DNAR orders were signed by the GP and reviewed with the person and decision makers to ensure the information on the actions to be taken were accurate.

Good

Is the service effective?

Where people refused support with personal care their care plan told staff the techniques to use on how to gain consent from the person. Staff described a variety of approaches used for people who refused personal care. They said advice from specialists was sought where "they struggled to meet people's needs." Staff were advised on how to develop trust and gain consent from people to care and treatment.

People were supported to have sufficient food and refreshments. They were offered a choice of hot and cold meals and their dietary requirements were catered. Some people were served with pureed meals and they were served in moulds for example, carrots shaped to look like carrots. We saw adapted cutlery and crockery was provided to help people eat independently and where people needed support the staff helped them to eat their meals.

People said "The dinner was beautiful. I like a good roast beef dinner. It was tasty and plenty of it." Another person said "I enjoy the food here, perhaps a little too much." We received other comments about the use of frozen vegetables. A few people said they would prefer fresh vegetables rather than frozen vegetables.

Adequate supplies of food and fluids were available for people to have a balanced diet. The chef said they catered for people's dietary needs which including enriched soft and pureed diets. They said training was provided by the Speech and Language Therapist (SALT) to ensure the correct texture meals were served. Enriched diets high in calorie were served to people at risk of malnutrition.

People participated in the preparation of the menus. The chef said people were asked for their menu suggestions and on admission people were asked about their food preferences.

Arrangements were in place for people to receive ongoing healthcare and some people received support with rehabilitation into the community. A record of GP visits were maintained along with the outcome of their visit. People had access to specialists for example, community mental health nurse. Staff told us there were weekly routine visits by the GP.

Some people were supported to return home following a period of rehabilitation. Weekly meetings with the GP and other healthcare professionals such as physiotherapist and occupational therapists (OT) attend the meetings.

Healthcare professionals told us people received appropriate care which helped in their rehabilitation. An OT told us the environment was pleasant and the staff were friendly. They said regular meetings were held to discuss people's progress. A physiotherapist working with people admitted for rehabilitation told us "the staff are brilliant and there are good working relationships. Staff follow guidance and there are weekly meetings where information is discussed."

Good

Is the service caring?

Our findings

Positive relationships with people were developed. Life stories about the person's background history and about their present lives were developed which provided information on their routines, preferences and interests. A member of staff said the life story was a holistic approach to care as they provide insight to the person. They said "relationships can't be forced. Staff have to prove they can be trusted. Over time staff form relationships with people." Another member of staff said they sat with people and asked their relatives about people's life stories.

People's preferences on how their care was to be delivered were part of their care plan. Keyworkers [designated member of staff] spent time with people to develop care plans which ensure the person has their care delivered in their preferred manner.

We observed a calm atmosphere in the home. Communal areas offered people space to sit alone or in groups. People had access to the garden and there was space to sit and relax if they wished.

Staff spoke to people appropriately. There was lot of laughter and light-hearted banter going on throughout the day as well as quiet calm dialogue. Some people said they liked the jokey, informal approach of staff and said that it brightened their day. We saw staff join in the banter. Relatives expressed confidence in the staff and were pleased with the interaction between carers and residents. One relative said "There is always a very jolly atmosphere in the home. No one on the staff seems miserable."

Advocacy was used for people who needed independent support to make decisions about their health and welfare and where there was no appropriate family or friend input.

People were helped to maintain links and relationships with children in their family. We saw children's activity packs distributed in communal areas for visitors with children to keep them occupied during their visit.

We saw staff respected peoples' dignity. Staff gave us examples on how they respected people's rights. For example knocking before entering people's bedrooms. Another member of staff said they respected people because people were given choices. People were treated with dignity and respect during the mealtime. They were asked where they would like to sit and if they would like a serviette (protective apron). People were asked if they would like some music on. There was enthusiastic agreement and soft music added to the ambience and helped to create a calm pleasant atmosphere in the room.

Good

Is the service responsive?

Our findings

People received care and treatment that was person centred. People told us their care was usually delivered by the same carer. One person said "I have had care from a male carer and he was very good but he has left now. They do ask me about who I would like to have to care for me but I don't mind who it is as long as I get along with them."

Systems were in place to assess, plan and deliver care and treatment to meet people's needs. People said they were involved with their care planning and the review of their care plan. A relative said the needs of their family member was assessed during their admission. They said in consultation with themselves and the physiotherapist the staff had devised a programme to improve their family member's general condition and increase their movement.

People's dependency was assessed and where risks were identified action was taken to lower the risk. Care plans and risk assessments were developed to meet the assessed need. Care plans gave guidance to staff on the support needed by the person and the actions needed to ensure their health and welfare needs were met. Care plans were evaluated monthly and updated where people's needs changed.

We found however, there were gaps in some people's records which meant the staff were not given guidance on how to fully meet people's needs. For example, how staff were to support one person with mental health care needs. The registered manager and senior staff took action and with the person they developed a detailed care plan. The care plan was available on the second day of the inspection. It gave staff guidance on how to care for the person when there was deterioration in their mental health.

