The Orders Of St. John Care Trust

OSJCT Isis Court

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

Summary of findings

Overall summary

We undertook an announced inspection of OSJCT Isis Court on 14 January 2016. OSJCT Isis Court is a purpose-built property in Donnington Oxford, providing extra care housing for up to 20 older people. The office of the domiciliary care agency OSJCT Isis Court is based within the building. The agency provides 24 hour person centred care and support to people living within OSJCT Isis Court, who have been assessed as requiring extra care or support in their lives. On the day of our inspection 16 people were receiving a personal care service

There was a registered manager in post. However, on the day of our inspection the registered manager was on maternity leave. The service was being managed by the area housing and care manager. They told us a new registered manager was applying for the post. 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.

We were greeted warmely by staff at the service who seemed genuinely pleased to see us. Throughout the day we saw visitiors to the service being greeted by staff in the same welcoming fashion. The atmosphere was open and friendly.

People told us they benefitted from caring relationships with the staff. There were sufficient staff to meet people's needs and people received their care when they expected. The service had safe, robust recruitment processes.

People were safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

Where risks to people had been identified risk assessments were in place and action had been taken to reduce the risks. Staff were aware of people's needs and followed guidance to keep them safe. People received their medicine as prescribed.

Staff had a good understanding of the Mental Capacity Act (MCA) and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The covering manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected.

People told us they were confident they would be listened to and action would be taken if they raised a concern. The service had systems to assess the quality of the service provided. Learning was identified and action taken to make improvements which improved people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

Staff spoke positively about the support they received from the covering manager. Staff supervision and meetings were scheduled as were annual appraisals. Staff told us the covering manager was approachable and there was a good level of communication within the service.

People told us the service was friendly, responsive and well managed. People knew the managers and staff and spoke positively about them. The service sought people's views and opinions and acted upon them.

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. There were sufficient staff deployed to meet people's needs.

People told us they felt safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments in place to reduce the risk and keep people safe. People received their medicine as prescribed.

Is the service effective?

Good

The service was effective. People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring. Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive. Care plans were personalised and gave clear guidance for staff on how to support people.

People knew how to raise concerns and were confident action would be taken.

People's needs were assessed prior to receiving any care to make

sure

Is the service well-led?

Good

The service was well led.

The service had systems in place to monitor the quality of service.

People knew the management structure of the service and spoke with managers with confidence.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

OSJCT Isis Court

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 the 14 January 2016. It was an announced inspection. We told the provider two days before our visit that we would be coming. We did this because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be in. This inspection was carried out by an inspector 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 care service.

We spoke with eight people, one relative and two care staff. We also spoke with a care team leader, the covering manager and the domiciliary care trust manager. We looked at five people's care records and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on their care.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR, previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe. Comments included: "Yes I feel safe and warm here", "Safe. Definitely, no problem", "Oh yes absolutely safe" and "I feel safe here, definitely". A relative said "Yes, mum is safe here".

People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to their manager or senior person on duty. Staff were also aware they could report externally if needed. Comments included: "I'd report to the team leader or manager and I can also go to safeguarding", "Oh I've had the safeguarding training so I would tell the manager or I'd call CQC (Care Quality Commission) and the local authorities" and "I can go to my manager or call safeguarding. My team knows what to do and I'm on call to support my team with any concerns they have". Records confirmed the service took appropriate action, investigated concerns and reported them to the appropriate authorities.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, one person was at risk of falls. A risk assessment was in place and staff were guided to use a hoist for bathing. Details of how to support this person were highlighted in the care plan including the requirement for two staff to support this person. Records confirmed two staff were consistently deployed to support them.

Another person was independently mobile and had been assessed as at 'low risk' of falls. Staff were guided to ensure the person's environment was safe by reducing trip hazards. They were also advised to monitor the person, particularly when they were 'tired or breathless' as this increased the risk to the person. Staff we spoke with were aware of the risk. Records confirmed the person had not fallen. We saw all risks were regularly reviewed.

