Oak Care Limited

Oak Tree Manor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 10 April 2018 and was unannounced. At their last inspection on 8 January 2016, they were found to be meeting the standards we inspected. At this inspection we found that they had continued to meet all the standards. However, there were some areas that required improvement. This was in relation to records, systems and processes.

Oak Tree Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Oak Tree Manor provides accommodation for up to 65 older people some who live with dementia. The home is not registered to provide nursing care. At the time of the inspection there were 34 people living there. The service planned on amending their registration to reflect the number of people they currently supported.

The service had a manager who was about to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

There were systems in place to monitor the quality of the service. However, they had not identified the areas that required improvement that we found on inspection. This was mainly in relation to records, systems and processes. People and staff were positive about the running of the home.

Accidents and incidents needed to have remedial actions taken recorded and a system for identifying themes and trends needed to be developed to ensure it was robust. Medicines were managed safely. However there were some areas for development.

People were supported in a safe way and staff knew how to recognise and report any risks to people's safety. However, staff knowledge in relation to evacuation in the event of a fire needed to be improved. Staff were recruited safely and received regular supervision and updates to their training. There were sufficient staff to meet people's needs in a timely way.

Most people were supported in accordance with the principles of the Mental Capacity Act 2005, however, documentation needed improving.

People were positive about the food. However it was not clear if people were aware there was a choice of meals. People had access to health and social care professionals as needed.

People were treated with respect and kindness. We also found that people's privacy and dignity was

promoted. People and their relatives were involved in the planning of their care. Confidentiality was promoted as staff spoke discreetly about people and records were stored securely.

People received care in a person centred way however care plans required further development to ensure they accurately reflected the care provided. People enjoyed the activities provided and there was a complaint's process which people and their relatives knew how to use.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Accidents and incidents needed to have remedial actions taken recorded and a system for identifying themes and trends needed to be developed to ensure it was robust.

Medicines were managed safely. However there were some areas for development.

There were sufficient staff to meet people's needs.

Most people were supported in a safe way.

Staff knew how to recognise and report any risks to people's safety.

Staff knowledge in relation to evacuation in the event of a fire needed to be improved.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Most people were supported in accordance with the principles of the Mental Capacity Act 2005, however, documentation needed improving.

People were supported by staff who were trained and supported.

People were positive about the food.

People had access to health and social care professionals as needed

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness.

People's privacy and dignity was promoted.

People and their relatives were involved in the planning of their care.

Confidentiality was promoted.

Is the service responsive?

Good

The service was responsive.

Most people received care in a person centred way however care plans required further development.

People enjoyed the activities provided.

There was a complaint's process which people and their relatives knew how to use.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were systems in place to monitor the quality of the home. However, they had not identified the areas which required improvement that we found on inspection.

People and staff were positive about the running of the home.

The manager was new to the role and about to register with the Commission.

Oak Tree Manor

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We also reviewed the provider information return (PIR) submitted to us. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.

The inspection was unannounced and carried out by two inspectors, an assistant inspector and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with 16 people who used the service, eight relatives, four staff members, the acting manager and the provider. We received information from service commissioners and health and social care professionals. We viewed information relating to four people's care and support. We also reviewed records relating to the management of the service.

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 due to their complex health needs.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person said, "I feel entirely safe." Another person told us, "I've nothing to fear from anything." Relatives told us that they felt people were safe. One relative told us, "My [relative] is safe 100%."

People were supported by staff who had a clear understanding of how to keep people safe. This included how to recognise and report abuse. Staff received regular training and updates.

We observed staff supporting a person in the lounge with a standing hoist. The staff member guided the person gently talking and reassuring them all the time. The person was slightly disorientated so the staff member took their time and gave instructions such as, "[name] place your foot here", or "Don't worry [name] we have you, just hold here."

Other people were seen being helped into wheelchairs, for example we observed a staff member ensure the brakes were on before they gently guided the person into the chair, put the footplates on and waited till the person was secure in the chair before moving them. The staff member spoke to the person all the time.

