Care Quality Commission

The Orders Of St. John Care Trust

OSJCT Paternoster House - Gloucestershire

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

What life is like for people using this service:

People told us they felt safe. They were protected from potential abuse and discrimination. Risks to people were identified, assessed and action taken to reduce these or remove them altogether. People lived in a clean and safe environment. Medicines were managed safely and staff provided the support people needed to take their medicines as prescribed. Enough suitably recruited and skilled staff were deployed in order to meet people's needs.

People's health needs were assessed and people had access to a variety of healthcare professionals to support them. People were provided with the right amount and type of food to meet their health needs. People had a choice in what they ate and drank. People's religious preferences were being met. At the time of our visit there were no diverse cultural needs requiring support, but staff explained that this would not be a problem if there were; these would be respected and met.

The principles of the Mental Capacity Act 2005 were followed. People were supported to make independent decisions and their care was delivered in the least restrictive way possible. 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".

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

Staff were kind and caring towards people. They maintained people's dignity and privacy. People's choices, preferences and wishes were known to the staff who had taken time to find these out. Relatives and representatives of people were made welcome. They were, where appropriate, able to contribute to the planning and review of people's care. Care plans gave staff guidance on how to meet people's needs. Further detail about people's care needs was also communicated to staff by means of staff handover meetings and additional information kept in the care office. Information about people's care and treatment was kept secure and confidential.

A team of volunteers, led by an enthusiastic activity co-ordinator enhanced the quality of people's lives. They supported people with meaningful activities and gave them opportunities to mix socially. Established links with local community groups, businesses and schools supported better outcomes for people.

Staff were experienced in supporting people, at the end of their life, to have a comfortable and dignified death. Professional relationships were in place to help support this, for example, with local GPs, pharmacies

and community palliative care specialists.

The home did not have a registered manager in position. 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.

An interim manager had started working at the service in July 2018 when the former registered manager had retired. The interim manager was an experienced manager who was providing strong leadership to the staff. The provider's quality monitoring processes had identified that some improvements were needed to the service. The interim manager had worked with the provider to achieve further action which was also planned as part of the home's on-going plan of improvement. Staff were committed to providing people with good quality care and improving their generally quality of life. Both people and relatives considered the home to be well-led.

Rating at last inspection:

The last inspection was in March 2016 when the service was rated as 'Good' overall. The service remains 'Good' overall.

Why we inspected:

This was a planned comprehensive inspection based on the rating at the last inspection.

About the service:

Paternoster House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service can provide accommodation and care to 40 people. At the time of the inspection 39 people lived there.

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 remained safe.	**Good** ●
Is the service effective? The service remained effective.	**Good** ●
Is the service caring? The service remained caring.	**Good** ●
Is the service responsive? The service remained responsive.	**Good** ●
Is the service well-led? The service remained well-led.	**Good** ●

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Detailed findings

Background to this inspection

The 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 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.

The inspection team:
Three inspectors and an Expert by Experience completed the inspection on 16 October 2018. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Paternoster House is a nursing home. It provides care and treatment to predominantly older people who live with physical needs and who required nursing care. Some people also live with dementia.

The service had not had a registered manager for three months. 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.

Notice of inspection:
This inspection was unannounced.

What we did:
Prior to the inspection we reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse and deaths. We used

information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also sought feedback from the local authority and health care professionals. We used all this information to plan our inspection.

During the inspection, we spoke with six people who used the service and three relatives to ask about their experience of the care provided. 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 ten members of staff which included the interim manager, a representative of the provider, nurses, team leaders, care staff, activities co-ordinator, chef and deputy manager. We reviewed a range of records. This included six people's care records and multiple medication records. We also looked at three staff recruitment files and the home's training record. We inspected the homes maintenance records and service certificates. Other records reviewed included a selection of audits and the service improvement plan. We reviewed the provider's equality, diversity and human rights policy, complaints policy and safeguarding adults procedures.