People told us there were sufficient staff to support them. We were told there was a "Stable staff group", with rare changes.

Staff told us there were sufficient staff to support people. Comments included; "We have plenty of staff plus some part time staff. Yes we have enough", "Yes there is enough of us, all shifts get covered. We have staff here at all times" and "At the moment, yes plenty of staff. We all work hard and we are a good team".

There were sufficient staff deployed to meet people's needs. The covering manager told us staffing levels were set by the "dependency needs of our clients". For example, where people required two staff to support them we saw two staff were consistently deployed for each visit.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role.

People received their medicine as prescribed. Where people needed support we saw that medicine records were accurately maintained and up to date. Records confirmed staff who assisted people with their medicine had been appropriately trained and their competency had been regularly checked. We spoke with staff about medicines. Comments included; "My competency is regularly checked and I am always checking with medicine to be safe", "I help people with medicine. I get regular checks from my manager" and "I've had the training which really helped to give me confidence. We get lots of support with this, such as information updates and checks on our practice".

Good

Is the service effective?

Our findings

People told us staff knew their needs and supported them appropriately. Comments included; "The carers are all very different, but all friendly and helpful. They all appear well trained", "I don't know much about this really but they definitely meet my needs. It is like living in a well-run hotel", "They are all very well trained here. It is so good to be here" and "They can meet my needs and they can't do enough to help me".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction and completed training when they started working at the service. This training included fire, moving and handling and infection control. Staff comments included; "The induction included lots of training and I did two weeks shadowing an experienced staff member before working alone", "Training is very good, very informative. If I need more training I just ask for it and I get it" and "Our training provides a positive benefit so we do things right".

Staff told us, and records confirmed they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. For example, one member of staff had requested extra training to support one person and meet their specific needs. We saw this training had been provided.

Staff were also supported through 'observation of care practice'. Senior staff observed staff whilst they were supporting people. Observations were recorded and feedback to staff to allow them to learn and improve their practice. Observations were also fed into staff supervisions. One member of staff said "I've had extra training and we have good support and development opportunities. I'm trained to level three in care and I am signed up for level four. Observations of our work are just part of the support process".

We discussed the Mental Capacity Act (MCA) 2005 with the covering manager. The MCA protects the rights of people who may not be able to make particular decisions themselves. The covering manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected.

Staff demonstrated a high degree of understanding relating to the MCA and how they applied its principles in their work. Staff comments included; "We presume they have capacity. I offer choices and go with their decisions. If I feel someone may be struggling with a particular decision I would tell the manager", "We assume our clients have capacity and if there are any issues I would refer to the manager and specialists to assess them. We always need to consider their best interests in cases like this" and "It is about people making decisions. All our residents have capacity but we watch closely and if there are any doubts or concerns I'd report it immediately".

We asked staff about consent and how they ensured people had agreed to support being provided. One staff member said "Even though they know what is happening and what they need I always ask permission first". We observed a member of staff supporting a person to leave the building. The staff member confirmed with the person they were happy before helping them with their coat and walking aid. All the care plans we saw

were signed by the person evidencing they had consented to the support plan.

The service sought people's consent. One person required the use of 'bedrails and bumper' to keep them safe at night. A bedrails risk assessment was in place and the risks had been explained to the person. Consent for the use of bedrails was fully documented and records confirmed this person had given their consent for their use.

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs and district nurses. One person said "The doctor is coming in to see me at 2.30pm today. The carers have called him for me". Another person said "The doctors are right next door but the carers get the GP for me. If they call in the morning by 11.00am they come that afternoon". Details of referrals to healthcare professionals and any advice or guidance they provided was recorded in people's care plans.

Most people did not need support with eating and drinking. However, some people needed support with preparing meals. People either brought their own food or families went shopping for them. Staff then prepared the food provided. One member of staff said "We help prepare food, whatever people choose. Families buy the food and we make some meals. Nobody here has specialist dietary needs at present".