People sat in the lounge always had their walking frames within reach so that they could get up and move when they wished. We saw different staff assist four people into the lounge and each time they placed people's walking frame beside them. One person said, "The staff are very good they always leave my walker where I can get it." Staff were seen going into the lounge to see if people needed anything. One person was frequently getting up and walking the corridor and getting disorientated but staff were seen to greet them and either walk alongside them or guide them into the lounge.

One relative said "My [relative] had a fall and the staff managed it so well they let me know they sorted out my relative ". Whilst it was clear that staff knew people and how to keep them safe this was not reflected in the risk assessments which failed to give clear guidance to staff as to how to manage situations that could pose risks. For example 'when using a standing frame extra care to be used and only trained staff to assist' this gives no indication of how to operate the hoist or keep the person safe.

A care plan for another person who had bed rails stated just 'bed to be kept in lowest positon and report any damages '. For a person who was bed bound and frail and who received personal care in bed there was a risk assessment for their skin integrity stating to' check skin whilst giving daily personal care, reposition regularly and use special pressure relieving mattress'. The assessment lacked the detail personal to that person and their individual needs. However staff could describe well how they protected and supported the person and their skin was in good condition. We were told that there were no pressure ulcers in the home which indicated the appropriate care was being provided however records needed further development to reflect this.

One person was said to have behaviour which challenged others hen being supported with personal care and had a behaviour management chart in place and staff spoke about how they had supported the person.

One staff member said, "I would reassure the resident in order to calm them down. Sometimes they get agitated without reason. Often it is for a reason and sometimes residents have delusions. I would change the subject particularly if they are agitated. I may swap with another work colleague – this can calm the situation down – maybe the person doesn't like my face at that time." The risk assessment in place to support the person when they felt this way did not give sufficient guidance as to how to either pre-empt a situation or support the person through it. The records in relation to risk management was an area that required further development.

All accidents and incidents were checked and signed off by the manager. However, these checks did not record what remedial actions had been taken and how the risk of a further incident was reduced. In addition, the analysis of accidents did not identify themes or trends, such as a higher number of falls occurring between 4pm and 9pm, and therefore there had been no action taken to investigate and resolve this. There was no overview or records relating to unexplained bruising. The manager was aware that unexplained bruising should be recorded, investigated and if needed, reported, however there were no records of this kind and we noted that one person had bruising on their arm with no explanation documented. This was an area that required improvement.

There were regular checks of fire safety equipment and fire drills were completed. However, there had been no practice of how staff would evacuate people who used the service. Staff knew how to respond in the event of a fire in regards to alerting the fire service, however, they were not sure how they would evacuate specific people with differing needs. There were evacuation plans in place but these did not detail the methods to be used for staff to remind themselves. There had recently been a fire risk assessment completed and the service was awaiting receipt of this. The provider ensured that other checks, such as electrical or health and safety assessments, were also completed to help maintain people's safety. However, staff knowledge in relation to evacuation was an area that requires improvement.

People told us that they felt there were enough staff to meet their needs. Relatives told us that there were enough staff available to meet people's needs. One relative said, "I come in at different times of the day and there are always staff around and they are always helpful." Another relative said, "There seem to be enough staff to keep them safe." Throughout the course of the inspection we noted that there was a calm atmosphere and that people received their care and support when they needed it and wanted it. Staff told us there were enough staff. One staff member told us, "Always busy, but the work is organised well and I feel there is still time to chat and find out about resident's needs."

Safe and effective recruitment practices were followed to help make sure that all staff were suitable for working in a care setting. They ensured all required documentation was received before a member of staff commenced employment. This included written references and criminal record checks.

People's medicines were managed safely. However, some areas needed to be addressed. There were no plans in place for medicines prescribed on an as needed basis and some dates on eye drops had expired. This was an area that required improvement. Medicines were stored safely and administered by trained staff. We checked a random sample of boxed medicines and found that stocks were accurate with the records. Control measures were in place to ensure these were managed safely. Staff received competency assessments prior to administering medicines. People received regular reviews to help ensure medicines they were taking were still appropriate for their needs.

There were systems in place to help promote infection control. These included cleaning regimes and schedules and training for staff. We saw that staff used gloves and aprons appropriately and the home was clean and fresh on the day of our inspection. We noted that the service had achieved five star rating for the

hygiene and practices in the kitchen and for the management of food safety.

