Joseph Rowntree Housing Trust

The Oaks

Inspection report

Hartrigg Oaks, Lucombe Way
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We undertook a comprehensive inspection at The Oaks Care home over two days on 18 and 19 February 2016 and the inspection was unannounced.

The home was previously inspected in November 2013, and at the time was meeting all regulations assessed during the inspection.

The Oaks Care home forms part of the Hartrigg Oaks retirement village in New Earswick, on the outskirts of the historic city of York. It is managed by the Joseph Rowntree Housing Trust. The home is purpose built and is registered to provide care and accommodation for up to 42 older people, some of whom need nursing care or have a dementia related condition. The Oaks has a number of facilities on site including a gym and pool, which can be used by people from the home. All rooms are en-suite and have either a balcony or patio. There is parking available at the front of the building.

The Oaks had a registered manager. 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 who used the service told us they felt safe and we found that staff knew how to protect people from avoidable harm. Risk assessments and risk management plans were in place and they were regularly reviewed and updated in line with the person's needs.

We saw care files contained personal evacuation plans that detailed any assistance a person required to evacuate the building.

The registered provider had policies and procedures in place to deal with and learn from accidents and incidents involving people at the home. We saw this was not always the case when accidents and incidents did not relate to people receiving a service but the registered provider was implementing plans to address this.

The service had sufficient experienced staffing in place to meet the care and support needs for people using the service. Recruitment processes were robust and ensured that staff were of suitable character to work with vulnerable adults. We saw, and people told us that staff and others at the home treated people in a caring way with respect and dignity.

People were supported to take their medication as prescribed. Medicines were stored securely, and there were systems in place to monitor the quantities of medications kept, and to ensure that it had been administered appropriately.

Deprivation of liberty safeguards (DoLS) were in place for people who needed them. Staff had received training in the Mental Capacity Act 2005, and knew the basic principles of the Act. Staff also identified when a DoLS may be required for a person.

A person's nutritional and hydration needs were met. People told us that they enjoyed the food and that there were different options available in either the assisted dining room or the café shop. People with special dietary requirements had their nutritional needs assessed and were supported to receive nutrition in line with guidance from professionals.

The home had two activities co-ordinators who worked with a team of volunteers to ensure a programme of activities was available to keep individuals and groups busy throughout the days and evenings. Activities on offer ranged from one to one sensory hand massages to themed evening meals and trips out. The activity planners told us they worked hard to ensure nobody in the home suffered unnecessary social isolation. People told us they could participate as much or as little as they wanted to and everybody told us, there was something available that they were interested in doing.

The registered provider had a complaints process in place and people told us they understood how to complain and we saw that their complaints were acted upon. People knew who the registered manager was and told us that they found they were approachable and responsive to their concerns. We saw a record of compliments and complaints was kept which outlined actions that had been taken in response to concerns that had been raised.

The home was clean and well maintained with no malodours. There were systems in place to monitor the quality of the service by both the registered manager and the registered provider. These looked at areas that included, staffing, training, health and safety, falls, pressure areas, medication indicators and resident engagement. Information gathered from these processes was used to generate improvement by identifying trends and putting in measures to help prevent them from happening in the future.

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 were protected against the risks of bullying and harassment.

They felt safe and staff had a good knowledge of safeguarding procedures.

People were supported to take risks whilst any known hazards were minimised to prevent harm or injury.

There were sufficient numbers of staff on duty who had the skills and knowledge to support people safely.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had access to relevant training and courses to keep their knowledge and skills up to date.

Staff felt supported and worked well as a team and with other health professionals.

The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS) and we found the Mental Capacity Act (MCA) (2005) guidelines were being fully followed.

People enjoyed their meals and had enough to eat and drink.

People at risk of losing weight were closely monitored and supported from multi-agency teams.

Is the service caring?

Good

The service was caring.

Feedback demonstrated that the service provided person centred care. It was clear the staff knew the people and put their needs first.

Privacy and dignity was consistently maintained and staff were respectful when providing care and support to people.

People were encouraged to be independent and to make their own decisions.

Is the service responsive?

Good

The service was responsive.

People using the service were encouraged to be involved in the planning and reviewing of their care plans. Care records were detailed, person centred, and people received individualised care and support which reflected their personal preferences and lifestyle choices.

People had the opportunity to participate in a wide range of activities that included day trips, activities and celebrations in their own home. There was something for everyone and space to be quiet if that was a person's choice.

