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

Overall summary

The inspection took place on 06 November 2014 and was unannounced. The inspection was carried out by one inspector.

OSJCT Ermine House is registered to provide accommodation and personal care for up 45 older people. There were 38 people living at the service on the day of our inspection.

There was a manager in post whose application for registered manager approval was in the final stages. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect

Summary of findings

people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves or others. At the time of the inspection no people had had their freedom restricted.

People felt safe and were cared for by kind and caring staff. People received their prescribed medicine safely from staff that had the skills to do so. Staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care.

People were supported by designated activity coordinators to maintain their hobbies and interests. People were involved in planning future social events including trips out for coffee and lunch.

People were given a choice of nutritious and well presented meals. There were plenty of hot and cold drinks and snacks offered between meals.

Staff were aware of people's choices and preferences. Staff had the skills to undertake risk assessments and planned people's personal, physical, social and psychological care needs. Staff had access to professional development, supervision and feedback on their performance.

People had their healthcare needs identified and were able to access healthcare professionals such as their GP or district nurse. Staff knew how to access specialist professional help when needed.

There were systems in place to support people and their relatives to make comments about the service or raise concerns about the care they received. People and their families told us that the manager and staff were approachable.

Staff felt that OSJCT Ermine House was a good place to work.

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 kept safe because they had their risk of harm assessed.

There were enough skilled and competent staff on duty to keep people safe from harm

Staff had access to safeguarding policies and procedures and knew how to keep people safe.

Good

Is the service effective?
The service was effective.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards. Staff had received appropriate training, and had an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to have enough to eat and drink and have a balanced diet.

Good

Is the service caring?
The service was caring.

Staff had a good relationship with people and treated them with kindness and compassion.

People were treated with dignity and staff members respected their choices, needs and preferences.

Good

Is the service responsive?
The service was responsive.

People's care was regularly assessed, planned and reviewed to meet their individual care needs.

People were encouraged to maintain their hobbies and interests including accessing external resources.

Good

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

The provider had completed quality checks to help ensure that people received appropriate and safe care.

People and their relatives were able to give their feedback on the service they received.

Staff and people living at the home found the manager approachable.

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 inspection took place on 06 November 2014 and was unannounced.

We reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. We used this information to help plan our inspection.

During our inspection we spoke with the manager, the area operations manager, seven members of staff, seven people who lived at the service and three visiting relatives. We also observed staff interacting with people in communal areas whilst providing care and support.

We looked at a range of records relating to the running of and the quality of the service. This included staff training information, meeting minutes and arrangements for managing complaints.

We also looked at the quality assurance audits that the manager and the provider completed which monitored and assessed the quality of the service provided.

We looked at the care plans for eight people. In addition, we undertook a Short Observation Framework for Inspection (SOFI) at lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Following our inspection we spoke with the local authority contract support officer for other information about the service.

Good

Is the service safe?

Our findings

The people we spoke with told us that they felt safe. One person said, "I'm safe here." Another person said, "I can't find fault with them."

Staff told us that they had received training on how to keep people safe and how to recognise signs of abuse. Furthermore, staff knew how to share their concerns with their senior managers and the local safeguarding authority. Staff had access to the contact details for the local safeguarding authority if they needed to raise a safeguarding alert. We saw that there was a policy available to guide staff on how to protect people from bullying, harassment, and avoidable harm and abuse that may breach their human rights. Up to date information leaflets were readily available in public areas for people and their families to access on safeguarding and legal matters.

We saw that people had risks to their wellbeing assessed before they entered the service and these risks were regularly reviewed and any changes to their needs recorded in their care plan. For example, we saw where a person was at risk of falling out of bed at night, they had a care plan for the safe use of bed rails and grab handles to support them.

We found the provider had a system for calculating the dependency levels for the people who lived at the service. These dependency levels then informed the manager of how many staff with different skill levels was needed on each shift. The manager told us that people's dependency levels were regularly reviewed. We saw a copy of the dependency tool was kept in individual care files. We noted that the manager was supernumerary to the amount of care staff needed on each shift.

We saw that call bells were always answered promptly. People told us that staff always responded to them in a timely manner when they called for help. However, during our inspection a fault was found with one of the call bell monitors. This could have led to a delay in a person receiving the care they needed in a timely manner. The manager asked the maintenance personnel to look at the fault and it was fixed as a matter of urgency.

People told us that staff responded to their individual needs. For example one person said, "The staff always see if you're ok. If you want them you just buzz and they come and see what the matter is."

There was a robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post.

We looked at the management of medicines. People told us that they received their medication at the same time every day. One person said, "I have them every evening and as they give them they tell you what they are for. They [staff] know their medicines." Another person told us, "I have 19 tablets a day and I know what most of them are for, they come round at breakfast time."