People received effective care. One person could eat independently but required 'special cutlery'. Staff were guided to ensure the person had their special cutlery and 'beaker' for every meal. Staff were aware of this guidance. Another person used a motorised wheelchair. Clear details of how to support this person were provided to staff. This included photographs and detailed notes for procedures for hoisting and positioning the person. We saw this person using their wheelchair and they had been positioned in line with the guidance.

Good

Is the service caring?

Our findings

People told us they benefitted from caring relationships with the staff. Comments included; "The carers are excellent, that is the only word for it", "Oh yeah, I am very well looked after here. They are patient, kind and never rush me", "The carers are generally good. The best ones are excellent. They will even do my shopping for me. They listen to me well and know how I like things done" and "The carers are good, I don't have any trouble with them".

Staff told us they enjoyed working at the service. Comments included; "It is nice here, people and staff. I just enjoy it. It's a passion", "I love it here, I love helping people and making sure they are clean, safe and happy" and "I love this job because I like working with elderly people".

People told us staff were friendly, polite and respectful when providing support to people. Comments included; "There are no problems with patience, dignity or treating me with respect, they are always kind to me" and "I am treated respectfully. They are great". One relative said "They are generally welcoming to me. They do know her (person) pretty well. I come and see her every day".

We observed staff communicating with people in a very patient and caring way, offering choices and involving people in the decisions about their care. People were given options and the time to consider and choose. For example, One member of staff asked the person if they wished to visit the bathroom before starting their midday meal. The person considered this and said no. This decision was respected.

People's dignity and privacy were respected. We saw staff knocked on doors before entering people's flats. Where they were providing personal care people's doors were closed and curtains drawn. This promoted their dignity. We saw how staff spoke to people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. Language used in care plans was respectful.

We asked staff how they promoted people's dignity and respect. Comments included; "I get my staff to treat people as human beings, with respect. I make sure they respect people's wishes", "I always ask what residents want. I knock on doors and when giving personal care I cover them up as much as possible" and "I always greet them first. I shut doors, close curtains and make them comfortable. I do things their way".

People's independence was promoted. For example, one person liked to go out to the shops alone. This person used an electric wheelchair to mobilise independently. We saw staff supporting this person to go out, opening doors for them and encouraging them to enjoy their trip. Another person went out every day and often in the evenings. We spoke with them about their independence. They said "It is important you keep active at my age. The girls are wonderful and keep me mobile. I go out when I want, do my own cooking and look after my medicine. They encourage me to do all this".

People were involved in their care. We saw people were involved in reviews of their care and had signed reviews and changes to their care. People were also informed about who was visiting them and when.

Visiting schedules were provided to people and gave information about dates, times and the name of the staff member visiting. They also stated what the staff would be doing. For example, staff visited one person to 'do washing up, empty bins and attend to any laundry'. Daily notes evidenced visiting schedules were maintained.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to accessing the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person had stated their hobbies were 'reading and walking'. We spoke with this person who said "I always get out when I can, every day. Staff are great and they support me to keep active". Care plans were detailed, personalised, and were reviewed regularly.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person could get dressed independently but had requested support. The support plan stated the person could 'dress themselves but needed support with zips, buttons and socks'. Another person was able to complete everyday household tasks but staff were advised to 'always ask the person' and if needed, to assist them. Staff were aware of this guidance.

People received personalised care. For example, one person was independently mobile and liked to do their own shopping. Staff were advised to encourage this person to do their own shopping. However, on occasion the person required extra support and staff were advised to go shopping with them. They were also guided to 'bring the shopping in and put it away for them (person). Daily notes evidenced staff followed this guidance when required.

People were supported by staff who understood, and were committed to delivering, personalised care. Staff explained to us how they tailored people's care to suit their personal preferences. Staff comments included; "It is about the person, how they like their tea or how they want to be washed. It's about them. I go with what they want", "They are people. I treat them how I would like to be treated. They all have their set ways so I follow that. It's individual" and "Personalised care is how they like it. I can help three people have a bath and each one will be different because it is personalised".

