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?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This unannounced inspection took place on 17 and 18 February 2015.

The Elms provides nursing, residential and respite care for up to 45 people, some of whom were living with dementia. At the time of our inspection 35 people were living there. The home is purpose built over two floors.

There was 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 2008 and associated Regulations about how the service is run.

All staff had received safeguarding training and knew how to recognise abuse and what action to take to protect people from harm. The omission of recording and communicating important information between staff put a person at risk from harm when there was a change in their mental health. Arrangements were in place for people to see healthcare professionals when necessary but we identified this had not happened. This required improvement.

Risk assessments were completed to minimise risks to people's health and welfare. People were supported by sufficient staff with the appropriate skills, experience and knowledge to meet their needs. However, people's needs

Summary of findings

were not always met promptly and we made a recommendation for this to be monitored to ensure improvements were made. Recruitment procedures used ensured suitable staff were appointed.

Medicines policies and procedures were followed and medicines were managed safely.

People had a choice of food and their dietary needs were met. Where people were at risk of malnutrition steps were taken to monitor and improve nutrition to meet their requirements.

Staff spoke with people in a respectful and caring manner, using an appropriate volume and tone of voice, giving people time to respond. People told us they were well cared for and enjoyed the company of the staff. People were treated with dignity and respect and their privacy was protected.

People were asked their views about their care and how the home was run. Concerns were listened to at residents meetings, where all aspects of the service were discussed. People told us staff listened to what they had to say and on the whole improvements were made. Regular checks were made to ensure the service was safe and well maintained.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We completed this inspection at a time when the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009 were in force. However, the regulations changed on 1 April 2015; therefore this is what we have reported on. You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires improvement

The service was not safe.

Although staff had received safeguarding training the service did not always recognise when abuse had occurred and had not prevented abuse from happening.

People did not always have their care needs met promptly.

People's medicines were given and managed safely and kept under review to ensure people were receiving appropriate medicines.

People were protected by thorough recruitment practices.

Is the service effective?

Good

The service was effective.

The staff were well trained and were able to look after people effectively.

People had access to healthcare professionals but did not always receive ongoing healthcare support.

People were supported to have a choice of meals and their individual requirements were met. Risk of malnutrition was monitored and people had professional support when required.

Is the service caring?

Good

The service was caring.

People were treated with compassion, dignity and respect.

Staff treated people as individuals and interacted with them positively.

People were involved in making decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

People received the care and support they needed and were involved in decisions about their care when possible.

Staff knew people well and how they liked to be cared for.

People took part in many activities and went out in the community. Staff engaged with people individually.

Comments or complaints were listened to and responded to respectfully and changes made where required.

Summary of findings

Is the service well-led?

Good

The service was well led.

The home was managed well and regular quality checks ensured that people were safe and improvements were made.

The registered manager was accessible to staff and people and knew what the visions for the service were.

Regular resident and staff meetings enabled everyone to have their say about how the home was run.

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.

This inspection took place on 17 and 18 February 2015 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with the registered manager, a GP, four nursing staff, five care staff, the activities organiser, an administrator, a training co-ordinator, a learning and development adviser and two catering staff. We spoke with seven people who use the service and two relatives. We looked at five care records, three recruitment records, quality assurance information and maintenance records. We had a copy of the staff duty rosters and an overview record of all staff training.

We contacted Gloucestershire County Council Quality Review Team and a tissue viability nurse. We asked them for some feedback about the service.

Requires improvement

Is the service safe?

Our findings

An incident regarding a person with a history of support from the mental health team had not been reported correctly. This meant they may not have been protected from harm because appropriate action had not been taken. The incident was not recorded in the daily care records or handover between shifts report which meant the nurse in charge and registered manager were unaware of the change in the person's health and wellbeing. Once we brought this to the attention of the registered manager a referral was made to the mental health team by the GP. This meant that without our intervention the GP would have been unaware of the change and not referred the person for additional support. Care staff had completed a record of the incident when the person became anxious. Nursing staff in charge told us this information would not be reviewed until the monthly review was due. This meant that people may not receive ongoing healthcare support in time to prevent harm.