People's views and opinions were sought in a variety of ways and their ideas and suggestions were responded to.

Is the service well-led?

Good

The service was well-led.

People and staff were actively involved in developing the service.

Quality assurance processes monitored the service provided to make positive improvements to benefit people's experiences of care.

Staff told us that management had an open door policy and that they would not wait to raise any concerns.

There was a warm friendly atmosphere and staff spoke of a positive culture where the managers promoted strong values and a person centred culture, which was supported by a committed staff group.

The Oaks

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 was carried out over two days on the 18 and 19 of February 2016 and was unannounced.

The inspection team consisted of one Adult Social Care (ACS) inspector.

Before the inspection, the provider completed a provider information return (PIR). The PIR 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 reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commission a service from the home and they told us they had no concerns.

On the day of the inspection, we spoke with five people who lived in the home, two activities co-ordinators, the cook, three members of staff, the registered manager, the deputy manager, and the homes providers.

As part of the inspection we reviewed the care records for five people including their medicines records and risk assessments. We also looked at five staff files and other records used in running a care home that included quality assurance systems, policies and procedures and health and safety records. We observed the care and support being provided to people and observed a medication round and the lunchtime meal in the dining room.

Good

Is the service safe?

Our findings

People receiving a service were protected against the risks of potential abuse and bullying. People confirmed they felt safe. One person told us, "I feel very safe and supported." Another person told us, "I do feel very safe here" and "I feel safe; there is always someone on the spot when you need them." We saw staff received up to date training in safeguarding vulnerable adults and they discussed with us what signs of abuse they looked out for and what they would do if they had any concerns about people's safety. Staff at the home had access to a comprehensive policy and procedure about safeguarding adults from abuse and these were written in conjunction with the local authority procedures for safeguarding adults from abuse. We saw the registered manager had raised concerns to the local safeguarding team and that they were dealt with effectively.

We looked at people's care plans and we saw that these provided consistent up to date information about their care and support including associated risk assessments and action plans. These helped the service to minimise risks associated with falls, infection control, and the administering of medication. Risk assessments were reviewed and updated with the involvement of people, families and professionals.

Where people had a lack of mobility we saw the registered provider managed the associated risks of pressures sores using a Waterlow pressure risk assessment tool. The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore for a person receiving a service. Where a person was deemed at risk, we saw care and support plans were in place and updated at least monthly. This meant the registered provider had procedures in place to minimise the risk of people developing pressure sores.

We saw a person with dementia had suffered several falls. Their file contained a falls report, risk assessment and a multi-agency response. We saw this included intervention by a doctor. A resulting support plan was seen that described the risks, the situations and methods in place to mitigate the risk and this had been regularly reviewed. We saw that the person had been provided with aids and adaptions including a walking frame and bed rails and they received regular checks and support. We saw the frequencies of falls for the person had reduced because of the care and interventions in place. This meant the person could remain mobile around the home in a safe managed way and that staff were aware of the risks.

The registered manager showed us maintenance certificates for the premises, which included the electrical wiring certificate, gas safety certificate and portable appliance checks. These were up to date and helped to ensure the safety of the premises. We saw monthly hot water temperature checks were carried out for each room and checks on all electrical items, hoists, tilt baths, and the cable system were all up to date with regular maintenance programmes in place. This meant the environment was safe for people and others.

We saw people were kept safe from the risk of emergencies in the home. People had a risk assessment in their care files for the environment and a personal emergency evacuation plan (PEEP). PEEPs are documents, which advise of the support people need to leave the home in the event of an evacuation taking place.

The manager monitored and investigated accidents and incidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. When people had accidents, incidents or near misses, these were recorded and included details of the event, any witnesses and the cause. We saw that where these linked to people receiving a service the process was monitored for trends and was linked back to care plans. However, we looked at the accident and incident file and saw that other recorded accidents and incidents did not always contain detailed outcomes and actions. We discussed this with the registered manager and they told us, "We have identified that actions are not always apparent [when accidents and incidents are recorded] and we have scheduled training for next week to look at how we can investigate and learn from all complaints, incidents and accidents." The training schedule we viewed, confirmed this and this showed the provider was taking steps to learn from those events.