Lessons learned were shared at team meetings and during supervision. Staff knew what was expected of them as a result of this information sharing. However, records could be improved to capture this in its entirety.

Requires Improvement

Is the service effective?

Our findings

People's relatives told us that they felt staff were skilled and knowledgeable to support people living at the home. One relative said, "The staff have a good working relationship, and they always explain what they are going to do."

Staff received training to support them to be able to care for people safely. This included training such as moving and handling and safeguarding as well as specific training modules such as dignity and dementia care. One staff member said, "I have done Dementia training. If we request training they would put you forward." Another staff member told us that the provider was willing to support with professional development. However another staff member told us that they were still waiting to start their vocational qualification. Staff completed an induction when starting work at the service.

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 when this is 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).

The manager demonstrated an understanding of when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. They had awareness of what steps needed to be followed to protect people's best interests and how to ensure that any restrictions placed on a person's liberty was lawful and they had their human rights to freedom protected. The appropriate applications had been submitted and conditions on applications authorised had been met. However, people only had one mental capacity assessment completed. This was not reviewed and was not decisions specific. Although we found that people were supported in accordance with the principles of the MCA 2005, best interest decisions were not documented in accordance with the MCA 2005.

Staff offered people choices each day even when they were assessed as not having capacity to make some decisions. Staff acknowledged that this did not mean they could not make any decisions and how people wanted to spend their day, what to eat, wear, were all decisions discussed with people. One staff member said, "[Person] can still express their wishes and needs and chooses whether to stay in bed, [person] knows whether to eat or not. Sometimes better communicating in the morning with [them]. If [person] doesn't understand me I will use body language, eye contact and try to make her feel OK."

The home was well maintained and people were able to walk through the entire home freely. The bathrooms had adapted bath and they were spacious enough to enable people access. The bathrooms had been made homely. People's individual rooms had all been personalised with photos, ornaments and some with their own furniture. There was a large lounge with ample seating for everyone and a dining area so people could enjoy a meal together if they wished. There was an accessible garden that people had enjoyed

in the better weather.

People were supported to enjoy with a variety of food and their individual likes, dislikes and dietary needs were well known by staff. One person said, "The food is excellent, I eat what they give me." Another person, "There's not much choice of food but it's quite good; I have a healthy appetite." We observed lunch in the dining room. The atmosphere was calm and relaxed with gentle background music playing. The staff plated people's meals and everyone had the same gammon mashed potatoes and vegetables. We did not see anyone offered a different choice. Everyone had a pudding with custard and we didn't see an option such as fruit or ice cream. One person said, "The meals are ok but they are always the same sort." Another person said, "We don't get a choice but it's good food." The chef told us that there were two choices, which were taken the previous day and if people didn't like what was on offer, something such as an omelette could be made. However on the day of inspection the wrong meal choice had been offered the previous day. Although there was a menu on the wall of the dining room, this was not especially visible to people and there was no reminder to people prior to lunch being served.

The majority of people were able to eat their meal independently. Those who required support were encouraged and handed a spoon and or fork to help them be independent. If they were unable to manage or were not eating staff supported them. For example, we saw one person sit in front of their meal, the staff described what it was and handed them a spoon guiding it to their mouth. The person then started to eat. The staff member returned a couple of times to prompt them. We saw one staff member say, "Do you need help can I cut your meat for you?" Another person required support and the staff member sat and supported them talking and relating to the person throughout the time. Each group of people at a table were served at the same time.

It was a four week rotating menu and there was not a choice except to say fresh salads were always available. There were photos of meals in a folder but we did not see them being used. We saw people being offered drinks and snacks during the day.

Assessments had been undertaken to identify if people were at risk from of not eating or drinking enough. We observed staff supporting people appropriately. People's intake was recorded on daily care notes if they were at risk of not eating or drinking enough. However we noted that fluid charts did not include targets for the amount people to drink or a tally of what people had consumed. We raised this with the manager. Staff were aware of the reason for any weight loss and were supporting people as needed. We saw people had been referred to the dietician when needed.

