Orders of St John Care Trust

Shotover View

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

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 announced inspection. The service was last inspected in July 2013. No concerns were identified at this inspection and no improvements were suggested.

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

Shotover View is a new, purpose built property in the Horspath area of Oxford. The service provides extra care housing (housing which is modified to suit people with long-term conditions or disabilities that make living in their own home difficult) for people living in 55 flats. The

Summary of findings

office of the domiciliary care agency is based within the building. The service provides domiciliary care for people living at Shotover View, as part of our inspection we only inspected the care people received.

On the day of our visit 37 people living at Shotover View received care and support from the provider.

People were safe from abuse and bullying. Staff had knowledge of safeguarding and were aware of their responsibilities to report any concerns. The registered manager knew of their responsibilities regarding the Mental Capacity Act 2005.

People received their medicines as expected. Staff had clear instructions to follow when administering medicines. Staff who administered medicines had received support and training to ensure people received their prescribed medicines.

The risks in relation to people's care were managed effectively. There were always enough staff to meet the needs of people. Staff had good knowledge around infection control and people were protected from the spread of infection.

Staff were trained to support people effectively. People spoke positively about the skills of staff. People's needs were assessed prior to care being given. Information about people's care was clearly recorded in their care plans. People had access to healthcare professionals and staff followed guidance provided to them by other professionals.

Staff developed positive relationships with people. Care workers respected people's privacy and dignity and involved people in their care.

People made choices about their care, and these choices were respected. Where people's needs changed, staff were responsive to these changes. People knew how to complain and were supported at resident meetings to make their views known.

People told us the service was well led. The registered manager conducted a range of audits to ensure people received a good quality service. The registered manager maintained clear communication between themselves, people and staff.

The service worked in partnership with community professionals, the local authorities and the local safeguarding team.

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 abuse or the risk of abuse. Care workers had been trained in safeguarding vulnerable adults and knew what action to take if they suspected abuse was happening.

People's medicine was appropriately managed and they were protected from the risk of infection.

There were sufficient care staff on duty to support people. Care workers underwent background checks before starting work with the service ensuring staff were suitable and safe for the role.

Is the service effective?

Good

The service was effective. People received care and support from appropriately skilled and trained care workers. The provider gave care workers the opportunity to access further training.

People were supported to maintain a balanced diet and people told us they had enough to eat and drink.

People had access to healthcare professionals and health services. Appropriate referrals were made to GPs, the district nurse and other specialists and their advice and recommendations were followed ensuring people received effective care and support.

Is the service caring?

Good

The service was caring. People who use the service experienced positive relationships with care workers.

People could express their views and were involved in decisions around their care. Meetings were held and the manager visited every person throughout the year.

Is the service responsive?

Good

The service was responsive. People were able to make choices about their care. For example, they could choose the gender of their care workers.

People told us they knew how to complain. The service had a complaints policy. All the complaints we saw had been responded to and resolved in line with the policy.

People received personalised care. We saw where people had individual care needs the service responded and met their needs appropriately.

Is the service well-led?

Good

The service was well-led. The manager promoted open and transparent communication in the service by being visible, approachable and by holding regular meetings. This gave people the opportunity to express their views.

Systems were in place to monitor and improve the service. Regular audits were conducted to help monitor the quality of service provided and learning from accidents, incidents and events was shared to improve the service.

Shotover View

Detailed findings

Background to this inspection

We visited the site office Shotover View on 17 July 2014. During the visit we spoke with four people who use the service, four care workers, the registered manager and an Order of St John Care Trust area manager. We looked at a range of records about people's care and how the service was managed. This included seven care plans and seven care workers' files. This was an announced inspection and we gave the provider 48 hours' notice of our intention to inspect.

The inspection team consisted of two inspectors.

Before our inspection, we reviewed the information we held about the home and contacted the commissioners of the service and other healthcare professionals to obtain their views. We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This enables us to ensure we were addressing potential areas of concern.

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 and free from bullying. One person said "yes I feel safe and I have never been bullied". Another person said "I do feel safe, the staff are lovely and I have my pendant so I can call for help if I need it. They come very quickly". We asked care workers about safeguarding vulnerable adults. Care workers understood their responsibilities and knew what action to take if they had concerns. Training records confirmed care workers were trained in safeguarding vulnerable adults. Dates for refresher training were also listed for September 2014. The service had a safeguarding and whistle blowing policy that was available to all care workers. They were aware of both policies and the need to keep people safe.