One person's relative told us that they did not always receive their twice daily skin cream treatment. We discussed this with the manager who said, "Staff apply the cream, they know it is a medication, but they do not always sign the chart." The manager showed us new guidance on the management of prescribed creams. They told us, "Care staff will take part in a workshop before their competency to apply cream is signed off."

At lunchtime we observed medicines being administered to people and noted that appropriate checks were carried out and the administration records were completed. Staff took time to offer people a drink and explained what their medicine was for. We noted that when a person was prescribed as required pain relief staff always asked them if they were in pain and if they needed their pain killers. As required medication is not taken routinely but only when a person has symptoms. We saw when a person declined as required medicine staff recorded this on their administration record. We saw that staff who administered medicines wore a red tabard to indicate to others not to disturb them during the medicines round.

People received their medicine from staff that were competent to do so. One member of care staff told us they had recently undertaken medicine training and would not administer medicines on their own until they felt competent. They said, "I have been shadowed on two medicine rounds."

When a person used pain relief skin patches, we saw there was a body map with their medication record chart to record the different areas of the person's body to be used to reduce the risk of damaging their skin from prolonged use of skin patches.

Good

Is the service safe?

We saw that the clinical room was clean and tidy and medicines were stored securely and there was timely disposal of unwanted stock. Staff had access to guidance on the safe use of medicines, the medicines policy and guidance on the covert use of medicines.

Good

Is the service effective?

Our findings

We found that staff were supported to undertake training that enabled them to effectively carry out their role. For example, the activity coordinator was enthusiastic about two workshops that focussed on activities for people with dementia that they had attended. They said, "I've had activity training on dementia and older people. I've now got to know them as individuals and we do reminiscence together. It's important to keep their mind stimulated." Furthermore, care staff told us that in addition to mandatory training, they also received training in subjects that helped them care for people's needs such as medicine management and record keeping.

Staff were supported in their roles through supervision and appraisal. One staff member told us that they had their appraisal the previous week and it was a positive experience. They told us their training needs had been identified and said, "I've also done supervision training and I'll now be able to lead supervision sessions with other staff. The manager is going to support me to do further supervision training with her before I start."

We found that people's consent to care and treatment was always sought by staff. We asked staff how they would obtain consent from a person who was unable to communicate. They told us they could tell by a person's body language and facial expressions.

We saw where one person lacked capacity their next of kin who was also their lasting power of attorney signed consent on their behalf. A lasting power of attorney is someone registered with the Court of Protection to make decisions on behalf of a person who is unable to do so themselves.

We spoke with the manager and care staff about their understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The MCA is used to protect people who might not be able to make informed decisions on their own about the care or treatment they receive. Where it is judged that a person lacks capacity then it requires that a person making a decision on their behalf does so in their best interests. A member of care staff told us of their recent experience of a best interest meeting with other health and social care professionals and the person's family to act in the best interest for a person who lacked the capacity to make decisions about their care and welfare. We saw that the provider had introduced a new DoLS policy in October 2014 and this had been discussed at the last staff meeting. No one living at the service had a DoLS authorisation in place. We found no evidence that people were being unlawfully deprived of their liberty.

People told us that there was always enough to eat and drink. One person told us, "Meals are good; I know what I am having for lunch. We chose from the menu. Yesterday I didn't want the main choices and had an omelette instead." Another person told us that they always had a full cooked breakfast on Sundays. The cook told us that they asked people about their likes and dislikes. We saw that a seasonal winter menu had recently been introduced following feedback from people. The cook told us, "I asked all the residents for their choices and then develop the menus with three different choices."

We spoke with the cook who explained what action they took to provide a balanced diet for people. If a person did not want the menu choices available alterative food options were offered, such as scrambled eggs or an omelette. The cook told us that they fortified some dishes to support people who may be at risk of weight loss. For example, we found cream was added to potatoes and puddings. We observed that people who were assessed at risk of malnutrition or dehydration had their food and fluid intake monitored on a chart. Staff told us that this information was shared with the person's GP or dietician if one was appointed.

Several people had their food and fluid intake recorded. The cook told us that if a person did not eat all of their meal they told care staff and the amount of food and drink taken would be recorded. and staff would offer the person an alternative meal or a prescribed nutritional supplement.

We observed lunchtime in the downstairs dining room and saw that people with special dietary needs were catered for. The cook told us that they used fresh meat and vegetables and if a person did not eat meat they made them a fresh vegetarian pie or casserole.

