The Orders Of St. John Care Trust

Jubilee Lodge

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 14 and 15 August 2017 and was unannounced. Jubilee Lodge Centre provides accommodation for 74 people who require personal care with nursing. There were 72 people living in four households in the home at the time of our inspection. The home provided personal care and support for people with nursing needs; people who live with dementia and those who required a short period of recovery and therapy before they returned to their own home. People had access to quiet and well maintained accessible garden.

A registered manager was in place as required by their conditions of registration. 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.

People were cared for by staff who were passionate about improving people's quality of life and who knew people well. People and their relatives praised the staff for their kindness and support. Staff supported people to attend health care appointments as required. The registered manager and staff had acted on people's views and personal wishes to improve their life at Jubilee Lodge. People enjoyed the meals provided. They were being consulted about their likes and dislikes
People's rights were protected. They were supported to make decisions about their care and support. People's care records provided staff with detailed information about their support needs, personal histories and social interests. Their individual risks had been identified and assessed. Whilst staff supported people to minimise their risks, there was not always clear recorded guidance for staff to follow.

The registered manager and provider were actively recruiting new staff to ensure people were being cared for by a consistent and familiar team. The management and administration of their medicines was based on people's individual support needs. The managers had taken action to address previous errors in the management of people's medicines.

People benefited from staff who had been trained and supported to carry out their role. Staff understood their responsibility to safeguard people and report any concerns. Plans were in place to implement and monitor the system to support staff. A clear recruitment process was in place to ensure people were supported by staff of good character. However conversations about any discrepancies in their employment histories were not always recorded.

The registered manager had a good understanding of their role and how to manage the quality of the care provided to people. Quality monitoring systems were developed to check and address any shortfalls in the service; however the systems did not always monitor the skills of nurses and senior staff and the recruitment processes of staff. Where concerns had been raised by people and their relatives these had been addressed immediately.

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 risks were being managed in line with their care needs. However information on how to support people with their risks was not always documented for some people. This had been identified by staff and being addressed.

The registered manager and staff had been flexible to ensure people's needs were being met by sufficient numbers of staff. Agency staff had been made available when required. The registered manager was actively recruiting for staff to ensure people remained safe.

Suitable systems to check the employment history of new staff were in place; although conversations around any discrepancies in staffs past employment was not always recorded.

At the time of our inspection, people's medicines were being managed safely. Investigations and actions had been carried out as a result of a number of medicines errors.

People were protected from harm as staff were knowledgeable about reporting any safeguarding concerns.

Is the service effective?

Good

The service was effective.

People were encouraged to make decisions about the care they received. The assessment of people's mental capacity to consent to their care had been carried out. People who being deprived of their liberty were being supported in the least restrictive manner.

People were supported with their personal care by staff who were trained to meet their needs.

People were referred appropriately to health care services if their care needs changed. People were supported to eat a healthy diet.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate to the people they cared for. People were treated with dignity and respect and their views were listened to. Relatives made positive comments about the approach and attitude of the staff.

Staff had gone out of their way to make people's wishes come true.

Is the service responsive?

Good

The service was responsive.

People enjoyed a range of activities and a new accessible garden. Their care plans were informative and provided staff with information about people support preferences and requirements.

Staff immediately acted on people's concerns and wishes. Complaints were dealt with in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The management was considering options to assist with the recruitment and retention of staff.

The registered manager had acted on people's feedback and was implementing plans to improve the quality of people's lives.

Systems were being developed to audit and monitor the care being provided.

Jubilee Lodge

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 14 and 15 August 2017 and was unannounced. The inspection team consisted of an inspector, a specialist advisor 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. The expert had experience and knowledge of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

During the inspection we spent time walking around the home and observing how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 13 people and three relatives and visitors as well as four visiting health care professionals. We looked at the care plans and associated records of 13 people.

We also spoke with 11 care and nursing staff as well as a kitchen staff member, a house keeper, an activities coordinator and the registered manager and a representative of the provider. We looked at staff files including the recruitment procedures and the training and development of staff. We also checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Good

Is the service safe?

Our findings

The registered manager was working hard to ensure people remained safe and were supported by enough staff. Due to the rural location of the home, the registered manager was experiencing difficulty in recruiting a stable staff team. They relied on the use of agency staff as well as permanent staff to carry out additional shifts to ensure people were being cared for by suitable numbers of staff. Staff shared with us that there had been enough staff to meet people's needs, but this had occasionally been compromised when there had been an unplanned staff absence. One staff member said, "It has been tough at times, especially if staff phone in sick at short notice. We always prioritise our time so we are with the residents but it means we can get behind on other jobs." Other staff told us they had worked hard across the home to ensure people's needs had been met in a timely manner.

