The Orders Of St. John Care Trust

OSJCT Meadowcroft

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

This unannounced inspection took place on 2 May 2018. OSJCT Meadowcroft is a residential care home providing accommodation for up to 71 older people who require nursing and personal care. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and care provided, and both were looked at during this inspection. There were 64 people living in the home when we visited and one person in hospital.

There was a registered manager in 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.

At our last inspection in April 2016 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Why the service is rated Good.

People continued to be safe in the service. Risks to people were assessed and there were plans in place to manage those risks. People received their medicines safely. There was a robust recruitment and selection process in place. This ensures prospective new staff have the right skills and are suitable to work with people living in the home. There were sufficient staff to meet people's needs.

People were supported by an effective service that ensured staff had the skills and knowledge to meet people's needs. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the procedures in the service supported this practice. People received food and drink to meet their dietary needs.

Staff continued to support people in a caring way, showing kindness and compassion. People were treated with dignity and their privacy was respected. People were involved in their care.

The service continued to be responsive to people's needs and valued them as unique individuals. The registered manager was planning to increase the scope of activities to ensure people's individual interests were met. Staff understood the importance of supporting people to have a good end of life as well as living life to full whilst they are fit and able to do so. End of life care plans include people's thoughts, feelings and wishes to ensure their passing is comfortable, pain free and as peaceful as possible.

The service continued to be well-led. The registered manager and wider management team promoted a person-centred culture that was open and honest. People, relatives and staff were valued and listened to.

There were effective systems in place to monitor and improve the service. Systems included gaining feedback from people and relatives about the quality of the service and drive improvements.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

OSJCT Meadowcroft

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 checked whether the provider is meeting 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 comprehensive inspection took place on 2 May 2018 and was unannounced. The inspection team consisted of three inspectors and two experts by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

Before the inspection we reviewed information available to us about this service. The registered provider had completed a Provider Information Return (PIR). The PIR is a form asking the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed safeguarding alerts; share your experience forms and notifications sent to us. A notification is information about important events which the provider is required to send us by law.

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 11 people and nine relatives. We spoke with the registered manager, area operations manager, head of care, a nurse and four care staff. We also spoke with the chef, kitchen assistant, two activity co-ordinators, maintenance person and cleaner. Following the inspection we asked for feedback from five healthcare professionals who regularly visit the service. We heard back from two of these.

We reviewed 13 people's care records, looked at five staff files and reviewed records relating to the management of medicines, complaints, training and how the registered persons monitored the quality of the service.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe and secure and had trust in the staff. A person living at the home said, "Yes, I feel safe". A relative commented, "We were suspicious at first when she needed care, but yes, she is safe. We visit at different times of day. If we weren't happy we'd move her".

Most people told us they felt there were enough staff. One person said, "Are there ever enough? They cope very well. If needed they come straight away". We saw that people had call bells. Comments included, "Yes. I have two. One by my bed and one around my neck". However, some relatives told us they did not feel there always enough staff on duty at the weekend. We discussed this with the registered manager who said staffing levels did not alter at the weekend and said care staff were often in people's rooms delivering care which may give the appearance of fewer staff. A system had been put in place to show if care staff were in people's rooms, which would reassure relatives where care staff were.

Policies in relation to safeguarding and whistleblowing reflected local procedures and relevant contact information. Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them. The registered manager and head of care were aware of their responsibility to liaise with the local authority if safeguarding concerns were raised and previous incidents had been managed well. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks had been carried out. DBS checks help employers to make safer recruitment decisions and prevent unsuitable staff being employed.

People's care plans included detailed and informative risk assessments. Staff understood the support people needed to promote their independence and freedom, yet minimise the risks. For example, one person had a mobility scooter and wanted to attend church independently. An assessment had been carried out and he was able to do this in full awareness of the risks.

Medicines were managed and stored safely and securely at the correct temperature. Staff completed medicines administration training and competency checks yearly. Medicine administration Records (MAR) contained accurate information about each person and were fully and accurately completed. The provider had a medicines policy which staff followed.

All areas of the home were visibly clean and free from malodours. There were effective systems in place to protect people from the risk of infection. For example, staff wore disposable aprons and gloves when supporting people with personal care. One person said, "They keep the rooms clean".