Care plans were developed for people at risk of pressure damage. We saw input from healthcare professionals such as the tissue viability nurse was sought. Photographs were taken and actions documented regarding dressings, regular repositioning and the need to encourage nutritional intake/supplements, with pressure ulcers documented on the body map. There was a tissue viability care plan and evaluation with the preventative measures such as pressure relieving mattress which was documented and the settings recorded. A plan for two hourly repositioning using a slide sheet, continence, diet, a requirement for dressings to be changed every three days, analgesia, liaison with the tissue viability nurse and the GP, monthly Waterlow scoring and the application of barrier creams were all documented.

Staff said some people used aggression to express their frustrations and emotions. A member of staff explained their response to diffuse situation when difficult behaviours were exhibited. They said the cause of the behaviours was explored to gain a good understanding of the person to then develop strategies on diffusion and diversion techniques. Ultimately the response from staff was to give people time to regain control over their behaviour.

A record of daily events was maintained which kept staff informed on people's daily life. Daily reports described people's routines, incidents and accidents and visits form healthcare professionals. Staff said they were kept informed about people's health and welfare. They said handovers when shift changes occurred kept them informed on people's daily needs and care plans gave them more detailed information.

Some people said they would welcome more things to do. Some of these individuals liked to stay in their bedrooms but wanted more opportunities for one to one activities. Two co-ordinators, supported by volunteers and care staff are responsible for implementing and running the activities programme. The coordinators were working to extend the range, scope and number of activities which the manager supported.

The programme of activities included coffee/tea socials, arts and crafts, quizzes, and trips out to local places of interest, bingo, and flower arranging. On the first day of the inspection we saw a cookery group making scones. This activity was enjoyed by the three people who were participating. Earlier in the day a pampering session had taken place in a lounge area. One person said "I enjoyed the trip to the Butterfly Farm and the Fete last weekend. I won all this on the raffle." Another person "I don't play bingo but I like to watch."

People told us their spiritual needs were being met and that they were able to see a minister from their faith. One person said "the priest comes in to see me today to give me Communion. I have been going to church all my life and it's good that he comes in here to see me."

Good

Is the service responsive?

A physiotherapist working to rehabilitate specific people back to the community told us independent living skills activities were to be introduced to people in the home.

People were given information on how to make complaints. The complaints procedure was placed on a notice board in the entrance hall. People and their relatives said they would feel confident to raise a concern and felt sure that it would be addressed quickly. One person said "I've never had a single thing to complain about whilst I've been here but I know that if anything happened then the manager would sort it straight away." Another said "I have no worries because XX, the manager, is really on the ball all of the time."

Members of staff knew the procedure to be followed for complaints. Carers said complaints were passed to the senior on duty. The registered manager told us "it's ok to say we are not doing a good job. This way [making complaints] we monitor and put things right. It's not to be defensive. We hear it [complaints] and put thing right." A log of complaints received was maintained. We saw recorded the nature of the complaints, the investigations conducted and actions to resolve the complaint.

Good

Is the service well-led?

Our findings

The quality assurance arrangements in place ensured the care and treatment people received was monitored. The registered manager told us quality assurance visits were twice yearly to assess all areas of the service. Action plans were developed from the visits on areas for improvements. Visits by the area manager to assess improvements from the quality assurance visits took place. Action plans with timescales were developed by the registered manager where standards were not maintained. Health and Safety audits were carried out and areas which required action were highlighted to ensure people's safety. For example, dating food in the fridge.

A range of audits which included medicine management, care planning and infection control were used to monitor internal systems and maintain people's health and safety. However, the when required protocols were not identified as needing reviewing at the last medicine audit.

The views of people were gathered through group meetings and questionnaires. Meetings with people and their relatives took place every two months. People told us they had attended house meetings they said their views were listened to and their input was valued. The registered manager said people had a say about how the money raised was spent in the home. Internal questionnaires were used to gather from a random selection of people their views on specific areas of the service. For example the dining experience of people.

There were clear reporting lines through the management structure. Staff were aware of their responsibilities and accountability and spoke positively about the support they received from the management team.

The service benefited from strong leadership. Staff said staff meetings were held and they were kept informed about policy changes, codes of conducts and house issues. Staff told us the registered manager was good and visible around the home. A member of staff said the registered manager helped staff with conflict resolutions. They said the registered manager helped staff to discuss difficult issues and helped them to reach agreements for moving forward. Another member of staff said "I have great respect for the manager." Members of staff also commented on the resources the registered manager ensured were available for staff to meet people's needs. A healthcare professional told the registered manager was excellent, efficient and handled difficult issues in a professional manner. For example, ensuring accommodation and personal care was only offered to people whose needs the staff were able to meet.

The registered manager said the culture was homely which gave people a sense of security. They said to gain people's trust the service had to be managed in an open and transparent manner. The service was going through a period of change and communication with people and the team was important. There was investment by the organisation but recruitment was a challenge particularly the recruitment of registered nurses. Where agency staff were used to cover vacant hours the same staff was used to maintain consistency to people.