Lunchtime was a social event. People sat together in friendship groups if they wished and we witnessed a lot of chat and humour. Some people joined in with care staff in a sing song before lunch was served. We saw staff offer people a choice of drinks with their meal and these were topped up several times.

Good

Is the service effective?

Hot and cold drinks were available throughout the day. People were offered a biscuit or piece of fruit with their morning and afternoon drinks. Each sitting area had bowls of fruit, crisps and biscuits for people to help themselves. One person who was sat in the main hallway and unable to help themselves called out for a packet of crisps and staff responded straight away and they were given a packet of crisps of their choice.

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, district nurse, dentist and optician. One person told us, "GP comes to us if we need him, or we can see the optician if we need our eyes tested." Another person said, "They arrange the GP for you. The doctor comes in when needed."

We found that care staff responded to people's changing healthcare needs. For example, where a person had developed a skin infection, care staff alerted the person's GP who referred the person to hospital for a course of antibiotics.

We were told that people living with dementia and their families had support from a specialist nurse, called an Admiral Nurse, appointed by the provider. We spoke with one person and their relative who told us that the Admiral Nurse had helped them make decisions about their future care. We also met with the service dementia lead. They told us that they worked in partnership with the activity coordinator to achieve the best possible outcomes for people living with dementia.

Good

Is the service caring?

Our findings

We saw that people were treated with kindness and compassion by staff. There was a good rapport between people and staff and people were treated with dignity and respect and made to feel that they mattered. One person said, "Staff look after us well, poor devils are run off their feet, but they always help when needed."

When staff spoke with each other about the people in their care they spoke about them in a kind and caring way. We saw that staff referred to people by their preferred name and people were treated as individuals. We asked people how staff maintained their privacy and dignity. One person told us, "My neighbours can visit anytime and we go to my room and we are undisturbed by staff." Another person said, "Staff knock on the door and ask to come in, It's great, it's my home now."

One person's relative told us they had looked at numerous homes in the locality and this was the best, they said their relative was safe and well cared for.

We found that staff approached people in a calm and professional manner. For example, we observed one person attempt to remove the table cloth from a dining table that had been set for tea. A member of care staff began to chat with them and calmly distracted the person's attention to the choice of drinks they could have at tea time. The staff member's caring attitude prevented an accident from happening and the person was made to feel valued throughout the incident.

People were supported to express their views and were actively involved in making decisions about their care, treatment and support. Some people told us that they had a care plan and had been involved in planning their care. We saw recorded in on person's care file that they wanted their relative present at their annual review to support them. One relative we spoke with said that they had been invited to all the reviews and felt involved in their relatives care.

We found that some people wanted to keep their care file in their bedroom and had signed their consent to this. One person told us that they liked to have their care files in their bedroom. They said, "They [care staff] do my review with me. I know what's in my file."

Leaflets on the role of the local advocacy service were on display. These provided care staff and people with information on how to access an advocate to support a person through complex decision making, such as permanently moving into the care home. We spoke with one person and their relative, who told us they were being supported by an advocate to make that decision and found them helpful.

We noticed that several people wore a pendant round their neck. We asked one person what it was for. They told us, "I use this to call on the staff if I need help with anything. I'm not so steady on my feet now and I worry that I might have a tumble if I go to the toilet on my own." The manager explained that the pendant system was part of the call system and staff carried a handset that identified who had called for assistance. They said this helped to reduce the response time when a person summoned help.

Staff we spoke with confirmed that they treated people with dignity and respect and gave us examples of how they did this. One staff member said, "When you walk into a room, say hello to each person who is in the room. Some people want their bedroom door closed; they want their privacy, knock before you enter." A senior staff member said, "We need to be compassionate with people. I listen to other staff and they speak well to people, they are good carers."

Staff told us that privacy and dignity had a high profile within the service and was regularly discussed at their supervision sessions and at staff meetings. We found that dignity and privacy was weaved through people's care files. For example, one person's care plan recorded the need for privacy when the person was accessing the toilet.

Good

Is the service responsive?

Our findings

People took part in a range of group and individual activities and pastimes. One person said, "Yesterday we had a duvet day. It was just like home. We sat with a blanket or duvet round us and watched a movie and had hot chocolate and mince pies." Staff told us that some people's relatives joined in.

We found that people were encouraged to spend their time how and where they wished. One person told us, "You can have quiet moments. It's up to you if you come down for lunch or tea or you can eat in your own room." Furthermore people told us that staff were responsive to their needs. For example one person said, "They ask you what you want to do or if you need anything."

One person was supported to run a shop on Wednesdays. They told us that they sold toiletries and sweets to people who had no one to shop for them. We spoke with people who confirmed they bought personal items from the shop.