The registered manager was aware of their responsibilities under the Mental Capacity Act 2005 (The Mental Capacity Act 2005 is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so). DoLS (Deprivation of liberty safeguard is where a person can be deprived of their liberties where it is deemed to be in their best interests or their own safety) do not apply to care in people's homes however, the registered manager was aware of legal changes from a court ruling and was discussing with the local authority if this had an implication for them.

Where care workers provided support to people taking medicines appropriate records were kept. Clear instructions were provided to care workers when administering medicines. For example, one person required cream to be applied twice a day. The instructions stated "using gloves, apply cream twice a day". Where a person refused their medicine this was recorded and the person's GP informed. Appropriate medicine risk assessments were in place. Training records confirmed care workers were trained in medicine administration. Two people told us staff assisted them with their medicines and they had no concerns.

Although people lived independently any risks they had were managed well. Assessments of risk were completed and reviewed regularly. We saw a "client fire risk assessment" which would show how people would be evacuated in the event of an emergency. One person would require assistance and an evacuation aid in case of a building fire. They were instructed to remain in their flat with the door closed until care staff arrived. Care plans along with the fire evacuation instructions were held in people's flats. The fire risk assessments were signed by care staff and the person ensuring they were aware of the instructions. We looked at another risk assessment regarding bedrails. These had been fitted to the person's bed at their request. Staff discussed the risk of bedrails with the person. The person was supported to make a decision and bedrails were fitted. Care workers were instructed in the risk assessment to carry out regular visual checks to ensure the bedrails were still safe to use. The daily notes confirmed this.

The service had an infection control policy which gave guidance to all care staff regarding infection and the measures they should use to reduce the risk. This included hand washing techniques and the use of protective equipment such as gloves and aprons. All care workers had signed a document stating they had read the policy. We asked people if care workers used protective equipment when giving care and support. One person said "they always wear gloves and aprons." Another person said "they are good with that. I've never seen the staff work without washing their hands or using gloves." Care workers told us they were aware of the risks of infection. They also told us they used protective equipment. One care worker said "I carry gloves all the time. I never work without them." Another said "infection can be a huge risk so I ensure I always use gel, aprons and gloves." A third care worker told us protective equipment was never in short supply. They said "there is always plenty of gloves and aprons. We just ask and they order more. It's the same with hand gel or any cleaning materials."

There were sufficient care workers on duty to support people. Staffing levels were dictated by the needs of people using the service. People told us there were enough care workers. One said "I think so, if I ring my bell they come quickly enough." Another said "there is always someone around to help if I need it so I think there is." We asked care workers if they felt there were sufficient staff to support people. One said "Once we are at work, yes, many clients are independent or need little in the way of help." Another said, "There are enough staff but we have to cover a lot of shifts".

The service had appropriate staff recruitment and selection procedures in place. We looked at care worker files and saw

Good

Is the service safe?

each contained the necessary checks including two references, one from the previous employer, and criminal background checks were obtained before they started work.

Good

Is the service effective?

Our findings

We asked people about the visits and support they received. One person said "I am well looked after. The girls are always on time, they know what I need and what to do. They are very good." Another person said "I do a lot for myself, my medication, getting dressed, that sort of thing. They help me to get up and make sure I am alright. Then they get my breakfast."

Staff told us they felt well trained to carry out their role. One care worker said "training is very good. When I first started I made a mistake but the manager supported me and I got extra training. It really gave me confidence." The training records confirmed that all care workers received induction and further training. This induction included safeguarding vulnerable adults, infection control, moving and handling, dementia and fire training.

All care plans we saw contained a visiting schedule that outlined what support the person needed and when. For example, one we looked at stated "assist out of bed and help with personal hygiene." Another stated "provide assistance with dressing needs and prepare breakfast."

People's needs were assessed prior to care being given. The assessments included medical history and the person's current condition. The assessments also included personal information. For example, people's preferred name, their likes, dislikes and preferences. We asked people if they were involved in the assessments. One person said "yes I was. I don't need much but I had my say and they listened." Another person said "my son and I were part of that. I get anything I want, they are very good."