Good

Is the service safe?

Our findings

People continued to be safe and protected from avoidable harm.

Assessing risk, safety monitoring and management:

•□The environment and equipment was kept safe and well maintained to avoid potential harm to people, staff and visitors.
•□Risks to people, such as falls, choking and developing pressure ulcers were identified and action taken to manage and reduce these as described in people's care plans.
•□Staff identified changes in people's behaviour and mood quickly and took action where needed to avoid people coming to harm.
•□A record of incidents and accidents was kept which showed these were appropriately responded to. The action taken was reviewed and lessons learned to ensure this action remained effective in preventing future incidents and harm to people.

Staffing levels:

•□The manager routinely reviewed the staffing numbers with the provider and these had been increased to meet people's needs.
•□New staff had been recruited so that there were enough staff with the right skills and experience to look after people.
•□Staff recruitment records showed appropriate checks had been completed and people were protected from those who may not be suitable to work with them.

Safeguarding systems and processes /Learning lesson when things go wrong:

•□The provider had found [earlier in the year] that staff had not always followed their guidance to ensure people were properly safeguarded from harm.
•□Action had been taken to address this and lessons had been learnt. Staff were reminded of their safeguarding responsibilities and the provider had increased their monitoring arrangements around all incidents to ensure people were safeguarded.
•□Staff knew what action to take if they suspected abuse or poor practice. One relative told us, "I feel they are safe. I visit three times a week and I've never seen anything that concerns me."
•□Managers reported and shared appropriate information with the provider and relevant agencies to safeguard people.
•□The provider's policies and procedures supported people's and staff's diversity and equality and any form of discrimination or harassment was not tolerated.

Using medicines safely:

- We observed people receiving appropriate support to take their medicines safely. One person commented that they received their tablets on time. Another told us they received the support they needed to take their medicines.
- Medicines were delivered to the home in time for people's use. They were securely stored and returned to the pharmacy if not used.
- Staff who administered medicines had received training and their competency was checked.
- Medicine administration records showed that people had received their medicines as prescribed and these were checked to ensure there were no recording errors.

Preventing and controlling infection:

- Cleaning schedules were followed by the housekeeping staff who kept the home sufficiently clean. One person said, "It's very clean and excellent." A relative told us, "The way it's kept [the home's environment] is very nice."
- Staff wore protective aprons, gloves and tabards when they delivered people's personal care and food to prevent cross contamination.
- Laundry was managed in a safe way to reduce the potential spread of germs.
- Arrangements were in place for people and staff to be vaccinated against the flu so that a potential outbreak could be avoided.

Good

Is the service effective?

Our findings

Care, treatment and support continued to achieve good outcomes for people, promoted a good quality of life and was based on best practice.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

• People's immediate and ongoing needs were fully assessed which included the need for pain relief and adequate nutrition and hydration. Treatment and care was planned and delivered in line with professional standards and guidance.
• Staff respected people's choices and their diverse preferences when planning their care.
• The home worked in collaboration with a range of external health and social care services including the Rapid Response team to prevent unnecessary hospital admissions. People with swallowing problems were assessed by Speech and Language Therapists (SLTs). Community dieticians visited one person to monitor their nutritional intake.

Staff skills, knowledge and experience:

• People told us the staff knew how to support them. One person said, "They meet my needs. They are very caring and know what my needs are." A relative told us their relative was "Very well supported and cared for".
• The home's training record showed staff had been provided with relevant training to meet people's needs and develop in their roles. Nurses were supported to maintain their professional registration.
• The manager had ensured that each member of staff had been provided with an opportunity to discuss their training needs, performance and any concerns they may have. This was part of the provider's 'Trust in Conversation' process which supported staff.