Accidents and incidents were reported and recorded. Investigations and appropriate actions had been carried out to reduce the risk of a reoccurrence. Where incidents had occurred, the provider had ensured lessons were learnt and communicated throughout the provider's services to support improvement in other areas where relevant, as well as services that were directly affected. For example, a choking incident in another home had resulted in changes across the organisation.

Good

Is the service effective?

Our findings

People's care needs were assessed prior to moving to the home. People and their relatives had been involved in this process. Comments included, "Everything was discussed with me and my family" and "Care leader went through everything with me". One relative said, "[Relative] had a full assessment and they asked all the relevant questions, preferences, about his general health. Everything was covered". Where advice and guidance from other professionals had been obtained this was incorporated. The PIR stated during assessments they were aware not to presume people were or had been married. They said they used the terminology of partner to allow the person to express their sexuality and relationship status.

People's communication needs had been assessed in line with the Accessible Information Standards (AIS). For example, records detailed if people needed glasses or hearing aids. People had access to speaking libraries and meal choices were shown. Large print documentation was available where needed. AIS was introduced by the government in 2016 to make sure people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS.

Staff received a comprehensive induction. Ongoing training was offered and staff could also request any extra training. Records showed staff were supported through 'Trust in Conversations' and yearly appraisals. Staff told us the training and support they received had given them the skills, knowledge and confidence they needed to carry out their duties and responsibilities effectively. One member of staff told us, "We have lots of good training offered by the Trust. It includes dealing with End of Life and wound management". Another member of staff said, "I received training in dementia. I am the dementia lead. I attend meetings with admiral nurses and disseminate to the team. We can refer residents [who exhibit] challenging behaviour to our admiral nurses".

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). The 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. Staff had completed training in MCA and understood the importance of making decisions in a person's best interest if they were assessed as lacking capacity to make a decision. Staff sought people's consent before supporting them and ensured people understood the choices available to them. Comments included, "Yes they always ask before they assist me with anything" and "Yes, I make all my own decisions".

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw appropriate DoLS authorisations were in place to lawfully deprive people of their liberty for their own safety.

We observed the lunchtime experience in four dining rooms. These observations were mainly positive. However, in the two smaller dining rooms people did not have the same experience as the larger dining rooms. For example, there was only one care staff for five people in the dementia unit. People were not shown meal choices or explanations about what the food was. There was not the choice of desserts as in the main dining room. The member of care staff was efficient and functional but there was little conversation or interaction with people. Toward the end of the meal a member of kitchen staff came to take a dish away and had to be told by a member of care staff that the person hadn't finished eating.

We spoke with the registered manager about this experience. They were surprised at our findings and said they would look into the staffing on that day to see if any issues needed to be addressed to avoid this happening.

People received food and drink to meet their dietary needs. People were complementary about the food. People with specific dietary requirements had their needs met. A person commented, "It's good; well-cooked and there are two choices twice a day". A relative told us, "If chef sees something in supermarket she thinks [person] would like she will buy it. Cannot fault their thoughtfulness". Another relative said, "Main chef, [name] is amazing. Sometimes she buys [person] some [food item] and she will happily cook them in a restaurant standard sauce".

People were supported by a range of healthcare professionals to ensure they had continued healthcare support to enable them to live healthier lives. For example, people had been referred for specialist support at hospital appointments, as well as to community health services for district nurse input and to occupational therapist support to improve mobility.

The home was a new purpose built home set on two floors. People could move around freely in the communal areas of the building and gardens. A relative told us, "There are lots of little areas where people can sit, inside and out. Residents don't need to sit in a large living room". The garden had ramps and railings and signs to help people orientate around it. There was an accessible path and seating in different areas, including a sheltered smoking area. There were raised beds where residents could grow vegetables. Staff told us the garden was well used in summer.

Good

Is the service caring?

Our findings

People continued to be supported by staff that were caring. People were positive about the staff supporting them. One person told us, "At the moment I'm quite happy, for the first time in my life. I feel comfortable here now". Another said, "They are kind to me. Been very kind". Relatives we spoke to also spoke positively about the caring aspect of the home. One commented, "They treat [person] like family". Another said, "They are very kind to her. They will make her toast when she wants it". Relatives also said they could visit at any time. One commented, "We visit unannounced at different times of the day".