People's day to day health needs were met in a timely way and they had access to health care and social care professionals when necessary. For example, GP, speech and language team (SALT) and a chiropodist. One relative told us, "[Person] has seen the hairdresser and can see a Doctor or Dentist when they want."

Good

Is the service caring?

Our findings

People spoke positively about the staff and how kind they were. One person said, "They are all very friendly." Another person told us, "The staff are good, and very helpful and polite." One relative said, "I can't believe I am so lucky [person] is here the staff are very caring. You walk down the corridor and all the staff talk to you and touch my [relative's] hand to say hello its lovely." Another relative told us, "The staff are friendly and greeted us when we first came. We've seen the staff knocking on the door and they are excellent as far as I'm concerned." We spoke with a visiting professional who said that there seemed to be a good atmosphere in the home and the staff were efficient.

Staff were calm and friendly with people and we observed them interact with people in a warm and caring way. Staff listened to people and gave people time when it took time for them to verbalise what they were communicating.

People's privacy and dignity was maintained and staff were discreet in helping people at lunch or suggesting to one person to change their top which had become soiled. One person said, "The staff always knock and treat me with respect; I'm quite contented." Another person told us, "The carers are very good to me, they do what I ask and always knock." We observed staff knocking on people`s doors before entering, being discreet if people needed to be supported out of the lounge to go to the toilet. Staff had time to walk with people along the corridor and we saw a number of interactions between people and staff members. One staff member was seen spending time to settle a person in the lounge where there was a concert on TV. The person was agitated but with encouragement from the staff began to sing along to the concert. Another person was walking back and forth along the corridor and different staff stopped to talk with them and check they were ok and then one suggested to sit and join in some entertainment.

People's records were stored in the office in order to promote confidentiality for people who used the service.

Reviews to people's care involved people and relatives where appropriate. One relative told us, "I've seen my [relative's] care plan and I've been to reviews." Care plans included letters which invited relatives for reviews and people were included at the meetings when they were able. A staff member told us, "Care plans are updated monthly if there are changes. We involve residents in the review of their care plans and families." People's preferences and choices were documented and we saw staff working in accordance with these. There was information about people's past history and what was important to them which was gathered on admission. It was difficult to see if this had been updated or changed though staff seemed to know people well and how to relate to them. People's religious preferences were noted and how they wished to be addressed.

People were encouraged maintain relationships in whatever form they took. This included with family members and friends. Relatives and friends of people who used the service were encouraged to visit at any time and felt welcome.

Good

Is the service responsive?

Our findings

People received care that was personalised. One person told us, "I'm happy here, the staff are very good and do anything I ask." A staff member told us, "When I come in the morning and see a resident who needs support, I help them look clean and smart and it is a good feeling." We saw people had an assessment of their needs prior to admission then a care plan was drawn once the person was admitted. Whilst the care observed was personalised how it was described in people's individual care plans were not so detailed to give the essence of the person and how they wished to be supported. However, this did not impact on the quality of care received as staff knew people well. A staff member told us, "We offer person centred care and treat everyone as an individual. Within their care plan there is details of the food they like, hobbies which will enable carers to talk about residents past. We chat with families in person. Over the weeks we actually spend hours together. Both residents and families can input into their care plans and fill out sections. It makes if far easier to strike up a conversation with residents."

Care plans needed to be reviewed in more detail to reflect what staff knew about people and how the supported them. In some cases, they required more information. For example, in regards to sling size and straps for hoisting, if a person needed to have their legs elevated. Although we did see staff working safely in regards to use of hoist and supporting a person to elevate their legs when needed

During the inspection we observed staff being prompt in supporting people and responding to their needs in a way that confirmed they knew people well. This included ensuring they had items around them that they enjoyed using and personal care at a time that suited them.

The service did not provide nursing care but at times they provided end of life care for people. Staff had prepared for this by ensuring people had their wishes documented in their support plans.