This was a breach of regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff had completed safeguarding training annually and had a good understanding about the different types of abuse and how to respond to them. They knew about 'whistle blowing' and to raise concerns with the nurse in charge or registered manager. There was a detailed safeguarding procedure for staff to follow that included informing CQC. There had been two safeguarding alerts reported to the local authority safeguarding team in the last 12 months. We looked at the records and the registered manager had completed a detailed response to the relatives and there were action completed to learn from the incident. People said they felt safe, commenting; "I feel safe here because there are always people around to help if I need anything".

A relative commented; "My relative is safe enough, but I don't think there are enough staff; when I visit I hear the buzzers going for a long time and my relative says they often have to wait for 10 minutes for a carer to come to take them to the toilet, then wait 'ages' for the carer to come back." People said the length of time it took carers to respond to their call bell depended on the time of day, mornings and mealtimes being the busiest. A person told us "staff usually come in two to three minutes at other times". We heard the call bells ringing and checked the records which showed that from 1:00 am to 13:00 hours six people had waited more than three minutes, one person had waited nine minutes and another person seven minutes. The registered manager was unaware of the results from the call bell system until we asked for confirmation. We made a recommendation for the registered manager to monitor staffing levels to ensure there are sufficient staff to meet peoples individual needs.

People were supported by staff with the appropriate skills, experience and knowledge to meet their needs. We reviewed four weeks of staff rotas that told us staffing levels were maintained. The registered manager told us people's dependency determined the staffing levels. Nurses calculated dependency scores monthly on computer. We looked at examples where people were either high, medium or low dependency residential care or required nursing care.

The calculations told us that there was sufficient staff available. There was a reduction in staff that worked the twilight shift from 18:00 to 22:00 hours as the service had a reduced number of people accommodated. The reduction was reflected in all shifts. The registered manage told us that full recruitment would begin as numbers increased. Agency staff had been rarely used in the last 12 months, covering only 12 shifts. The service used their 'bank' nurses and care staff for unplanned staff absences. Care staff were also supported by catering, laundry and cleaning staff.

The recruitment procedures followed helped to ensure people were protected from the employment of unsuitable staff. The three recruitment records we looked at were complete.

Accidents and incidents were recorded and staff meetings were held to discuss what happened, what went well and improvements to reduce future accidents. We looked at the minutes from a meeting about four people who had fallen and staff had discussed how they could improve care. Another meeting was planned to review improvements. We observed that people were wearing appropriate non-slip footwear. People commented; "I would love to open my window wide and have fresh air, but for safety reasons

Requires improvement

Is the service safe?

windows can only be opened a small amount" and "The garden has been designed so that we can walk around outside in complete safety; there are no steps and it is completely enclosed".

There were clear policies and procedures in the safe handling and administration of medicines. Medication administration records demonstrated people's medicines were managed safely. There had been no errors involving medicines in the last 12 months. One person told us; "They have a system for giving out tablets so that it cannot go wrong".

People had risk assessments recorded in their care plans to minimise any identified risks. These, included risks relating to falls, moving and handling and fire safety. Some people were at risk of falls from their bed and were safeguarded because bedrails were used to reduce the risk of a fall where appropriate. There was an emergency plan accessible to all staff that covered many areas, for example fire and power failure. People had individual emergency evacuation plans and staff knew whom to contact in an emergency.

There were risk assessments of the environment that included safety checks for fire safety, water temperatures and equipment. Legionella water system risks were checked monthly. The registered manager had completed a three monthly internal audit of all aspects of safety. There was a record of actions required and dates when they had been completed. A maintenance log recorded issues identified by the staff each week that had been dealt with immediately or planned.

Equipment was colour coded when the next service was due and staff knew not to use any equipment if incorrect colour was displayed. Visual checks were completed of all equipment by care staff and maintenance staff and taken out of use, for example any worn moving and handling equipment.

We recommend that the service monitor staffing levels to ensure there are sufficient staff to meet people's individual needs.

Good

Is the service effective?

Our findings

A staff member told us there were handovers between shifts where information about people was given to staff arriving on duty. We observed a handover where staff were given information about people to help ensure continuity of personalised care. The staff knew which gender people preferred for personal care, and there were both male and female care staff available. However important information about an incident was not correctly provided during a handover to ensure the person had ongoing support from healthcare professionals arranged. We have made a recommendation that people receive ongoing healthcare support.