We heard examples of the staff team arranging events that were important to people. For example, one person who liked a particular group was given tickets for a tribute band. Another person who had a very significant birthday loved birds of prey and these were brought into the home as a surprise for her birthday.

We asked people if they would recommend Meadowcroft to other people. Responses included, "Yes I would. It's a nice place with good staff" and "Oh yes I would. Staff are very good. A relative said, "I would have no hesitation in recommending the home to any one of my family. They are such nice people and look after [person] very well". People's relatives, friends and children and pets could visit without restriction. A relative said, "Yes, we are made welcome and offered a drink when here".

We saw good interactions between people and care staff in the home. Staff spoke with and about people with great affection. Staff greeted residents when they passed them in corridors, offering support and reassurance where necessary. Housekeeping and maintenance staff also chatted with residents as they went about their work.

People were treated with dignity and respect and were well-groomed and dressed appropriately for the weather. We saw staff support residents with their personal care discreetly to protect their privacy. We saw staff knock on people's doors and wait before entering. Doors were closed when staff were giving personal care. We saw staff speaking to people respectfully and using their preferred names, and making eye contact. Comments included, "Never any embarrassment. Will knock before coming in and keep door shut. Respectful" and "They will close doors and curtains. Refer to me by name and knock before coming in".

People were involved in decisions about their care and where appropriate people's representatives were included. One relative told us, "We do have a review and a chat from time to time".

The provider had effective systems in place to protect information in line with data protection legislation. People's confidential personal information was stored securely. Where information was stored electronically these records could only be accessed by staff that had authority to do so.

Good

Is the service responsive?

Our findings

The service continued to be responsive to people's needs. Following the initial assessment, information was incorporated into a care plan detailing people's needs and how those needs were met. As the person settled in further information was obtained from the person and their relatives about likes, dislikes, preferences, routines and social history. This information was incorporated into a booklet "All about me" kept in people's rooms. One person said, "They [staff] know my background. We often talk about my interests". However, not everyone had these. Staff said sometimes they had to wait for relatives to provide enough information. As this information was separate from the care files, this meant some people had limited information about their social care needs in their care plans. We discussed this with the registered manager who said life stories were to be completed in more detail. Care plans were regularly reviewed to ensure information was up to date.

The service had not fully enabled people to follow their interests or provide social activities relevant to their interests. The quality and range of activities was limited and we saw no evidence of tailoring to individual interests, or any one to one activities outside of care tasks. We saw some people were interested in sport, wine and classical music, but did not see these interests catered for in the activity plan. The home displayed the National Activity Providers Association poster (NAPA). This organisation sought to ensure every resident has a meaningful activity and a meaningful conversation every day. Any activities or 'meaningful conversations' were not recorded in daily logs so it was not clear how the service monitored peoples' activities. There were no regular activities on Saturdays and only a church service on Sunday afternoons.

We asked the registered manager about their response to the feedback on activities. The registered manager was aware that this was an area for improvement and said an activity survey had recently been circulated to gain people's views. The PIR also stated the service was planning on further developing people's wishes and choices in areas such as activities.

The activity programme was on display and each person had a copy in their room. A PaT (pets as therapy) dog visited the home weekly. In summer the programme included some trips outside the home, such as visits to garden centres or to see snowdrops, daffodils and lambs or autumn leaves. One person said, "Yes they do have trips out, or you can go into the garden if weather is good. I enjoy the trips". The home had its own minibus, but it was limited to being able to accommodate only one wheelchair which meant this restricted the amount of people who could enjoy trips out. However, the registered manager told us trips were done on rotation so people did not miss out.

The PIR described some activities arranged such as local brownies and rainbow groups coming to sing with people. They said a big band had visited to play for people and they were having stalls at the local community market and the Mayor's Charity fair. On the day of the inspection about six people were taken for afternoon tea. The home held word games and scrabble. Outside entertainers visited on occasions, such as Thame Pop Choir or 'New Time Music Hall'.