We reviewed the staffing rotas over a three week period. The rotas showed that on occasions there had not always been the number of care and housekeeping staff on shift in accordance with the provider's expected staffing levels. The registered manager shared with us that they had on these occasions asked the housekeeping staff to prioritise their cleaning tasks and asked care staff to cover additional shifts where possible to ensure there were sufficient numbers of staff to meet people's needs and maintain hygienic standards in key areas of the home. People and relatives felt that staff mainly responded in a timely way to their needs. We received comments such as "We see the same staff on a fairly regular basis", "The night staff are different", "Staffing was tricky last week because of holidays. It is normally very good" and "I ring the emergency bell and they come fast."

The registered manager produced a weekly report of the response times of staff when people had used the call bell system to alert staff for assistance. Any unacceptable response times were investigated and highlighted to the unit leads and senior staff to ensure that staffing levels reflected the support needs of people. For example, extra staff had been made available when it had been identified that people had required additional support and reassurance such as in the evening. On the days of our inspection we found that staff had adjusted their work patterns to ensure people were supported by sufficient numbers of staff. From our discussions with the registered manager we were assured that they were proactively recruiting new staff to ensure the home ran effectively. They also had made arrangements to ensure people's needs were being met on the days their staffing levels fell short of the provider's requirements.

People who had nursing requirements were cared for by a nurse who was supported by the unit leads. The unit leads had received additional clinical training to allow them to carry out simple health care duties such as taking blood pressure and carrying out simple wound dressings. The registered manager explained that the nurse acted as a community nurse across all the households but were predominantly in post to support people who lived on the nursing households. We found the nurses and unit leads had a good understanding of people's health needs and were managing their clinical needs appropriately. However there was no system in place to monitor the competencies and training requirements of the nurses and unit leads. The clinical skills of agency staff had not always been identified on their employment profiles. This meant the registered manager was not fully aware that people were being supported by staff who were competent in their role. This was raised with the registered manager who told us that a system to monitor to the

competencies and training of nurses, unit leads and care staff would be implemented as part of their action plan.

Senior care staff and nurses felt the home required additional clinical support when the registered manager was not available due to the increasing medical needs of people. The provider and registered manager informed us they had recognised that the present management and clinical senior structure was not effective in supporting the nursing and care staff with clinical and managerial decisions and with driving improvements across the home. At the time of our inspection, the provider was reviewing the roles and positions of the management team and senior staff to ensure there was adequate management and clinical support across the home to ensure people were supported by the right numbers of qualified staff.

The home followed safe recruitment practices in line with the provider's recruitment policy. Records relating to the recruitment of staff showed the majority of relevant checks had been completed before staff worked unsupervised at the home. However, we found that whilst the registered manager was aware of employment histories of potential new staff, they had not consistently recorded their conversations about previous health and social care positions or any gaps in their work profile. We raised this with the registered manager who told us they would be more vigilant in the recording of their conversations with new staff to ensure people were supported by staff of good character.

People were supported by staff who had a good understanding of protecting them from harm and abuse. Staff had been trained in recognising types of abuse and understood the provider's whistleblowing and safeguarding policy. They told us the actions they would take if they were concerned about someone's safety or wellbeing. One staff member said, "First I'd report to my shift leader, unit leader and colleagues. Senior staff would then decide on further action as appropriate, such as calling an ambulance or contacting the person's GP." The registered manager had notified the appropriate authorities including CQC and acted promptly when staff had raised safeguarding concerns about people to ensure they remained safe while living at Jubilee Lodge. People and their relatives were confident about the care they received and told us they felt safe in the home. We received comments such as "They are good they look after me" and "I'm happy here, I feel safe. The staff are wonderful."

People's risks had been assessed and were managed and monitored such as risks associated with their skin integrity, their moving and handling needs and the risk of falls. The outcome of people's risk assessments were reflected in their care plans and regularly reviewed to ensure staff had the information they needed to support people. For example, one person had been identified as at risk of falling which was reflected in their mobility care plan. The care plan provided staff with additional information to help reduce the risk of falling such as reminding the person to walk with their mobility aid.

Staff were knowledgeable about people's risks and were able to share with us how they supported people to reduce the risk of harm and take positive risks in their life. Whilst most people's care plans provided staff with specific guidance about the management of people's risks, some required further details. For example, one person's care file did not fully provide staff with the information they needed to support them with their incontinence and catheter care. Their fluid intake per day had not been consistently completed which meant staff were not always fully aware if the person had adequate fluids to help the risk of a urinary tract infection. However we found that the person's catheter care needs were known and being met by staff. Gaps in some people's care plans had been identified during an internal audit of people's care files and were being addressed by senior staff.

