The Orders Of St. John Care Trust

OSJCT The Elms

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection of OSJCT The Elms commenced on 31 January 2018 and was unannounced. This inspection was prompted in part by the provider's notification to CQC of a significant event. The information shared with CQC about the choking incident indicated potential concerns regarding people's safe care and treatment. This inspection examined those risks and reported on the findings in the safe and well led questions. This incident is subject to a separate police and coroner investigation and as a result this inspection did not examine the circumstances of the incident.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'OSJCT The Elms' on our website at 'www.cqc.org.uk'. The last inspection report was carried out 14 and 15 June 2017. At this inspection the service was rated as "good" and was meeting all of the relevant regulations.

OSJCT The Elms provides residential and nursing care for up to 45 older people. At the time of our inspection 38 people were using the service. Some of the people living at the home were living with dementia or other long term health conditions. Some people were staying at The Elms for a short period of time before returning to their own homes.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager was on leave at the time of this inspection. An Area Operations Manager employed by the provider was managing the home on a day to day basis.

The service was safe. Where people were at risk of choking this had clearly been assessed and comprehensive guidance was available to care and nursing staff. Nursing and care staff understood people's risks and knew how to ensure people were protected from these risks. Nursing, care and catering staff felt they had the skills and resources they needed to protect people from the risk of choking.

All staff, including agency care staff received a handover at the start of their shift. This ensured staff had current information on people's needs and risks. Agency staff who were unfamiliar with people living at The Elms were supervised and only assisted a small number of people to ensure they understood people's needs and risks and promote familiarity between people and agency staff.

Management systems were in place to ensure people were kept safe from preventable harm. The provider, registered manager and senior staff took action where shortfalls had been identified. The provider had learnt lessons from the incident to prevent future harm. These lessons were being shared with other homes operated by the provider.

We have a recommendation to the provider as part of our inspection, to further build on their good practice in relation to the actions they have taken to protect people from the risk of choking.

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

Care and nursing staff had clear guidance to protect people from the risks associated with choking and to meet their nutritional needs.

Staff understood people's eating and drinking guidelines and we observed people being supported to eat and drink safely.

There were enough nursing and care staff deployed to support people who required additional support when eating and drinking.

Is the service well-led?

Good

The service was well led.

Management systems were in place to ensure people were kept safe from preventable harm.

The provider, management representatives of the provider, registered manager and senior staff ensured action was taken where shortfalls had been identified. The service learnt lessons from incidents within the service to prevent future harm. These lessons were being shared with other homes operated by the provider.

OSJCT The Elms

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.

We undertook this unannounced focused inspection of OSJCT The Elms on 31 January 2018. This inspection was carried out by one inspector.

The inspection was prompted in part by notification of a choking incident which had a serious impact on a person using the service. This incident is subject to a separate investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of people living at OSJCT The Elms. This inspection examined those risks.

The team inspected the service against two of the five questions we ask about services: Is the service safe? and Is the service well-led? No risks, concerns or significant improvement were identified in the remaining three Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

We spoke with three people using the service. Additionally we spoke with eight members of staff which included one nurse, four care staff, the chef, the Head of Care and an Area Operations Manager for the provider. We also observed the lunch time meal service and attended a staff handover meeting. We reviewed seven people's care records. We also reviewed management records in relation to staffing and incidents and accidents at OSJCT The Elms.

Good

Is the service safe?

Our findings

People's individual nutritional risks including the risk of choking and malnutrition were assessed by nursing staff. This risk information was used to develop people's care plans. Care plans provided clear and comprehensive guidance for nursing and care staff to follow to reduce risks to people's health and safety. For example, one person had been assessed as being at risk of asphyxiation (when a person is deprived of oxygen, which can be caused by their airways being blocked). The service had sought guidance from Speech and Language Therapists (SALT) to enable them to reduce the risk of the person choking. This included guidance around how the person's food and fluids should be provided, including the consistency of fluids and the body position the person needed to be in when being assisted by staff to eat. We observed care staff assisted this person with their lunch meal and drinks in accordance with their SALT guidance throughout the day. This included assisting the person with their meal and drinks at their pace and ensuring their drinks were thickened to a "custard" consistency. One member of care staff told us how they assisted this person, they said: "It has to be a custard consistency, which is two scoops, when it's like this it stays on the spoon. If it's not thick enough (person will tell us)." Another staff member told us, "You have to take it slow, use a tea spoon at a nice relaxed pace, they will tell you if they are okay."