Eating and drinking:

• People liked the food and meal choices. One person said, "It's [the food] fine. I can go to them [the staff] and tell them my preferences. I have a choice and I enjoy it."
• Staff supported people to make their meal choices. We saw that staff provided visual options to support people living with dementia to make their meal choices. Staff supported people to eat and drink in a dignified manner.
• People's nutritional needs and choking risk had been assessed and the food provided met people's dietary needs. This included foods with additional calories to help people maintain their weight and texture altered food and drink to reduce risks of choking. One relative said, "My relative has problems swallowing so their food is pureed and this is fine."
• Cultural and religious food preferences could be met when required.

Health care support:

•□Staff worked together and with other health and social care professionals to deliver effective care and treatment. One person said, "I feel supported to be healthy." At the time of our visit another person was waiting for transport to attend a hospital appointment.
•□Arrangements were in place with local GP surgeries so that people received the support they needed from a GP.
•□People were also supported to access opticians, dentists and a chiropody service visited the home. One person said, "I was worried about my teeth after I had a fall and I lost a tooth, but they [the staff] looked after it and a dentist came here."

Ensuring consent to care and treatment in line with law and guidance:

•□The home obtained consent to care and treatment in line with legislation and guidance. For people who lacked mental capacity to consent, written records showed mental capacity assessments and best interest decisions had been completed and documented to comply with legislation. Care was delivered to people in the least restrictive way.
•□Staff had sought appropriate authorisation when restrictions had been placed on people , in their best interest, to ensure they would remain safe.
•□On or soon after admission staff established who people's legal representatives were. This ensured that the right people were consulted with, where needed, about people's care and treatment.

Good

Is the service caring?

Our findings

The service involved and treated people with compassion, kindness, dignity and respect.

Ensuring people are well treated and supported:

• Staff treated people with kindness, respect and compassion. Feedback from people was positive about the way staff treated them. One person said, "Staff are really friendly, kind and polite" and another said, "Staff remember what people like and don't like."
• Written compliments received by the staff in particular highlighted the compassion, care and friendship staff had shown to people during their stay at the home.
• Staff understood people's personal, cultural, social and religious needs. One person said, "I'm treated as an individual" and another said, "They ask me what I want."
• People's independence was supported. Two relatives commented, "The right efforts are made to help my relative be independent but this is balanced with the risks." and "My relative is definitely independent. They [staff] encourage her to do things for herself, for example, to dress, but she gets help with personal care [personal hygiene]."

Supporting people to express their views and be involved in making decisions about their care:

• In the main people told us their views, choices and preferences were listened to and they received the care they needed, in a way they wanted to receive it. One person commented that staff left before they had a chance to always answer them.
• Care plans outlined people's communication needs and gave guidance to staff on how to support these. One person's care plan highlighted the fact they could get frustrated and agitated when finding it difficult to verbalise their choices. It guided staff to use prompts in order to help the person. Another person's care plan guided staff to be more aware of the person's facial and body language because their verbal communication was limited. It pointed out that the person could understand what was being said to them, but was unable to verbally respond.

Respecting and promoting people's privacy, dignity and independence:

• People told us their privacy and dignity was maintained when staff delivered their care. One relative said, "I can visit whenever I want and we go to her room if we want to be private."
• Care plans highlighted what people could do independently. One person could independently use their commode, as long as staff placed it nearby. In doing this staff helped to maintain this person's dignity.
• Care plans identified what gender of staff people preferred to deliver their personal care and their choice was respected.
• Information about people's care and treatment was kept secure and confidential.

Good

Is the service responsive?

Our findings

People continued to receive personalised care that was responsive to their needs.

Personalised care:

•□People's care plans outlined how people's care was to be delivered. Staff attended handover meetings when they first came on duty to keep updated with people's needs and any changes in care.
•□People's care was reviewed with them and with their relatives, where appropriate to do so.
•□The provider's equality, diversity and human rights policy set out the provider's approach to how people's care would be planned and delivered in line with their diverse needs and preferences.
•□People were provided with opportunities and support to socialise and take part in organised activities. One person said, "I join in everything and I feel happy here. I wouldn't be happy on my own and the surroundings here make me feel happy and close. I take part in it all."
•□Arrangements were in place to support those who found socialising more difficult and who were at risk of self-isolation.