We looked at staffing levels across the home. The registered provider used an electronic staffing dependency tool to calculate the appropriate staffing levels to meet the dependency needs of the people using the service. We looked at staff rotas; we saw there were sufficient numbers of suitably trained and competent staff, and that staffing levels were regularly reviewed. One staff member told us, "Staffing levels are good; there are enough [staff] to make sure no one is neglected." Another told us "Staffing has improved, we now have four night staff including a nurse" they continued, "if we feel unsafe due to lack of staff we can just speak to the manager, they are very responsive and will help out if needed." One person who received a service told us, "I have a call bell and if I need support I just push the button, the response is very fast." We observed staff supporting individuals in a timely and unhurried manner, using a caring and patient approach.

Variations in staffing numbers related to the priorities of each shift, such as appointments, activities and other service requirements. We were told a range of ancillary personnel supported management, nursing and care staff. This included domestic and kitchen employees and a maintenance team that worked across the organisation's group of services.

We checked the recruitment records for six members of staff. We saw that an application form had been completed and two references had been obtained. Other checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. We saw nursing staff registration checks were maintained with PIN numbers, expiry dates and appropriate qualifications and that these were up to date. The registered manager monitored when nurse registrations were due to be renewed, to verify they were safe to practice. These checks help employers make safer recruiting decisions and help to prevent unsuitable people from working with children and vulnerable adults. The registered manager advised us that staff shadowed experienced workers and had recruitment checks in place before being allowed to work independently. It was clear that these checks had been undertaken and that the registered provider had received this information prior to the new employees starting work at the home.

The registered provider had a medication policy and procedure in place and this followed guidance provided by 'The National Institute for Health and Care Excellence' (NICE). We saw this was annually reviewed and updated. We saw changes were communicated and discussed with staff at staff meetings and staff were required to sign to say they understood any changes. Staff told us additional training was provided when appropriate.

The registered provider told us on their Provider Information Return (PIR), 'Medication is administered by the Nursing staff and Senior Care Assistants only, most of whom have attended refresher training with the Community Pharmacist.' We looked at staff files and saw staff involved with medication received appropriate up to date training. Monthly documented competency checks were recorded and included

observations on staff administering and recording medication to ensure staff remained competent to administer medication safely.

We observed the administration of medication. We saw non-controlled drugs were kept in locked cabinets in people's rooms. Controlled drugs were kept in a locked safe next to the manager's office. Weekly stock checks were evidenced and these included documented checks ensuring the remaining number of tablets was consistent with those administered, expiry dates had not passed and that stock was rotated and kept to a minimum in the cabinets in people's rooms. The blister packs were colour coded to denote the time the medication needed to be administered, and medication administration record (MAR) charts had corresponding colour coding; this reduced the risk of errors occurring.

The nurse told us that medication risk assessments were completed that determined the level of support required by a person. We saw that these were documented in people's care plans and that they were reviewed at least monthly. This ensured people retained their independence as much as possible with respect to the management of their medication. We saw that people were always asked if they were ready to take their medication and noted that the staff member gave the medication to the person concerned with a glass of water to help them swallow tablets.

We saw medication administration records (MAR) charts were kept in people's rooms and that staff did not sign the MAR chart until they had administered, or for people who self-administered, observed, the person had taken their medication. We saw one gap on one MAR chart without a corresponding entry. We asked the nurse about this and they told us that this should have been completed. The nurse told us the gap would have been picked up during the weekly audit. They told us where a staff member missed three recordings; they would receive a supervision and additional training. We looked at a staff file and saw supervision had been recorded for medication errors. We saw that a discussion had taken place and that this had been reviewed with improvement noted. This meant the registered provider had taken steps to ensure staff were competent with the correct skills to deliver and record medication in a safe way to people.

We checked the storage and recording of controlled drugs (CDs). CDs were stored in a locked CD cabinet within the medication cupboard in line with regulations (misuse of drugs [safe custody] regulations). Access to them was restricted and the keys held securely. We saw that recording was accurate and the amount of medication held matched the balance recorded in the CD book. We saw that the deputy manager checked the CD book regularly to ensure that the records and the amount of medication held in stock balanced. We saw other medication audits in quality assurance records; this evidenced that the medication system in the home was regularly monitored to ensure that people received the right medicines at the right time in line with current and relevant regulations and guidance.

We saw staff received guidance regarding non-prescribed (homely) medicines that included paracetamols and simple linctus. People were encouraged to discuss homely remedies with their GP or pharmacist and inform their key worker so that a MAR chart could be implemented to ensure people received the right medicines at the right time.