People knew how to raise concerns and were confident action would be taken. All the people we spoke with told us their relatives would generally deal with any concerns but they felt confident they could raise issues or complaints with staff if needed. We saw one person raise an issue to the covering manager who went immediately back to the person's flat to resolve the issue. One person said "I don't have worries, they look after me well here with what I need". Another said "I have no complaints at all. They listen well enough and if there is a problem they fix it".

Details of how to complain were displayed in the reception area and contained in handbooks given to people when they joined the service. The service had received very few complaints. Historical complaints had been dealt with in line with the provider's policy. Staff told us they would assist people to complain. One said "Yes I can help. I would help with the forms and arrange for the manager to see them". Another said "They can come to me and if I cannot solve it I'd take them to the manager".

The service sought people's opinions. 'Client care quality visits' were conducted every month. A senior member of staff visited people in their flats to obtain their views on the service. Records confirmed all people were visited on a regular basis. The covering manager told us "Where issues are raised we resolve them". We saw the results of the January 2016 quality visits. There were no issues raised and feedback from people was overwhelmingly positive.

Good

Is the service well-led?

Our findings

People we spoke with were aware of the management structure at the service and felt there was a good level of communication. They told us they had received a letter telling them a new registered manager was soon to join the service. People also told us they knew the team leader. One person said "He comes round to check from time to time and is helpful". During our visit we saw both the covering manager and the area domiciliary care trust manager engaging with people in a warm and friendly manner. People responded with conversation and smiles and spoke to them with confidence.

Staff told us they had confidence in the service and felt it was well managed. Comments included; "This is a good service and the managers are very supportive and treat us all equally. I've learnt a lot from them", "This is definitely a supportive organisation and management are approachable. There are good, open communications between us" and "The managers are really good. They are supportive and approachable. The area managers are also very good".

The service had a positive culture that was open and honest. The covering manager told us they welcomed the inspection as "It's another set of eye's that may well help us improve what we do.
We have been looking forward to this visit". Staff told us they felt the service was open and honest. One staff member said "Yes it is open and honest here. All the clients come to us openly. No one has anything to hide". Another said "I think it is honest here, yes. We all make mistakes at some point and I'd happily go to the manager and say I've made a mistake. They don't look for blame".

Accidents and incidents were recorded and investigated. The results of investigations were analysed by the provider to look for patterns and trends. The results of investigations were also analysed to see if people's care needed to be reviewed. For example, one person was found in the communal lounge very late at night. The person did not want to return to their flat and staff were concerned for their wellbeing. The person's relative was called who resolved the situation. Actions following the investigation included a 'social work review' with specialists to assess the person's needs and establish if their needs had changed. The service was awaiting the result of the review.

Learning from accidents and incidents was shared through a 'serious incident learning' notice circulated to all services by the provider. A summary of incidents was highlighted and learning from the incident shared. For example, a series of near misses at other locations raised an issue relating to sensor mats moving when people walked on them. Services were reminded all sensor mats should have 'anti slip backing' and be fit for purpose.

Staff told us learning was shared at staff meetings and briefings. Comments included; "We get regular briefs to inform us about incidents. We discuss these at staff meetings" and "We have briefings and reflective meetings where we share learning. If things happen in one service we get to know by alerts from the trust (provider). All learning is shared". Records of staff meetings evidenced learning was shared and we saw incident alert notices on display in staff areas.

Team meetings were regularly held where staff could raise concerns and discuss issues. For example, staff raised and discussed the issue of the Mental Capacity Act (MCA). Following this discussion staff received further learning and information on the Act. Staff signed the minutes of the meeting to evidence they had read them.

The covering manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care and were modelled on the five domains used in CQC inspections. Audit results were analysed and resulted in identified actions to improve the service. For example, one audit identified a training need for staff. An action plan was created so progress could be monitored. The action was completed and the staff training had been provided. Medicine audits were conducted every month and all the medicine audits we saw were compliant with guidance and the provider's policy. Audit results were sent to the providers head office for analysis to look for patterns and trends.

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.