Where accident and incidents had occurred staff had recorded any injuries or bruises that the person had suffered on a body map. The incidents were investigated and people's injuries were monitored by staff.

Records showed that additional medical help had been sought when required. There was evidence that the recommendations of health care professionals regarding people's risks had been implemented such as dietary advice sheets and plans for the treatment of wounds.

People's mobility needs and support requirements were also recorded as part of their individual personal emergency evacuation plan. This information was kept with the 'grab bag' at the home's fire evacuation point to be used in the event of an emergency.

Peoples' medicines were administered safely by staff who had been trained and assessed to manage people's medicines. We observed people being given their medicines as prescribed. Medicines Administration Records (MAR charts) had been completed appropriately with no gaps in the recording of administration on the MAR charts. Protocols were in place to provide staff with guidance on the administration of occasional medicines such as pain relief. People's medicines were stored in an environment which was safe and at the correct temperature. The stock balance of medicines which could be misused was regularly checked and counted. Medicines audits were carried out monthly on each household to ensure staff had adhered to safe medicine practices and medicines errors had been identified, investigated and acted on to prevent reoccurrence.

Good

Is the service effective?

Our findings

People were receiving effective care from staff who had been trained and supported to carry out their role. Staff told us they felt competent and skilled and were able to meet people's needs. One staff member said, "I think the training at OSJ (the provider) is very good." A training matrix was used to monitor the care competencies and training requirements of staff. The matrix showed that most staff had received training which was deemed as mandatory by the provider such as moving and handling, person centred care and supporting people with dementia. Staff were also supported to undertake National Vocational Qualifications also known as Qualifications Credit Framework or QCF in health and social care. A staff member told us the course had assisted them to develop and feel more confident in their role.

Nurses referred to the additional clinical training they had received such as in catheter care, end of life care and a forthcoming tissue viability course. They told us that new ways or working emerged from training and it was important to keep their knowledge updated. Unit leads had also received additional training in some clinical skills such as clinical observations. They worked alongside the nurse on duty to ensure people's well-being was being monitored and managed in line with their care needs.

Staff told us they felt supported in their role and could request support and advice at any time. The provider were implementing new methodology in staff support and reviewing their performance. The registered manager explained the provider was supporting and training staff and their line managers to understand how to plan, measure and review staff's personal objectives under this methodology. They recognised that not all staff had received regular support meetings during the transfer period to the new system. The registered manager had plans to introduce a system to monitor the regularity of staff support and probation meetings in line with the provider's expectations once all staff had completed their first support meeting using the new methodology.

We checked whether the service was working within the principles of the Mental Capacity Act and whether any condition on authorisations to deprive a person of their liberty were being met. Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)

Staff had a basic understanding of the principles of the MCA, although they were unable to recall the key points of the law. However, staff demonstrated in their care practices how they supported people to make choices and were able to provide us with examples of how they prompted people to make decisions about their day such asking people where they want to sit and what they want to eat. We observed people's human rights being respected and staff supporting people in a least restrictive manner.

Where significant decisions had been made, staff had assessed people's mental capacity to make the specific decision and had considered their previous decisions and consulted with significant people such as families and health care professionals when best interest decisions had been made on behalf of people. However we found that some MCA assessments had not always been reassessed in line with the review of people's care plan. Senior staff were aware of this and were reviewing the assessments as part of the process of reviewing people's care plans. The registered manager had made appropriate applications to the local authority when they had identified that staff and the environment were restricting people's liberty. Authorised applications of DoLS were in people's care records. A unit lead explained that the inconsistent review of people's MCA assessments and the limited care planning around people's DoLS authorisation had been identified as part of their care plan auditing process and would be addressed as part of the unit's action plan.

People's dietary needs were catered for to ensure they received adequate nutrition and drinks to maintain a balance diet and keep hydrated. We observed that people had access to drinks throughout the day and were offered a choice of drinks at lunchtime. People were offered wet wipes to wipe their hands before the meal and were shown samples of the meal options for the day to help them decide. Extra meal portions and drinks or different meals were offered to those who wanted additional or alternative meals. People told us they enjoyed the meals. People said comments such as said, "The food is wonderful", "Food is lovely. Always a good choice" and "The meals are always very nice. I always enjoy them." The meals looked appetising and pureed food was presented so people who were at risk of choking. Staff told us that people enjoyed regular traditional afternoon tea and noticed people ate more when eating foods which could be managed with their fingers.