Two care plans held Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documents. Both these documents were appropriately completed and had been signed by a GP and the person. We looked at the training records and saw that five care workers had received training in end of life care. A further 13 care workers were scheduled for this training through August, September and October 2014. This training would enable care workers to support people during end of life care in line with their wishes.

People had access to healthcare professionals. In the care plans we saw appropriate referrals to GPs, occupational therapists and the district nurse. One person used a wheel chair and a standing turner. The occupational therapist had assessed the person and given guidance on the use of this equipment. For example, the care plan stated "two care workers must attend" this person. Care workers were instructed to stand either side of the person and support them whilst using the turner. This would allow the person to turn and be positioned appropriately. Care workers were also told not to use the turner if the person was unwell. If care workers experienced any problems they were told to contact the occupational therapist immediately. The care plan had been reviewed and no changes to this person's care were deemed necessary.

Another person was assessed as at risk of pressure sores. Their condition was being treated by the district nurse. The person's GP had been contacted and cream had been prescribed. Guidance from the GP and district nurse was being followed and the care plan recorded that cream was being applied twice a day. A pressure relieving mattress had been recommended and supplied, however the person had refused to sleep on it. Care workers had respected this person's decision and monitored and recorded their skin condition in the daily notes. Their skin integrity was maintained and they did not have a pressure sore. One community healthcare professional we contacted told us they thought the service effective. They said "the service is more reactive than proactive but they have followed up with my advice. Several people I have moved into the service are happier with their situation, the moves have been successful."

Good

Is the service caring?

Our findings

We asked people if they experienced positive relationships with the service and care workers. One person said “the girls are lovely. They are caring and cheerful and so kind.” Another person said “definitely friendly and kind.” We asked if the care workers were respectful and respected their privacy. One person said “definitely. They always knock on my door or ring my bell before entering. They are very polite. Even though I am a few floors up they still close the curtains before helping me.” Another said “I don’t need much help but they are polite and respectful. Always offering to help if I need it.”

We asked care workers about relationships and how they respected people’s privacy and dignity. One said “I love my work. The clients are great. I get to know them which means I can help them in the way they want. I close the curtains when giving any personal care and talk through what we are doing to reassure them.” Another said “I absolutely love working here. Staff are friendly and the people are lovely. I protect their dignity by closing doors and curtains before giving any care. I am polite and respectful and because so many of them are independent I get time to chat with them.” Care workers were polite and respectful in the way they referred to people. Preferred names were used along with references to people’s titles.

People felt involved in their care. One said “I feel involved, yes. Things are alright.” Another said “I am involved but I don’t need much, though I do have my say.” We asked care workers how they involved people in their care. One said “I try as much as I can. People here are mostly independent but we pick up on things and the daily notes help to inform us. I always try to offer them choices. It helps them take part in what we are doing.” Another care worker said “I ask what they want to do and how they want to do it. You get to know their routines so it is easy to fit in with their preferred ways.” Care notes prompted care workers to offer and respect people’s choices. For example, one plan stated “assist with dressing. They choose what to wear.” Another plan described how the person required assistance with meals. It stated “ask the person what they want and respect that choice.” All the care plans we looked at had been signed by the person and clearly documented their involvement in planning their care.

Good

Is the service responsive?

Our findings

People were able to make choices about their care. For example, they could choose the gender of their care workers. This was documented in people's care plans. One person had chosen not to use their pressure relieving mattress. The service had taken appropriate steps to protect the person by monitoring their condition closely. The service responded to changes in people's needs. Where community healthcare professionals made recommendations we saw these were documented and followed. One community professional said "Once I raised concern, they followed up everything I asked i.e. GP app, weight and meal monitoring, menu planning, but I would have hoped they could have thought of some of that themselves."

One person was identified as having difficulties with mobility. The person could move around with an electric wheelchair but needed assistance getting in and out of bed. The person had been assessed by an occupational therapist. They had recommended the use of a standing hoist. Hoisting guidance was contained in the care plan and included pictures to give clear information to staff. Training records confirmed all care workers had been trained in moving and handling techniques. The person said their care was "very good, they are all very good. They know my needs and they always explain what they are doing."