Improving care quality in response to complaints or concerns:

•□People, relatives and other visitors to the home could raise a complaint. They were confident their concerns would be addressed. One person said, "There's always someone to help. I'd use the carer [care staff] first, then a nurse and it would get sorted."
•□The provider's complaints policy and procedures were displayed and outlined how complaints would be responded to. These could be provided in different formats to meet people's needs, for example, large print or a different language.
•□A record was kept of all complaints which recorded how each complaint had been managed, the actions taken and the outcome. This record showed that people's complaints were responded to according to the provider's policy and procedures.

End of life care and support:

•□Staff supported people at the end of life to have a comfortable and dignified death.
•□No-one was nearing the end of their life at the time we visited, but staff were monitoring those who were very frail and receiving palliative care.
•□There were well established links with GPs, pharmacies, community nurses and the community palliative care team to support people's end of life needs.
•□Advanced care plans recorded people's end of life care and treatment wishes as well as their pastoral and religious preferences for that time.
•□Where appropriate, relatives and representatives were involved in people's end of life care and given support where needed.

Good

Is the service well-led?

Our findings

The management of the home continued to support good outcomes for people and made on-going improvements to the overall service.

Leadership and management:

•A registered manager had not been in place for three months. An interim manager was managing the service and they had applied to the CQC to be the registered manager to ensure the provider would meet their registration requirements.
•People, relatives and staff told us the home was managed well. One person said, "I've met the new manager and I think it's well-led." Staff comments were all positive about the interim manager's leadership.

•The interim manager had a clear vision for the home, understood issues and priorities relating to the quality and future of the services provided. They understood the challenges of this and were addressing them.

Plan to promote person-centred, high-quality care and good outcomes for people:

•A collaborative way of working had led to successful changes being made to how staff organised their work, for example, staff had reviewed with managers the timing of their breaks to ensure enough staff were available to support people throughout the day.
•Senior staff monitored staff practices closely, supported staff and care processes were structure to meet people's needs effectively and compassionately.
•Where previous mistakes had been made, lessons had been learnt, and there was an open and transparent culture in place.

Managers and staff were clear about their roles, and understand quality performance, risks and regulatory requirements; continuous learning and improving care:

•The new management team was supported by existing staff who were committed to the home's success.

•Effective delegation of tasks and responsibilities had begun to take place following the recruitment of a new deputy manager.
•Arrangements were in place for a daily review of all risks and quality issues with heads of departments, which resulted in these being promptly addressed.
•Structures, processes and systems to support good governance and management were clearly set out, understood and effective. Provider support ensured the interim manager was able to meet regulatory requirements.
•Effective auditing and a regular review of the service's on-going 'service improvement plan' (SIP) meant necessary actions for improvement were closely monitored, by both the interim manager and provider.

Engaging and involving people using the service, the public and staff:

- Stakeholders' views and concerns were encouraged, heard and acted on to shape the service and culture. Regular meetings were held with people, relatives and staff and an open door policy supported good communication either way.
- The views or people and their relatives had been formally sought by the provider in September 2018 but the collated results of this had not yet been received by the interim manager. Once received they told us they would address any necessary actions.
- Managers were open to receiving feedback and suggestions which could help improve the overall service provided.

Working in partnership with others:

- The service was well respected in the local community and had established links with numerous community groups, other care homes and businesses. These supported better outcomes for people, for example, more social outings for people and help with improvements to the garden.
- Links with local schools promoted and supported integration between older and younger people. Younger people visited the home and undertook job experience so they could broaden their understanding of adult social care.
- Close working arrangements with local NHS hospitals and commissioners of health and social care helped people access and sustain the support they required.