Care and nursing staff understood how to keep people safe from the risk of choking. They knew which people required their drinks thickened and those who required a pureed or soft diet. This information was clearly recorded on handover sheets and "resident fire evacuation status and current condition/needs" documents which each member of staff received at the start of their shift. For example, for one person the document identified one person was at "high risk of choking" and cited the specific support they needed to protect them from this risk. Staff told us this information was useful and alongside a handover at the start of the shift gave them the information they required to meet people's needs. One member of staff said, "It gives us the information we need to ensure people are safe and their needs are met." Any agency staff contracted to work within the home received the same information to ensure they understood people's health and wellbeing needs and risks.

Where possible people were involved in managing and assessing their own risks. For example, one person liked to have a mainly vegetarian diet and liked to have their vegetables soft as they felt they had swallowing difficulties. The person's preferences and choices had clearly been recorded. We spoke with the person who told us, "I've lived here for nearly five years, I didn't think I'd be here that long as I was very unwell. I'm vegetarian; however I do like the odd sausage. My vegetables are always soft as I like them."

People were supported by enough care and nursing staff to ensure their needs were met and they were protected from risk. Prior the inspection an outbreak of infection had been identified within the home. This meant that most people were staying within their own rooms for meals and staff were following stringent infection control techniques to protect infections spreading within the home. These actions were being undertaken to ensure people were protected from these risks. Care, nursing and management staff ensured that people received their meals within their rooms. Where people required observation to ensure their safety was maintained, care staff carried this out, whilst respecting people's dignity. For example, one person was independent with eating their meals, however required regular and discreet observation due to

a reduced swallow reflux. We observed care staff observing this person and ensuring any concerns were reported to nursing staff.

Care staff felt there were enough staff to assist people with their daily needs. While the home was managing the spread of infection, care staff were positioned around the home and understood their duties and responsibilities to meet people's needs and protect them from the risks associated with their care.

Where people's needs changed, care and nursing staff ensured their plan of care was amended. For example, care staff ensured where changes had been made this was discussed with nursing staff and where relevant a referral to a healthcare professional was made. Care staff raised concerns about one person they were observing who was at risk of choking. They discussed this concern with nurses and the head of care and the plan was to carry on observing the person at mealtimes to ensure their wellbeing. We spoke with a visiting GP who spoke positively about the home. They said, "We have no concerns about the service. We have a regular weekly visit, or more frequently if asked. The communication is good and the nurses are knowledgeable."

All staff, including care, nursing and catering staff felt they had the skills and resources to meet people's needs and protect those who were at risk of choking. We spoke with the home's chef who informed us they had the equipment they required to ensure people who required pureed diets received this in a way which maintained the person's dignity. For example, individual food types were blended individually to ensure people could identify the different food types through smell and colour. The chef explained how they planned meals to ensure people had a diet appropriate to their needs and preferences. The chef was due to attend refresher training in regards to dysphagia and specialised diets for people who were at risk of choking.

People's nutritional needs and preferences were recorded at admission or when their needs changed. This informed dietary notification forms which were held by the catering team within the home. We discussed the dietary notification forms with the Area Operations Manager and how they could be personalised to better reflect people's preferences regarding their nutritional needs. They told us they would be reviewing these forms immediately as part of their wider actions following the choking incident.

Since the incident, all staff employed by the provider had received a "dysphagia in the social care and healthcare sectors" information booklet. All staff had signed to say they had received these booklets. Staff spoke positively about receiving this information which helped them understand the individualised textured diets people could enjoy. The booklet provided clear information on which foods were not suitable for people who required a pureed or mashable diet.

Care and nursing staff had been supported to reflect on the incident. The provider had carried out a reflective meeting in relation to the incident, which covered staff feelings and identified learning and improvements which staff felt needed to be considered. Staff had identified that the amount of agency staff within the home needed to be reduced, and that all staff were to receive a thorough handover. Staff felt that all staff should be involved at mealtimes and handover sheets were to be updated with details of people at risk of choking. The Area Operations Manager told us and we observed these actions had been incorporated into the service and were being shared with other services operated by the provider. You can find more details in "Is the service well led?"