People who required assistance with their meals were supported in a sensitive manner and at a pace which was led by the person. We spoke to one staff member about a person who was not eating and appeared distressed about their food. The staff member was knowledgeable about the person's needs and managed the situation sensitively and provided the person with jelly which they liked. Kitchen staff were made aware of and catered for people's dietary requirements and their preferences. The head chef consulted with people and their relatives about their favourite meals before planning the monthly menu.

Records showed a range of health care professionals, including the district nurse, community mental health nurse, and speech and language therapist (SALT) had been involved in people's care and treatment. People confirmed they had been supported to have additional health care treatment and support. People said comments such as "They (the staff) are very helpful, they try to get us on our feet" and "I've seen the doctor and the physio and the district nurse comes to do my dressing." A GP regularly visited the home to review the medical needs of people. The visiting GP was positive about the home and the staff who supported people and said "On the whole, they're really good. They really know the patients. As a practice, we find it a very nice nursing home. You can see it with the patients."

Good

Is the service caring?

Our findings

People were supported by staff who knew them well and who spoke passionately about the care they provided for people. One staff members said comments such as "I've met lovely people. It's just like a home you know. I work with really nice people", "I love it here. I love what I do" and "I am here for the residents. I want to make their day great not just eating and sleeping." Throughout our inspection we found that staff were kind and attentive to people's needs such as offering them a fresh drink or sandwich or providing them with reassurance if they became distressed. Staff cared for people respectfully and explained the care they were about to provide and sought the person's consent. People were encouraged to express their views and were involved in making decisions about the care they received. They appeared relaxed and comfortable around staff and we saw people and staff chatting and exchanging warm and humorous stories.

People were overwhelmingly positive about the support they received and said comments such as "Fantastic place", "A good hotel!", "The staff are helpful, pleasant and lovely. They call us darling and love which is OK", and "The staff are good, and they do anything for you." Relatives also praised the caring nature of staff. They told us they were welcomed into the home at any time and were informed of any changes in their loved ones well-being. The registered manager held an accolades file of compliments and praise from relatives of the service being provided.

People's dignity and privacy was valued. Staff knocked on people's bedroom doors before they entered and helped people with their personal care behind closed curtains and doors. People had personalised their own rooms with photographs and objects of interests. There were items in the corridors such as hats and household items which reminded people of past memories of their own home. The home had good links with the local community and volunteers. A recent fund raising event at the home and a monetary gift from a corporate company had provided staff and people with the money to develop a sensory and wheelchair accessible garden. People and their relatives told us about the benefits of sitting and walking in the garden. One person said, "Oh the garden is lovely. I love going out there. It reminds me of my garden at home." Another person said "Carers are wonderful, food is wonderful. The carers will assist with anything you want done" and added "It's as good as being at home, well almost."

Each household had a wish tree. We were told that staff were working with people to help them to make their wishes come true. For example, one person was supported to visit their previous place of work; another person was supported to have a Chinese meal as part of their wish and staff had brought in Italian food and items for one person who was fond of the Italian culture.

Where known, people's cultural and religious needs were considered and being met. For example, a weekly church service was held in the home for people with Christian beliefs. Staff had gone the extra mile for a person who did not speak English as their first language. Staff had learnt some simple words and translated the menu into their 'mother tongue' as well as providing cultural items such as traditional foods from their country and flash picture cards of day to day items to assist with their communication with the person.

Good

Is the service responsive?

Our findings

People's care records mainly reflected their needs. A one page profile of each person provided staff with key information about what was important to them and how they liked to be supported. Most people's care plans detailed their risks and support requirements and gave staff the information they needed to support people to maintain their well-being. For example, one person's care plan reminded staff to prompt them to eat, drink and wear their hearing aids. People's risks associated with their health such as their skin integrity and or nutritional intake were being monitored. For example, the management of the pressure area of one person had been documented including the use of pressure relieving equipment, topical creams and the input of a specialist health care professional had been recorded. Staff appeared knowledgeable about the people they supported and were responsive to people's changing needs. Staff completed daily notes on each person which described their day such as their well-being, the support they required or if they had refused an aspect of their care such as refusing a daily meal or a shower.

People's care plans were reviewed monthly. A system of resident of the day ensured that people's holistic needs were reviewed by a staff member from each department such as a staff member from the kitchen and housekeeping section. This helped to ensure people's care plans were regularly reviewed and reflected their health, social and environmental needs.