The home was clean and there were no malodours. The registered provider had policies and procedures in place and we saw that staff had received training in health and safety in the home, infection control and food safety. We carried out a tour of the premises and saw that toilets and bathroom facilities were clean with liquid soap and paper towels available. We observed staff using personal protective equipment (PPE) such as aprons and gloves during our visit.

The registered manager was responsible for completing a quarterly quality assurance report for infection

control. Quarter four of 2015 was not compliant. We spoke to the registered manager about this who told us and we saw, because of the findings and recommendations, care plans for people had been updated with additional risk assessments for infection control. This meant the registered provider had taken steps to ensure the service was kept clean and hygienic and that people were protected from the risk of acquired infections.

The registered provider undertook regular housekeeping checks. The housekeeping audit included monthly checks on water temperatures in each room and six monthly checks were observed on equipment for moving and handling of people and specialist tilt baths. We saw details of premises checks including gas certificates, cable system certificates, portable appliance testing, and showerhead checks were completed and were all up to date. Maintenance programmes were in place and the registered provider had the use of an internal maintenance team. We saw a maintenance worksheet included a reported hole in a path that was repaired as per the associated action. This showed that the registered provider had monitoring systems in place to ensure that the premises remained safe for people who lived and worked at the home.

Good

Is the service effective?

Our findings

People using the service said staff knew how to support them and had an understanding of their needs. People told us "Care workers support me with the things I like to do," and "They [care workers] have the right skills to look after me." A member of staff told us, "We have lots of meetings both with a variety of people involved in a person's support and care and with people themselves" they continued "It's important we have good communication so we can understand peoples everyday needs as these change."

The registered provider told us they were implementing a new induction process that incorporated the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working. We looked at staff files and saw the induction covered eight principles of care that included, duty of care, person centred approaches, positive behavioural support, equality and diversity, privacy and dignity, health and safety and infection prevention and control. This demonstrated how staff were supported to understand the fundamentals of care.

Staff told us they felt the service supported them to ensure they had the right skills to undertake their work. They told us and we saw from employment records they had attended an induction and additional mandatory training before working independently with people. This included safeguarding, moving and handling, dementia awareness, fire safety, and The Mental Capacity Act. The training was a mix of e-learning and classroom based tuition. The registered provider told us on the PIR, 'The induction includes an introduction to the environment and use of all equipment i.e. the call system, fire arrangements, hoists, baths, lifts etc.'

We looked at files for staff and saw that training was adapted and provided to meet people's individual needs. This included personal needs, assisting with eating and drinking, and challenging behaviour. We saw from care worker files that they received certified training in dementia awareness that included a 'Virtual Dementia Tour' that provided them with an understanding of what it is like for people to live with dementia.

During their probationary period, we saw that new staff undertook their first week shadowing a supervisor to ensure that they had the required competencies and that they were introduced to people in the home. The registered provider told us on the PIR submission, 'Care staff spend time with the Activity Team getting to know residents on a social level.' This meant staff knew people and people knew the staff so that they received care and support appropriate to their needs.

Staff had a training plan in place and we saw how this was managed and updated to ensure that they had the knowledge and skills required to effectively carry out their duties. Competencies were annually reviewed and records were kept in staff files. We saw documented observations were carried out including moving and handling and medicine management.

We looked at staff files and saw that they received quarterly structured supervisions, an annual appraisal and development review. Staff told us they had supervision meetings and we were able to view documented quarterly supervisions and annual Performance Development Reviews (PDR's). These included records of

training, development needs and any concerns care workers had about the people they cared for. This meant staff received effective support, induction, supervision, appraisal and training to support and care for people's needs.

Staff had received training and understood the requirements of The Mental Capacity Act 2005. 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).

Where people had been deprived of their liberty, applications had been submitted to the local authority for a deprivation of liberty safeguard (DoLS) authorisation. A DoLS provides a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. The registered manager was aware of changes (March 2014) in the case law around DoLS and that, additional DoLS authorisations may need to be submitted as a result.

We looked at people's care plans and saw people or their representatives were involved in their care planning and where people had capacity consent had been sought that confirmed they agreed with the care and support provided. There was evidence that for those people unable to make decisions about their care, decisions were made in their best interests.