All staff had completed Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. The MCA provides a legal framework for those acting on behalf of people who lack capacity to make their own decisions. The registered manager had a good awareness and understanding of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a lawful way to deprive someone of their liberty in the least restrictive way, provided it is in their best interests or is necessary to keep them from harm. There were no DoLS required at the service, although a person transferred to another service recently had one in place before they transferred.

One person's communication care plans recorded that they could make simple decisions and that staff seek verbal consent. The person had made the decision to have bedrails and this was recorded. People had consented to have their 'flu' vaccinations. We observed a staff member seeking a person's consent to put their lap rug over their legs as they had noticed their catheter bag was exposed. Care staff were heard asking people's consent before carrying out any personal care, they used the phrases; "Can I…"? "Is it alright if I…"? "Would you like me to…"?

There was a comprehensive training package provided by internal and external trainers and e-learning which included practice based competency checks, by a mentor. Topics covered were: Common Induction Standards, diversity and equality, pressure area care, moving and handling, nutrition, infection control, falls prevention, emergency life support and dementia awareness. There was supervision training planned for care leaders. The registered manager commented that supervision was not as good as it could be. However, 38 staff out of 60 had a supervision completed in 2015. The registered manager told us all staff should have two supervisions and two personal development reviews (PDR)'s each year.

Staff told us training was good, but currently there was no system to monitor whether training was effective, other than observing practice during shifts. The training co-ordinator monitored staff to ensure they completed training within time scales. We noticed not all staff names were on the training log where training completed was recorded. The information was added to the training log during the inspection and included all new members of staff.

Supervision records did not always record training completed, for example one record for a new staff member did not record moving and handling training. However, the staff member we checked had completed the training and the knowledge test and there was a good evaluation of their competency recorded in their training file. We also looked at staff personal development records where the registered manager had identified specific training required, for example; care plan training for one care staff member. The learning and development adviser assessed staff training but this was a new post since July 2014 and they had been providing training since November 2014. A recent in-house training session had been about 'Understanding Distress' where people's behaviours may challenge how the staff support them effectively. The adviser told us that dignity and consent to care was part of every training session.

A new staff member told us they had completed 'back to basics' training and their Skills for Care Induction standards were almost complete. We looked at the back to basics training booklet and it covered all aspects of personal care in detail. They told us they had completed all mandatory training for the service which included moving and handling.

People and visitors told us they felt staff had the required skills and knowledge to provide care that was effective. They said, "Staff are well trained, they are always having training sessions, they are very competent" and "The carers know my relative's routine and the way they like things done, I don't know what else they could do to improve on this".

Good

Is the service effective?

People told us, "I can cope with the food with the exception of the lunches. I am used to the best of everything, well cooked. Here they use poor quality foods, I bring this up at every residents' meeting, it is noted but does not improve", "Food is pretty good, can't grumble", "No complaints about food it is very good, we get a choice" and "Food and drinks are never hot".

People had risk assessments for malnutrition and weight was monitored on admission, and then monthly. A malnutrition universal screening tool (MUST) was used which assessed people's weight and identified anyone at risk from malnutrition. The catering staff had Individual dietary advice in the kitchen, 13 people had a soft or pureed diet and 18 people required a supplemented or fortified diet. The information was checked monthly with the care plan and revised as necessary. The catering staff checked daily to ensure that any additional requirements were catered for. Special diets, for example, diabetic diets were catered for. People had a choice of food and their preferences were met if they wanted different food. The daily menu was available to people in written and pictorial form on the dining room tables. Staff asked people what they would like to eat before meals and at mealtimes. This gave people an opportunity to change their minds.

Menus were based on people's likes and dislikes. The chef attended 'residents meetings' and had conversations with people about the food provided. People told us they felt able to make complaints about the food. Several people told us later the liver was overcooked and dry, one person said the cauliflower cheese was just about acceptable. The chef told us they responded positively to any criticisms and made changes where they could. We observed people waiting a long time to be served and a lack of organisation on the first day of our inspection. The registered manager was unaware that there was no team leader organising lunchtime.

There were a lot of plastic beakers and mugs used which looked institutionalised. However, when people had an afternoon 'cream tea' activity they used bone china tableware. Staff told us some people preferred plastic beakers as they were afraid of spilling their drinks. Some people had their meals in their rooms and staff supported people to eat their meal at a pace dictated by them without being rushed. They were offered sips of drink as well.