People were supported to participate in activities. We observed two different group activities. Both were musically based with either singing or quizzes and people seemed to be enjoying them. The hairdresser visited once a week and people were very happy to have their hair done. There was also organised entertainment from outside groups arranged each month. We noted that there was reference to people's hobbies, interests and preferences. For example, knitting and gardening. People told us that they enjoyed what was on offer. One person said, "I join in with all activities, especially flower arranging." Another person said, "I like the quizzes and songs." Relatives told us that staff supported people to do things that they enjoyed. Activities on offer included arts and crafts, quizzes, sensory sessions, armchair exercises and reading. We discussed with the provider and manager that when supporting people living with dementia they may need to consider being more creative for people who had become more of a challenge to get engaged in activity and communication to avoid social isolation. We noted that records showed activities were on offer most days.

Complaints and minor concerns raised had been investigated. People and their relatives told us that they knew how to raise concerns but had not needed to. One person said, "I've had no problems and I've no complaints." We did note that the complaints process was in folders in people's rooms. The service may

benefit from having this in an easy read, more accessible place for people who may not look in the folders. Staff told us that they knew how to respond to complaints. One staff member said, "I would chat with them to find out what they are not happy with. Sometimes it may be that they are having a bad day and sometimes service would need to be changed. In particular with Dementia – behaviour can change, along with wishes and habits. I would also report to the manager. I would not keep this to myself. Making your concerns known is good for both staff and other residents."

People, relatives and professionals were asked for their views through a survey. Results seen from a 2017 survey were positive. The survey recently sent out had not yet had the responses returned. There were resident's meetings where people were asked for their views on the service. However we discussed with the management team the need to capture people's voice within the notes from the meeting to demonstrate suggestions were considered and acted upon.

Requires Improvement

Is the service well-led?

Our findings

The registered manager for the service left before this inspection. We were told that the deputy manager had been acting manager since then and had recently agreed to take the role and register as a manager. We found that they were known throughout the home and people were comfortable around them. Staff told us that when needed they provided support to people and knew people well.

People told us that they knew and they liked the manager. One person said, "I see the manager come round and we have a chat." Relatives were also positive about the management team and how the service was run. One relative said, "[Manager's name] is always so friendly, always gives us info it's wonderful." Another relative told us, "The home should be rated excellent because it is brilliant; it's such a lovely place. The manager comes round and has also kept in contact with me about my [relative]. We have seen three other homes and this is the best by far." A third relative said, "We see the manager regularly and she's brilliant; she puts herself out for you." A fourth relative said, "We see the manager and the owner. We've seen three homes, this is the best."

Staff were very positive about the manager. One staff member said, "I feel listened to." We noted that the manager was new to the role and still learning in some areas but keen to develop to ensure that they provided a good service for people and that staff had the right knowledge for their roles. The provider was supportive of the manager and told us that they felt they had the makings of a good manager. They were committed to providing them with the support they needed to develop and this included further education.

In particular ensuring a robust quality assurance system was in place to monitor people's care. We saw there were quality assurance systems in place but whilst information on for example falls had been recorded it did not link to any action being taken. Equally for fluid charts the optimum amount of fluid for people was not recorded nor the amount for each day added up. There were medication audits but like the other audits they did not pick up on the areas identified at the inspection. We discussed the benefits of having a more robust medicines audit to ensure it would identify any shortfalls. We noted that audits looked at all areas of the home. However, these did not always identify areas that needed developing further. For example, issues in relation to MCA and best interest. However, this was an area that required improvement.

There was a regular visit from an operations manager who completed audits to ensure the home was working well. We saw that actions arising from these visits were shared with the home manager but we could not find where these were signed and dated when completed.

The management team worked with the local authority to ensure they were working in accordance with people's needs and obligations with the commissioning contract. There had not been a recent monitoring visit form the local authority however they were not aware of any concerns. The service was also supported by a local care providers association who provided support with activities and training to help keep staff`s knowledge up to date.

There were regular team meetings where staff were told of any changes to practice and any issues. The

meetings included information to help staff remain informed about changes to the home and future plans. However, we noted that the notes for these meetings did not include a record of discussion or staff voice. This was an area that needed to be developed to ensure all feedback and ideas were captured.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. However, we could not be sure that we had been informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken. This was an area that required monitoring.