We walked around the home and we saw that one person with limited mobility had an air mattress in place to help reduce the risk of skin tears. We saw bed rails and bumpers were used to prevent them rolling out. We looked at the persons care file and saw the file contained a bed rail and equipment risk assessment tool and that these were reviewed monthly. We saw the person had a lack of capacity and the file contained a Best Interest Decision assessment and associated documents that followed the principle of the MCA. We saw the provider had engaged the use of an Independent Mental Health Adviser (IMHA). This ensured decisions made on behalf of the person by the registered provider and others were in their best interests and as least restrictive as possible.

We asked management and staff how they managed anxious behaviour by people in the home. The registered manager told us "We avoid restraint and use de-escalation techniques in line with policy and procedure." A care worker told us, "We don't restrain people, we walk away unless there is a danger to themselves or others, then we use de-escalation techniques." The registered provider told us they had monthly meetings with other health professionals where they discussed challenging behaviour and associated guidance. We saw where required, staff received training in challenging behaviour and managing aggression and violence. A member of staff told us "Training is available if we need it but I do not need it."

We saw the care home environment was secure with all visitors entering the home via the reception. This was staffed between the hours of 9.00 a.m. 5.00 p.m. Outside of these hours the registered provider told us on the PIR, 'Entry is via a programmed fob (made available to residents if they wish and family members) or via the door entry system answered by staff, a CCTV camera covers the entrance.'

The provider told us on the PIR that the home had twenty-one people with a, 'Do Not Attempt Cardiopulmonary Resuscitation, (DNACPR) on file. We saw these were available at the front of peoples care plans with the rationale for this decision. DNAR orders are a decision made in advance should a person

suffer a cardiac or respiratory arrest about whether they wish to be resuscitated.

We saw peoples dietary requirements noted in their care plans. A member of staff told us, "We have regular discussions with people about their individual needs with regards to eating" they continued, "Any requests are then discussed, either at the monthly meeting we have with the cook or if it is a dietary requirement we speak with the chef, there's never a problem." We saw minutes of recent meetings and observed a communication book in the kitchen. The book contained details of people's individual dietary requirements and included information when people required extra fibre, low sugar and vegetarian options.

People were encouraged to eat healthily. The home had an assisted dining room and an informal coffee shop area. The assisted dining room had adapted furniture to facilitate people in wheel chairs. Tables were colourful and there was a choice of juice and water available throughout the mealtime. An activity co-ordinator told us, "We take people from the assisted dining room into the coffee shop to eat" and "The change of environment helps to improve their eating and their well-being." We observed the lunchtime meal and saw sufficient staff were on hand to support people with eating and drinking if they required it. We observed a calm unrushed atmosphere with people clearly enjoying their food. The menu was varied and people's additional dietary requirements were catered for. The menu was changed every week. One person told us, "The food is filling; plenty of choice and it seems to be nutritious." Another person told us "I have been really surprised at the quality of service, absolutely delightful food, well presented too."

We spoke to the chef who told us "The food is brought in fresh from [supplier]." We saw a variety of snacks, fruit and cakes available throughout the day and juice was fresh and accessible to people in all communal areas.

The kitchen had an environmental health officer food hygiene rating [FHRS] award of 5. The rating was awarded on 11 December 2014. Ratings are based on how hygienic and well-managed food preparation areas are on the premises. A food preparation facility is given "FHRS" rating from 0 to 5, 0 being the worst and 5 being the best. An FHRS rating of 3 is acceptable.

People were supported to maintain good health. Care plans contained detailed information to ensure people were not at risk of malnutrition. We saw the use of 'Malnutrition Universal Screening Tool' ('MUST'). These were completed monthly and where risks were identified, we saw the person's care and support plan had been updated. A care worker said, "We monitor a person's health using charts, it's an ongoing process" they told us, "If it [a person's health] does not improve we discuss the situation at the handover with the nurse and may contact a GP if required."

We saw care plans identified persons daily care needs. These included people's night-time support requirements and daily living; including bowel movement, blood pressure, weight and skin integrity plans. We saw these were reviewed at least monthly and as appropriate involved documented multi discipline team visits to help support and care for people. Where people's needs changed quickly we saw the registered provider had made referrals to and we saw people had access to a range of health professionals and these included opticians, doctors, occupational health staff, physiotherapists and others. This meant staff understood people's needs and the registered provider had ensured processes were in place and information was available to ensure people's day-to-day health needs were met.