We recommend that the service ensure people are supported to maintain good health and receive ongoing support from healthcare professionals.

Good

Is the service caring?

Our findings

We heard staff speak with people in a respectful and caring manner, using an appropriate volume and tone of voice, giving the person ample time to respond. People used friendly banter with staff and they appeared calm and relaxed with them.

A member of the activity staff spent the lunchtime period with a person who had their nutrition through a Percutaneous Endoscopic Gastrostomy (PEG) tube. They gave them a hand massage and painted their fingernails a distance away from the dining room. They engaged in a different activity with the person at lunch time every day to distract them from the smell of food which they were not allowed to eat.

People were well dressed for their age and gender which reflected their previous lifestyle. People told us they were free to get up when it suited them. However, one person who required complete personal care said sometimes they had to wait a long time until staff were able to assist them. They told us they were always up by lunchtime. People told us staff started getting them ready for bed at 18:00 hours but one person said; “By then, I am ready for my bed”.

People told us they were happy with their care, commenting; “Carers are kind, they are always cheerful, I joke with them, they know how I like things done”, “ Staff do their job very well and look after me, if I ring my bell someone will come and help me, they dress me and do everything I want, we have a good laugh”, “Staff are kind and caring, they are very pleasant and helpful” and “I wouldn’t have a word said against staff, they are wonderful, the standard of nursing care is excellent, they all have a sense of humour and it amazes me how cheerful they are, I am very settled here and wouldn’t want to be anywhere else”.

Relatives told us; “Staff are all very kind, some carers are outstanding, I am full of admiration for them, they know my relative so well and care for them in such a fantastic way” The relative explained how a staff member told them, “I hope [the person] doesn’t have a sleepy day tomorrow because it is their favourite meal”. A relative told us they were happy with the care most of the time. However, often they have not got their hearing aid in, or it is not working. The same relative had found staff caring and understanding to them when they were upset during a visit.

Good

Is the service responsive?

Our findings

People or their relatives were able to contribute to the planning of their care. People who were able to comment on their care said their needs were being met. Care plans were reviewed with relatives every six months where possible. One relative said they were involved in their relative's review and another said they were asked if they wished to be present but had declined. We found that a person's son had attended a six monthly review and was happy with the care provided for end of life. The person had a care plan for pain control which was reviewed monthly with them.

Two relatives were present for another six monthly review, the relatives had "no worries" and the review recorded the person found the food was more appealing.

The personalised care plans for people had detailed information, daily records and staff handovers between shifts to help ensure that people had continuity of personal care. Monthly reviews of all risk assessments and care plans were clear. For example a pain tool assessment and care plan for a person with moderate arthritic pain was completed and reviewed monthly to identify care to lessen the pain. A person unable to communicate effectively was supported by an optician, audiologist and a speech and language therapist. Staff had advice from the healthcare professionals to help improve communication with the person and a friend had attended their six month review. The friend was happy with what was happening for the person.

The activity co-ordinator spent time with people who preferred to stay in their rooms which helped to prevent them feeling isolated. There were no restrictions on visiting and we saw many relatives visiting. The activity co-ordinator had written detailed personal histories with the help of some relatives in "This is my life" books. The information had helped them to purchase personalised birthday gifts. For one person, who enjoyed the Archers, a set of recordings was bought. This person relaxed when hearing the recordings and they were used in conjunction with a sensory bubble machine whenever the person was anxious.

Group activities were completed in the dining room. The activity co-ordinator had attended activity champion meetings and was enthusiastic about providing activities and taking people out in the minibus during the warmer months. Weekly activities include bingo sessions, films, board games, knit and natter, quizzes, table top skittles and games involving exercises. Special days and seasonal events were celebrated and appropriate activities took place. People said they enjoyed the activities and gave high praise to the activities co-ordinator who they believed did a wonderful job. Visitors also commented on the good variety of activities on offer, although one thought more could be done, especially at weekends. There were no activities listed for weekends, other than time with family and friends and group viewing of 'Songs of Praise' on the television. The registered manager told us that additional activity hours were planned in April 2015 to cover seven days a week.