Regular meetings were held with people who lived at Shotover View. While people had individual flats at Shotover View, there were shared facilities such as a restaurant and lounges. The manager met with people at "residents meetings" and people also met with senior staff every three months. The meetings were advertised in the newsletter sent to every person. The manager also visited every person at least twice a year in their flats. The manager told us this was an opportunity for people to raise issues or concerns. They also told us they operated an open door policy whereby people could call into the manager's office anytime to raise issues or concerns. During our visit people freely entered the manager's office to ask questions or to just chat. We asked people about meetings. One said "they do have meetings but I don't go. There is nothing I need to complain about." Another said "I have been to a meeting, it was good." We asked if people had raised issues at the meetings but we were told they had not. One person said "I can raise things or complain and I think they would listen but I have nothing I think needs their attention."

People told us they knew how to complain. One person said "I do know but I've never had the need to." Another said "I would just see the manager or tell my son." All the care workers told us they knew how to support people with making a complaint. One said "I know how to help them. I would ask if they wanted to do it confidentially, no problem." Another said "I have done. I helped them with the form." Complaints were appropriately dealt with and responded to in a timely manner. The service had a complaints policy that was available to all people and care staff and was also on display in the foyer at the entrance to the building. We looked at the complaints folder. There had been three complaints since January 2014. All the complaints were resolved in line with the provider's policy. For example, one person had raised a complaint regarding keys and we saw their locks had been changed. Where appropriate we saw that families, social services and the safeguarding team had been contacted and informed regarding complaints. None of the complaints we saw raised concerns about the quality of care being provided.

The service held events such as bingo, cheese and wine parties and movie evenings. These events were advertised in the newsletter. This was published every other month and issued to people and displayed on the notice board in the foyer and gave people the opportunity to maintain community links.

Good

Is the service well-led?

Our findings

The service had a registered manager who was available to people, relatives and staff. We were told by people who use the service and staff, the manager was popular with everyone and very approachable. One person said "I see the manager all the time. I can talk to them." One care worker said "the manager is very open and supportive. There is an open door policy." People and staff knew the manager and area manager's role within the organisation.

The service had a whistle blowing (a person who exposes concerns occurring within an organisation) policy available to all care staff. Details of how to whistle blow were displayed on the staff room notice board. Care workers were aware of the policy and how to raise concerns. The policy contained contact details for the local authorities and the Care Quality Commission.

Accidents and incidents were recorded and investigated. We looked at the records and saw one incident Actions taken following the incident which were recorded and shared. This reduced the risk of the incident reoccurring.

Information regarding accidents, incidents and complaints was sent to the head office. The manager told us this information was analysed to look for patterns and trends. The manager told us this information was then passed onto care workers at staff meetings. For example, falls analysis was shared to enable care workers to reduce the risk of people falling.

The registered manager enabled open and transparent communication. Care staff meetings were held monthly. Care workers felt the meetings were useful and informative. One said "they are very good." Another said "they help to get things changed. We raised the issue that some care staff were not doing the little things that make life so much easier, like replacing pages in care plans when they are full, that sort of thing. That has now changed for the better." We looked at the minutes for staff meetings and saw that care workers were able to raise issues. Information and learning was shared at care staff meetings. For example, in one set of minutes learning from a medicine error was discussed. The medicines policy was read and care staff signed to say they had read the policy.

The manager visited five people every week. This gave people the opportunity to raise issues or concerns with the manager. We spoke with people and asked them about these visits. One person said "they are useful, I get things explained. I think communications are very good." Another person said "I know the manager. I can talk to them. I see them regularly." The meetings with people were recorded and any actions arising from the meetings were highlighted. For example, one person had told the manager an outstanding repair still had not been addressed despite the service reporting it. We saw from the recorded notes the manager had raised the repair again with the responsible body.

The service conducted regular surveys. The service sought people's, and their relative's opinions about the service. This included opinions regarding care and support, communal facilities, scheme involvement and general opinions on the service. 63.3% of people rated the service as excellent in the last survey. 32.7% rated the service as good and 4% as adequate. Comments recorded were very positive. For example one person had written "I am happy in my home. Independent with carers on call." Another had written "I like being near my daughter and feeling safe." The results of the survey were published and available to people. One person said "I always do the survey. I think it works." The manager told us that all comments were looked at to ensure that the quality of serviced people received could be improved.

The service worked in partnership with community professionals, the local authorities and the local safeguarding team. Information was readily shared between stakeholders to support care provision and improve the service. For example, one person contacted their own doctor. The doctor visited the person and along with the person provided guidance and recommendations to improve their care. The recommendations were passed to staff who ensured they were being followed.