The home was easy to navigate and well signposted for people. The Oaks care home forms part the wider Hartrigg Oaks community owned by the registered provider. This meant people had access to the Health Activity Centre/Spa Pool and on site massage therapist. We saw peoples religious needs were catered for with on-site opportunities for worship that included weekly services at a Quaker Meeting and Meeting for

Worship. Residents had access to a private garden and wider areas of The Oaks Centre and Hartrigg Oaks generally. The registered provider told us on the PIR, 'Residents can entertain visitors in their own rooms or use one of the four communal sitting rooms within the care home/other areas within The Oaks Centre.'

Good

Is the service caring?

Our findings

Everybody we spoke with was complimentary about how caring the staff were. Our observations during the inspection confirmed that staff knew the people in the home and knew how to treat them calmly and with dignity and respect. We did not hear any raised voices and we saw attentive staff gently persuade and encourage people. People told us, "They [staff] are very kind" and "I do feel cared for, they [staff] are really friendly and respectful."

We asked staff how they knew people in the home. They told us "We have to make time and speak with people to get to know them." Another told us, "We use the care plans, they are always up to date and the ones in the rooms provide a quick reference." We looked at the files in people's rooms. They included a, 'What's Important to Me' section of the care plan, a photograph of the person, details of their key worker, and an activities record. We saw this was used to develop a personalised service for people. A commissioner from the local authority told us, "Senior staff were always available to answer any queries I had and appeared to know this person well and their family circumstances."

People who used the service told us they knew their key worker. The registered provider told us on the PIR, 'Relationships [between staff and people] are reviewed to ensure they are positive ones and action is taken if relationship not working.' The registered manger told us they try and match staff and people to meet their needs and interests and that this was reviewed. From our observations we saw that people reacted in a positive manner, often smiling when friendly faces approached.

Staff we spoke with told us that people, their families and advocates were involved with their care and support planning, they said, "We regularly speak with family members and invite them to meetings with the person and their key worker." We saw from care files that there was good documented communication between the registered provider, people, their families and other health professionals. People told us their views were listened to and that they were involved with developing their own care and that it met with their needs.

We saw from care plans that where people did not have full capacity or were unable to express their views they were provided with information and assisted to make a referral to an advocacy service. Advocacy is a process of supporting and enabling people to express their views and concerns and enables people to access information and services to promote their rights and responsibilities.

Discussion with staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided for within the service and by people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Staff understood how to respect people's privacy, dignity and human rights. We observed staff knocking on

doors before entering people's rooms, speaking with people politely and asking or explaining what they would be doing before carrying out any care interventions. Staff addressed people in the way they wanted to be addressed. People were appropriately dressed and employees were mindful that any personal care should be offered in a way that promoted the individuals dignity. Staff told us they understood what was meant by 'confidentiality'. One person told us, "I never talk about a person to anybody except the people directly involved, who need to know" but they said, "If it was a safeguarding concern I would share that with the local authority."

We spoke with staff and they confirmed to us that they had a good appreciation of what was meant by treating people with dignity and respect. One care workers told us "I would always make sure people understood their care and support and that we always had the right amount of staff available to provide it." A commissioner from the local authority told us, "The home is very respectful of resident's privacy and dignity."

People were supported to make their preferences for end of life care known and these were recorded. Where people continued with their end of life care with the service we saw they received compassionate and supportive care provided by care workers that knew and understood their wishes. The registered provider showed us a comprehensive end of life care package and leaflets. We saw that a support package was also available to help families support people with end of life and to ensure they were supported by the home with the persons final requests. We saw the home worked with palliative care services including Macmillan nurses and the Hospice. Palliative care is a multidisciplinary approach to specialised medical care for people with serious illnesses.

Good

Is the service responsive?

Our findings

We spoke with people using the service, family members, the registered manager and care workers and the feedback demonstrated that the service was very responsive to meeting the needs of not only people living at the home, but also their relatives.

The registered provider told us all new people coming into the home were allocated a key worker. The key worker was responsible for welcoming new residents into the home and helped people to settle into their new environment and become acquainted with like-minded people and staff. One person we spoke with told us, "My move into the home was a difficult decision for me and my family but I have been so well supported and have already made like-minded friends" they continued, "Even the handy man is helping me to put up pictures, it really is starting to feel like home."