People knew how to raise concerns and had the complaints procedure in their Residents Handbook. Residents' meetings were held regularly and chaired by the registered manager. A person told us they complained about the food during the meetings but, "Nothing is done". The meeting minutes recorded that when people complained about food alternatives were tried. An example was the quality of battered fish was a concern raised and a different source was found. Most people said it was an improvement two weeks later. Target dates for reviewing concerns were recorded when people raised them during meetings. Waiting too long for staff to serve desserts was raised and the registered manager dated the review for three weeks. Some people said they had not raised a concern but would tell staff or their family if necessary. We found a complaint was investigated thoroughly and relatives were satisfied with the registered manager's response.

Good

Is the service well-led?

Our findings

People said they see the registered manager walking around and many could tell us his name. They said they did not have much to do with him but were sure they would be able to ask to talk to him if they wished. Relatives said the registered manager was very approachable; one relative said they thought he had a settling influence on the home and felt the home was well run.

The nursing staff felt they were listened to and told us the head nurse communicated well with them and the registered manager. Learning from a safeguarding incident had taken place and additional training for staff completed. Care staff found the registered manager approachable and said he was mainly visible on the ground floors. Staff told us when care leaders were not allocated on every shift they were not well organised. They also said they did not have individual portable devices to indicate which room a person was ringing for assistance. The information was displayed at various points in the corridors, which added to their response times.

Gloucestershire County Council Quality Review Team had reviewed the service and completed follow up visits to help improve the service. It was clear from the records that the service had a vision of improvements to the service. For example the planned vision for a member of staff to become a dignity champion. The registered manager had planned to complete a Dementia Leadership Award training this year but in the interim was meeting with specialist dementia nurses to develop dementia care in the service. Some people were living with a dementia but the home was not designed to be dementia friendly. However, the straight wide corridors which formed a loop were helpful for people who liked to walk with purposeful intent to do so safely. There were handrails on either side of the corridors for increased safety. Apart from their name and number on the bedroom doors there was nothing to help people to recognise their own room.

Monthly operational reviews were completed where operation managers from the provider visited the home and looked at the quality of service provided. We looked at a recent review in February 2015. The kitchen refurbishment had been completed and been given the highest rating by Environmental Health. Many areas were looked at by the operations manager. These included when people had fallen, significant weight loss, care plan reviews and recruitment. Some shortfalls were identified in recruitment audits and the quality audit in October remained under review with some outstanding actions.

The provider's quality audit completed in October 2014 was reviewed in February 2015 and most areas were dated as completed. Where issues were ongoing the registered manager was aware of these and they were included in the visions planned for later in the year. The registered manager shared some future visions with us, for example; improve the dining room, have pictures of local areas on the walls, improve bathrooms, increase activity hours provided and develop staff skills through increased training.

The registered manager had notified CQC about events and we used the information to monitor the service and ensure they responded appropriately to keep people safe.

The service encouraged an open communication with people their relatives and staff. Resident meetings were held in September 2014 and February 2015. People were offered to complete a survey if they did not wish to attend a meeting. Generally the surveys told us the care was good but the food could be better. The February 2015 resident's meeting minutes recorded where changes had been made to improve the food. There was a good attendance at the residents' meetings with 14 or 15 people there. At the last meeting detailed notes were taken of peoples concerns and a target date recorded for completion. Waiting times for people had improved in February 2015 but there were still some instances when people had to wait to have their call bells answered.

A staff meeting recorded there was a good result from the providers' "mystery shopper", this was where staff were judged how people were welcomed to the home. A compliment was posted on NHS Choices website that praised the home for looking after a relative well for many years and they were always greeted with warmth from the staff when they visited. The key changes were discussed with staff for example; with regard to a new training system where a competency assessment will be used to identify staff that required training updates. Housekeeping staff had a meeting with the registered manager in January 2015 and the staff had reported the need for some carpets to be replaced. Target date for new carpets was recorded as April 2015. An audit of all mattresses, bedrail bumpers and commodes had been completed

Good

Is the service well-led?

There was a clear line of accountability in the organisation where the registered manager reports to the provider about all issues and support was provided by the operations manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People were not safeguarded against the risk of abuse because reasonable steps were not taken to identify the possibility of abuse and prevent it before it occurs. Regulation 11 (1) & (3) (d), which corresponds to Regulation 13 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.