We asked people about what they did to keep occupied. One person said, "I like to watch my own

programmes, rather than going into the lounge. I do go to some activities". Another person said, "If you want to get involved there are things going on".

People knew who they could go to if they had a problem or concern. We had comments such as, "You can go to any of them, they're lovely. If we had a problem we'd go to [care leader] or the registered manager", "Our gripes are listened to" and "There's always someone to ask". The provider had a complaints policy and procedure in place. Records showed complaints were investigated and responded to in line with the provider's policy.

The registered manager and staff understood the importance of supporting people to have good end of life care. We saw emails and cards of thanks from relatives regarding the high quality care people had received. A relative contacted us after the inspection to describe the support they and their parent received following the death of the other parent at Meadowcroft. They said, "End of life care is excellent. On-going support. [Parent] is grieving and the staff often go out their way to sit and be with him". Reflective meetings were held when a person passed away so memories and good practice could be reflected upon.

People and their relatives had the opportunity to state preferences and choices for end of life care. One person said, "It has been discussed and noted". Another said, "The home is fully aware of my preferences". Relatives could stay at the home when a person was at end of life care. We also heard a member of staff had introduced an 'End of life trolley'. This composed of kettle, beverages, wash bags and toothbrushes (for relatives). We saw an email from a relative who had commented on this initiative who said, "I think having the 'tea trolley' in the room when someone starts the end of life pathway is outstanding". We also heard the family received flowers following the relative's death.

Good

Is the service well-led?

Our findings

The service continued to be well-led. There had been a change in the registered manager since our last inspection. 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.

The management team and staff continued to demonstrate a shared responsibility for promoting people's wellbeing, safety and security. The registered manager was visible and seemed well respected by staff and by relatives. One person said, "Yes, she is often around the home. Easy to talk to". People felt the atmosphere was a positive one. One person said, "Staff are happy and the mood is positive". Another said, "It's a very good home and the staff are very caring. Yes, I would say they are happy".

Staff were complimentary about the management team and felt valued. Equality and diversity were actively promoted in the workforce to ensure staff were treated equitably. The staff we spoke with were proud to work for the home, and felt it was a supportive environment to work in where there was always someone to ask for advice. A member of staff said, "[Registered manager] is very good. She is approachable and listens to our ideas. For example, we suggested 12 hour shifts and this was considered". Other staff comments included, "This is a good organisation to work for"; "They appreciate staff. We have awards ceremonies where staff can nominate each other" and "We are an open and transparent organisation, we learn from mistakes".

There was a regular schedule of staff meetings every quarter, for all areas of staff such as night staff, housekeeping and the care team. A daily morning meeting was held for key staff in all areas of the service to update them of any overnight changes.

There were effective systems in place to continually assess, monitor and improve the quality of the service. Audits were completed including: safeguarding concerns and incidents and accidents, care plans, medicines, complaints, health and safety and catering. Where issues were identified there were action plans in place to ensure improvements were made.

People and their relatives were engaged with to seek their opinions and feedback. For example, there were quarterly resident meetings and six monthly relatives meetings to listen to suggestions or for people to raise issues. A residents meeting had recently resulted in getting a cat for the home as this is what people wanted. People commented, "I have filled in a feedback form and they have regular residents meetings". A relative said, "I'm here often and have been asked my opinion on things". We were told, "Whatever is brought up is resolved or an explanation given."

The home was hoping to achieve a dementia accreditation due to a plan to redecorate and furnish the dementia unit. The provider was involved with dignity.co.uk. One care leader has developed an End of Life trolley which one relative (a nurse for 40 years) suggested should be a countrywide initiative.

Staff told us they had a heath care student on placement. The provider was an Accredited Activity Provider (AAP) for the Duke of Edinburgh Award enabling young people to fulfil the volunteering element of their Award with the Orders of St John Care Trust, so this was another source of volunteers.

The service liaised with many professionals such as district nurses, a local hospice, dementia nurses, tissue viability nurses, SALT teams, Community Mental Health team and care home support service (CHSS) visit monthly to provide assessment and care planning advice for those residents who have fallen or who are at risk of malnutrition.

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. There were systems in place to report appropriately to CQC about reportable events.