We looked at a recent survey and saw that 56% of people knew who their key worker was. We spoke with the registered manager about this and they showed us the minutes of a recent 'Oaks Group' meeting. The minutes showed the registered provider had undertaken an audit that identified out of 43 residents, only 5 families had not been contacted in the previous six months. The minutes identified, a new team leader had been employed to implement actions to improve the role of the key worker further. This meant that the provider had taken into account people's views and had put measures in place to ensure people and their families were supported and welcomed into the home.

We looked at people's care plans. The registered provider told us in the PIR that care plans contained a one page person profile; 'What is Important to Me' and that these had been developed in consultation with a focus group of staff and residents. We saw care plans were detailed and person centred. They reflected the individual way in which people wanted to be cared for which included their choices and preferences. We saw the one page profile 'What's important to me.' This included; 'a personal history', 'the support I need', 'preferred communication', 'things that worry and upset me' and 'how I like my medication'. We saw these had been completed with and agreed to, by the person or their relatives.

The provider told us on the PIR, 'The 'excellence themes' confirm what residents told us are the important things for them to continue to have a good life" and "The documentation highlights the need to review care and support plans and obtain/review resident involvement with the plan.' We saw regular reviews were carried out and people using the service and their relatives were involved in these. This helped to ensure that the care provided was consistent and met people's changing needs.

We saw people were supported to follow their interests and take part in social activities. We looked at people's care plans and we saw they included information about leisure time. One person told us, "I am encouraged to follow as many of my interests as I want to", "I can visit the library or go out to [events] with my friends and family." We spoke with two activity co-ordinators employed at the home. The co-ordinators worked with a team of volunteers to ensure people had access to a range of individual and group activities.

One activity co-ordinator told us, "We try different techniques to get people engaged with the activities on

offer" they said, "We meet with people and assess what they want to do, this can be in their own rooms, over a coffee in the coffee shop or during review meetings." The co-ordinators wore pink bibs so they were recognised as they moved around the building. One person told us, "It's the ladies in pink, something good is going to happen." We observed how people sat up in their chairs in the communal areas as they approached. Activities included games nights, trips out and one to one activities such as a hand massage and nail care. We saw the home had a number of communal areas where people could sit together but also smaller areas with individual activities such as jigsaws were available so people could spend time on their own if that was their preference.

We observed a person with dementia receiving a sensory hand massage. A person told us, "They [activity co-ordinators] are always thinking of new ideas." They told us "Tonight we are having a Chinese meal." We saw one of the communal areas had been themed for the meal with lanterns, fortune cookies and even chopsticks.

Someone from the local authority told us "The service the Oaks offered to [person] was tailored to their individual needs," they continued, "[Person] was unable to leave their room and the staff came to them regularly" and "At quieter times for [person] during the day, they would stay to talk for a while." This ensured the person did not remain unnecessarily isolated.

People using the service were encouraged and supported to develop and maintain relationships with people that mattered to them. One person told us "Family and friends visit all the time, I have just had my birthday and it was a real celebration." Another person we spoke with said, "I have lots of friends and visitors and there are a few people in the home that I talk to." A member of staff told us "We encourage families and friends to visit relatives and have a meal with them in the café restaurant."

The registered provider had a complaints policy and we saw this was available on a noticeboard in the home. The registered provider told us on the PIR submission, 'Comment slips are also available for residents/families/visitors to use and these can be addressed appropriately to the 'Hartrigg Oaks Residents' Committee' or a manager.' A member of staff told us, "People have information in their care plans about how to complain and we encourage positive or negative feedback from open dialogue." We spoke with people and asked them if they knew how to complain, they told us "I have a booklet about the complaints process but I haven't needed to use it" and "If I have any concerns or complaints, I speak with [registered manager] who is very thorough." The registered manager demonstrated the process for dealing with complaints that included a summary of actions, outcomes and a written response to the complainant within defined timescales. We saw that information from complaints and compliments was collated and fully investigated with a view to future learning and improvement.

The registered provider told us on their PIR submission, 'Transfer of a resident from the wider Hartrigg Oaks community into The Oaks is supported by the on-site Community Care and Support Team; information is shared to ensure smooth transition with the staff teams working together.' Care staff we spoke with told us they worked with a range of health professionals and others to ensure people received a smooth transition between services. One person had sent in a thank you letter to the home after spending some time in respite and transferring between services. They wrote, "You are a wonderful team and quite unique, rather like a large family."