Care and nursing staff explained the actions they would take in the event of a person's airway becoming blocked when eating and drinking. Staff felt they would work together and had received first aid training. Although staff had the skills to respond to a choking incident, there was no clear written protocol for staff to

refer to in relation to the actions they should take if a person at risk of choking started to asphyxiate. We discussed this with the head of care and the Area Operations Manager. They told us they would discuss this with the Director of Care for the provider. We recommend that the provider consider implementing a protocol for staff to follow in the event of a person choking. This protocol should be recognised best practice.

Good

Is the service well-led?

Our findings

The inspection was prompted in part by notification of a choking incident. The provider took prompt action following this incident to ensure people who were assessed as being at risk of choking would receive safe care and treatment. The Area Operations Manager informed us of some of the actions the provider, registered manager and staff had taken following this incident. Care and nursing staff had been involved in reflective learning, where they discussed actions they would take to ensure any potential incidents were reduced. These included ensuring all staff (including any agency staff) received a full handover and all staff to be present at mealtimes to reduce the concerns. The registered manager and head of care had also ensured nutritional care assessments for all people who were at risk of choking, or required a soft diet were reviewed to ensure they provided care staff with effective information. The Area Operations Manager and Head of Care were completing meal time observation audits to ensure people had a mealtime experience which met their nutritional needs and promoted their individual wellbeing. These audits were also being implemented within other homes operated by the provider. Representatives of the provider were completing an investigation of the incident and would be sharing this information with CQC when completed.

The provider had taken effective action to reduce the possibility of a future incident. Action had been taken in relation to ensuring all staff including agency staff received a full handover, even if they were unable to attend the handover meeting. For example, one member of care staff arrived later on the day of our inspection as they had been asked to cover a shift. They told us, "When I arrived on shift, I received a full handover. Everyone does to ensure we all have the right information."

Additional staff meetings had been implemented to improve communication within the service, which had been identified as an area of improvement by care and nursing staff in reflective meetings. These meetings were carried out every afternoon and staff discussed any concerns they had and discussed the needs and wellbeing of people staying at The Elms. During our inspection we sat in this meeting, which staff informed us was beneficial for improving communication. Care staff used the meeting to discuss concerns they had over some people who were currently unwell due to an infectious outbreak within the home. Agreements were made to increase people's fluid intake to ensure the health and wellbeing of these people.

A new protocol had been implemented in relation to agency staff. All agency staff received a full handover when they started on shift. Additionally agency staff were now supported to only work with a limited number of people with close support from permanent staff. Additionally at mealtimes all agency staff will work alongside permanent employees. The provider operated an agency staff checklist. These records had been completed when an agency member of staff came on shift, however they did not always provide clear details of what had been discussed. We discussed this with the Area Operations Manager and Head of Care. The Head of Care informed us that agency staff were made aware of the needs and risks of people they were caring for however this was not being recorded. The Area Operations Manager told us this form was currently being reviewed to ensure it captured details of where people were at specific risk to ensure a record of this was kept and understood when an agency member of staff came on shift.

The Area Operations Manager had also implemented an agency staff profile record to ensure they had complete information on their skills, training and professional background. Agency staff were not permitted to work within the home without a copy of their profile. These profiles were held by the nurses and Head of Care which enabled them to improve consistency of usage amongst agency staff and ensure all agency staff had the skills they needed to work with people in the home.

Systems were in place to monitor risks and quality of the service and improvements were made when shortfalls were identified. The provider had implemented mealtime experience audits in all of the homes they operated. These audits focused on ensuring people had a meal that benefited their health and that all people had a positive mealtime experience which benefitted their wellbeing. These audits were being completed over a period of time. The Area Operations Manager informed us this was due for completion early in February 2018 and an action plan would be implemented for any shortfalls or concerns identified.

The provider had provided dysphagia (difficulty in swallowing) information for all staff and was providing training for catering staff in relation to dysphagia to enable them to "refresh" their skills. Lessons that had been learnt from the incident were being shared across all other services operated by the provider to ensure that people who had been assessed at being at risk of choking were protected from these risks. One action that had been identified was reviewing the lunch time medicine round, to ensure that a nurse was available within the dining room at lunch times. Staff spoke positively of this change.