One of the households at Jubilee Lodge was commissioned to provide a short period of re-enablement for people to regain strength in their activities of daily living skills before they returned home. Staff collated as much information as possible about the person before they were admitted to the unit. This process ensured that the person met the admissions criteria and would benefit from a period of rehabilitation. An initial assessment of the person's needs and re-enablement goals were carried out in conjunction with the therapy team. The assessment provided staff with information about people's current medical, social and support requirements. Records showed the therapists involvement and people's re-enablement progress. Staff attended a weekly multidisciplinary meeting where people's goals and progress was discussed and recorded. As a result, care staff were knowledgeable about people's re-enablement goals but this was not always clear in their care records. This meant that staff may not always have a clear understanding of people's goals if they relied on people's care records. This was raised with the unit lead of the re-enablement unit who said that they would ensure that people's re-enablement and therapy goals would be made clearer in people's care records.

People enjoyed a range of activities in the home and the community. Volunteers supported the activity coordinator in providing activities and spent time with people who preferred to stay in their own bedroom. People had the option to take part in a schedule of activities such as music, art and garden activities. A minibus was available for some people to enjoy trips out into the community. People benefitted from a home which had formed good links with the local community, including schools and churches. We noted that items of interest were placed around the households for people to touch and use as they pleased.

People and their relative's views and concerns were routinely listened to. Relatives felt that staff who worked on the households were approachable and knew their family members well. They told us their day to day

concerns were encouraged, explored and responded to in good time. People and their relatives told us they were confident that any problems they raised would be addressed. They had opportunities to air their views at regular 'friends meetings' where people and their families were invited to discuss events in the home with afternoon tea. We were told about the provider's plans to send a resident survey out in the near future which would highlight if there were any patterns or trends of concern in the home.

One formal complaint had been made since our last inspection. Records showed that the registered manager had investigated the concern and responded to the complainant in line with the provider's policy. The registered manager had informed them of their investigation findings and the action they had taken to address the issue.

Requires Improvement

Is the service well-led?

Our findings

Jubilee Lodge had an open and transparent culture. The registered manager and staff were willing to learn from any shortfalls in their care practices or the running of the home. For example, we discussed the possible root cause and management of a number of recent medicine errors with the registered manager and a representative of the provider. They clarified their investigation findings and the areas of concern found in the management of people's medicines. We were reassured of the action they had taken to address the shortfalls such as changing the timings of people's medicines and the storage containers of some medicines. The registered manager said, "We want staff to be open and honest if an error is made. I will thoroughly investigate it and deal with it appropriately and take actions with the staff member involved." The provider's evaluation of the medicines errors had also highlighted that staff would benefit from extra clinical support. This was being considered as part of the recruitment and restructuring of the senior and management team.

The registered manager was actively recruiting new staff in order to reduce the use of agency staff which would provide a consistency in the quality of care that people received at Jubilee Lodge. They shared with us the challenges of recruiting staff in a rural area. The executive management team was addressing these challenges by considering alternative staff benefits to attract potential new staff and retain the present staff team. The senior staff and management structure was also being reviewed to ensure staff had a clear and consistent line of support when the registered manager was not available and provide additional clinical assistance when needed.

Systems were in place to assist the registered manager to understand the standard of care being delivered to people and the performance of the home. They sought feedback from people and their relatives as well as holding regular meetings with staff in all departments such as night staff and health and safety and area lead meetings. The chef reported that they attended regular meetings with people and their families to ensure that the menus reflected the dietary needs and preferences of people.

Representatives of the provider carried out regular inspection visits of the home and supported the registered manager with any significant management decisions and safety incidents including identifying trends in people's falls, pressure areas and other health and safety issues. Systems to monitor areas which may put people at risk such as infection control, health and safety and medicines audits were also carried out monthly. Although records of the actions taken as a result of the audits were not consistently recorded, therefore it was not always clear if the actions had been carried out and evaluated. The registered manager was not always aware that staff were competent in their role and suitably recruited as systems to monitor the competencies and training requirements of the nurses and unit leads and the recruitment processes were not in place.

Records showed that staff had recorded if people had had an accident or near miss incident and the action they had taken. The registered manager analysed accidents for any trends and acted when patterns or concerns were found. The registered manager and staff were working on the home's action plan which included actions such as implementing the provider's new staff support system and the introduction of a

falls prevention lead and regular audits of people's falls. A schedule of maintenance and fire checks on the premises was regularly carried out to ensure people lived in a safe environment.

Staff spoke of a good work ethic across the home where they helped each other if additional support was needed. They felt supported and confident in the management and running of the home. Most staff praised the management and leaders of the home but some felt communication from the provider and registered manager could improve particularly around actions that have been taken to address the staffing levels.