We saw where a person was unable to express their needs and preferences verbally that care staff encouraged them to use hand gestures and facial expressions such as thumbs up for yes and a frown for no. This person communicated to us that their care needs were being met.

Some people offered to show us their bedroom. We found they were supported to personalise their bedroom with items from home such as small pieces of furniture, photographs and keepsakes.

People were given a choice of where to spend their time, Some people chose to sit in one of the quiet lounges, others in the main dining room where activities took place and one person sat in the main hallway watching people and staff come and go. Throughout the day people had access to books and magazines, cold drinks, bowls of fruit and sweets and biscuits.

We observed a meeting between several people and the activities coordinator and a senior care leader. People were asked for their preferences for future social events and were encouraged to join in the discussions. We saw that people were at ease and spoke out about changes that could be made to keep people up to date with events in the service. For example one person suggested that they have a quarterly newsletter and others agreed. We later spoke with this person who told us, "I still have apart to play."

We spoke with a designated activities coordinator about how they planned activities with people. They told us, "I talk to them. I go to everyone individually. One person would not come out of their room. I found they liked gardens, so they went on a visit to a local garden centre. They really enjoyed it." In addition, they explained how they had an outing checklist to ensure that places of interest were accessible to people. They said, "Before we go anywhere, we check if there is disabled access, if we need to take a packed lunch and who needs assistance."

People had their care needs assessed and personalised care plans were introduced to outline the care they received. For example, where a person was at risks of falls, we saw that they had a pressure mat at the side of their bed to alert staff if they got out of bed at night. Their care file recorded the risk assessment and action staff would take. We looked at the care file for a person assessed with communication difficulties. We saw that they were offered a pictorial menu to assist them to make their food choices. This meant that ensured that people's individual care needs were met.

Care staff told us that they understood how to use care plans to meet people's needs. One senior member of care staff said, "We give person centred care. We know them because their care plans tell us what they like and don't like, we talk to them." Another carer added, "And we keep a record of what they do."

We asked people what they would do if they were unhappy with their care or wanted to complain. One person said, "If I was unhappy I would tell the carers or the manager." We spoke with a visiting relative who told us they were happy with the staff and had no need to complain.

Comment cards were on display at the main entrance for people and their relatives to make comments or suggestions about the service. The manager told us that they had received three comments in the last year. We read each comment and found they were taken seriously and actioned and the person who made the comment received a response.

Good

Is the service well-led?

Our findings

People told us that the service was well led and that the manager was approachable. One person said, "It doesn't leave you wanting anything. It's very amiable. The boss is good. Plenty of good communication. No need to query anything."

Staff meetings were held for all staff groups, including care staff, housekeepers and catering staff. We found the topics discussed were relevant to their roles. For example, catering staff discussed a more flexible breakfast time and housekeeping staff discussed the management of waste. The minutes of these meetings were shared with all staff.

We also saw that staff had a handover at the beginning and end of each shift to share the care a person had received and if there had been any changes to their condition or care needs.

The manager who was new to post told us that they were well supported by senior management. We spoke with the area operations manager who told us that they visited at least once a month to undertake a review of the service with the manager. We saw the results of the last review included actions taken when a person had lost weight, the outcome of any safeguarding alerts and the referral process to other professionals when person had sustained damage to their skin.

We saw the results of an annual survey for people and their relatives that was undertaken in October 2014. All the comments we read were positive. For example, people thought that staff were always available and had the ability to support them in a timely manner.

A programme of regular audit was in place that covered key areas such as health and safety, medicines and infection control. An action plan was produced to address any areas in need of improvement. The manager told us that the outcome of the audits were shared with staff. We found that the manager had the leadership skills to support their staff to continually improve the quality of care within the service.

We saw that the manager was visible during our visit and had an overview of all activity in the home. We saw that the manager knew people and their families and watched them interact in a positive and confident manner with people, staff and visitors.

Staff told us that their experience of working in the service was a positive one. One member of the kitchen staff told us, "[The manager] is quite new and approachable. I'm made to feel part of it. We have team meetings and I have a say in the kitchen." Another staff member said, "The home is well run, well managed, I would have my parents live hear."

There were systems in place to support staff when the manager was not on duty. Staff had access to an on call management rota who provided support at any time of the day or night. There was a contingency plan to be actioned in an emergency situation such as a fire or electrical failure. Arrangements had been made with the local community to evacuate people to the local church if there was an emergency.

We discussed two recent clinical incidents of concern and the manager explained how these had been resolved and lessons had been learnt from them to prevent a repeat. They told us that the district nurse had been invited to come in to talk through the incidents to prevent a recurrence.

Staff were aware of the whistle blowing policy and knew how to raise concerns about the care people received with their manager, local authority and CQC.

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.