People told us and we saw that staff responded quickly to call bells. One person told us "You never have to wait long; staff are very quick at answering [the call bell]."

Good

Is the service well-led?

Our findings

There was a registered manager in place. The registered manager was on duty and supported us during the inspection, along with a deputy manager. There was positive feedback from everyone we spoke with about the leadership and there was a high degree of confidence in how the service was run. A member of staff told us, "Management and leadership are very good, they are always available and one is always on call over the weekend." Another care worker told us, "The manager always attends the handover shift and has a genuine interest in people's care and support and any concerns, especially around medication." There was a clear management structure in place and staff had an understanding of their roles and responsibilities. The registered provider told us on the PIR, 'The Care Home Manager is supported by Senior Managers from the wider organisation (some of whom are based on site) and are available for advice and support as required.'

Management knew about their registration requirements with the Care Quality Commission (CQC) and were able to discuss notifications they had submitted. This meant they were meeting conditions of their registration.

Care staff told us the service had a positive culture. They told us that management had an open door policy and that they would not hesitate to undertake whistle-blowing. One person said, "I would not hesitate in raising concerns to protect people" and "Management have an open door policy, I know my concerns would be dealt with in a professional and confidential manner."

The registered provider had a statement of purpose. We saw that this included visions and values of the service and that a programme of quality assurance upheld these. Monthly audits were undertaken that lead to a quarterly evaluation of the service. We saw this resulted in action plans being implemented for improvement where targets were not met. We asked care workers if quality assurance helped to drive improvement and they told us "Yes, the last survey had a positive impact on staff morale." Another care worker said, "We always try and learn from mistakes to improve the care [for people]."

We saw that peoples care was person centred and empowered people to make choices and remain independent in a safe, managed way. Care workers told us they were supported and kept up to date with changes, not just for people but also in best practice and organisational changes. A care worker told us, "We are constantly updated about people's needs, not just verbally and at staff meetings but also documented in daily hand over notes and from new information in people's files."

We looked at minutes of staff and service user meetings. Staff and people using the service told us and we saw from care plans that the registered provider worked effectively with external agencies and other health and social care professionals to provide consistent care, to a high standard for people.

The culture of the service was inclusive and positive and staff told us they felt valued by the management team. One staff told us "There is a happy environment, we all get on well and have a good work ethic." Another said, "It's about team work, we have a good reputation and get on well with other health professionals which benefits people."

We saw regular staff supervisions with documented feedback to employees indicating what they had done well and what needed improvement. These included practical observations on daily activities carried out by staff for example, moving and handling and medication administration. We asked staff how they knew they had done a good job. A staff member told us "If the person we care for is not happy they will tell us or someone else." Audits were also carried out on care plans and medication systems. This showed that the registered provider regularly checked that staff followed and understood policies and procedures at the home.

The provider had put in place a large number of policies to underpin service quality and safety. These include procedures related to environmental safety, staffing and care practices. Staff were required to read policies and sign their understanding to assure a safe and effective service delivery.

People using the service were encouraged to have their say, we saw service user meetings were held where people were given the opportunity to discuss any issues and raise any concerns. The registered provider told us on the PIR, 'The Oaks Group is made up of a group of bungalow residents who specifically take an interest in The Oaks; the Group is a sub-group of the Hartrigg Oaks Residents Committee. The Group meets approx. 4 times.' We saw copies of minutes from the meeting and it was clear that people were involved in shaping the care and support they received and that people's concerns were looked into and actions implemented as a result.
We saw the registered provider had undertaken an annual survey with people in the home. The results of the service showed that out of 18 people, 12 people agreed and 3 people strongly agreed that, "Staff listen, talk to me and make me feel that my views matter." The results also showed that out of 18 people 7 were neutral, 8 agreed and 3 strongly agreed that, "I think staff know me as an individual and understand what is important to me." This meant the registered provider had taken steps to make sure that, people were involved in making decisions and planning their own care, that they felt listened to, respected, and had their views and wishes respected.

People, staff and others told us and we saw from care plans that people received multi-agency support and care from other health professionals. The registered provider told us on the PIR submission, 'The Oaks has a good relationship with the local GP Practice which includes weekly attendance on site (plus emergency call out) and as appropriate the care home has involvement with District Nurses, CPNs, Consultant Psychiatrist, Speech & Language Therapist, Funded Nurse Care Assessors.' This meant people received holistic care that met with their changing needs and preferences.