Unity Homes Limited

Oakbank Care Home

Inspection report

Oakbank
off Rochdale Road
Manchester
Greater Manchester
M9 5YA

Tel: 01612058848

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10 October 2017

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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

The inspection took place on 10 October 2017 and was unannounced. At the previous inspection we identified breaches of the with regard to staffing, recruitment, nutrition and quality monitoring. At this inspection we found improvements had been made in all areas.

Oakbank Care Home is owned by Unity Homes Limited and is in the Harpurhey area of Manchester. Local shops and amenities are within easy walking distance of the home. The home is registered to provide accommodation for up to 58 people including those who need nursing care. On the day of the inspection there were 44 people using the service.

There was a registered manager in place. 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.

There were sufficient numbers of staff on duty on the day of the inspection to adequately meet the needs of the people who used the service. Staff recruitment was robust and staff files included relevant documentation.

There was an appropriate safeguarding policy and procedure in place. Staff demonstrated an understanding of the procedure and had undertaken training in safeguarding.

There was a health and safety policy and procedure and staff undertook training in infection control. General and individual risk assessments were in place to help ensure people's safety.

The service had an appropriate medicines policy in place medicines systems were robust.

The induction process was robust, mandatory training was undertaken and there were ample training opportunities for staff.

The environment was pleasant and well appointed. There were no unpleasant odours detected within the home and there was some signage to help people orientate around the home.

The food was plentiful and nutritious and there were ample choices. The mealtime experience could have been enhanced with more conversation and interaction.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People who used the service felt the care was good and staff were kind and caring. We observed staff

interactions and saw they offered care with compassion and respect.

Privacy and dignity were maintained by staff knocking on people's bedroom doors and waiting to be invited in. All rooms were single occupancy and people were able to spend time in their rooms if they wished to have some privacy.

People who used the service and their relatives, where appropriate, were involved with care planning and reviews of care. There were regular scheduled meetings for relatives and friends to attend.

People who used the service that we spoke with felt they were listened to. Care files included information about people's backgrounds, interests, significant events and things that were important to them. We saw evidence of regular care file audits, with actions to address any shortfalls.

Activities included arm chair exercises, table top games, film afternoons, shopping trips, arts and crafts, sewing, relaxation hand and arm care, dominoes and card games and one to one chats with people.

Questionnaires were completed regularly throughout the year by people who used the service, relatives and professionals. Recent questionnaires completed by people who used the service were positive

There was an appropriate complaints policy which was displayed within the home. There had been six complaints or concerns recorded for 2017 and these had been responded to and actions taken. A number of compliments had been received by the service.

Staff we spoke with felt supported and said management were approachable. Staff supervision sessions and appraisals were undertaken regularly to help ensure staff were supported.

There were systems in place for monitoring and assessing the service and a number of audits were completed regularly. The registered manager had oversight of all incidents at the home.

Results of questionnaires were analysed and actions taken to address any suggestions or concerns raised. Residents' and relatives' meetings were held regularly and feedback from these meetings was also used to drive improvement.

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.

There were sufficient numbers of staff on the day of the inspection to meet the needs of the people who used the service. Staff recruitment was robust and staff files included relevant documentation.

There was an appropriate safeguarding policy and procedure in place. Staff demonstrated an understanding of the procedure and had undertaken training in safeguarding.

There was a health and safety policy and procedure and staff undertook training in infection control. General and individual risk assessments were in place to help ensure people's safety. The service had an appropriate medicines policy in place medicines systems were robust.

Is the service effective?

Good

The service was effective.

The induction process was robust, mandatory training was undertaken and there were ample training opportunities for staff.

The environment was pleasant and well appointed. There were no unpleasant odours and there was some signage to help people orientate around the home. The food was plentiful and nutritious and there were ample choices.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People who used the service felt the care was good and staff were kind and caring. We observed staff interactions and saw they offered care with compassion and respect.

Privacy and dignity were maintained by staff knocking on people's bedroom doors and waiting to be invited in. All rooms were single occupancy and people were able to spend time in their rooms if they wished to have some privacy.

People who used the service and their relatives, where appropriate, were involved with care planning and reviews of care. There were regular scheduled meetings for relatives and friends to attend.

Is the service responsive?

Good

The service was responsive.

People who used the service that we spoke with felt they were listened to. Care files included information about people's backgrounds, interests, significant events and things that were important to them.

There were various activities taking place at the home. Recent questionnaires completed by people who used the service were positive

There was an appropriate complaints policy which was displayed within the home. Complaints and concerns were responded to appropriately. A number of compliments had been received by the service.

Is the service well-led?

Good

The service was well-led.

Staff felt supported and said management were approachable. Staff supervision sessions and appraisals were undertaken regularly to help ensure staff were supported.

There were systems in place for monitoring and assessing the service and a number of audits were completed regularly. The registered manager had oversight of all incidents at the home.

Results of questionnaires were analysed and actions taken to address any suggestions or concerns raised.

Oakbank Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting 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 took place and was unannounced. The inspection was undertaken by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had personal experience of older people living with dementia.

Prior to the inspection we looked at information we had about the service in the form of notifications, safeguarding concerns and whistle blowing information. We also received a provider information return (PIR) from the provider. This form asks the provider to give us some key information about what the service does well and any improvements they plan to make. We also contacted the local authority commissioners of the service and the local safeguarding team. We did not receive any negative feedback.

During the inspection we spoke with the registered manager and 13 other staff including carers, kitchen staff and activities staff. We spoke with six people who used the service and three relatives. We looked at four staff files, six care files, staff rotas, training records, supervision records, meeting minutes and audits. Following the inspection we contacted two health and social care professionals. We did not receive any negative feedback.

Good

Is the service safe?

Our findings

People told us they felt safe at Oakbank. Comments included; "I did not want to come here but I could not manage anymore on my own. I am happy here I am safe and well looked after. The staff are lovely"; "I am happy that my [relative] is well cared for. She is treated with dignity and I am reassured she is safe"; "I feel safe because the staff use a special hoist to help me stand from my chair".

We saw staff rotas, which evidenced good numbers of staff for each shift. A dependency tool was used to calculate each individual's level of need to help ensure the correct levels of staff were deployed. There were sufficient numbers of staff on duty on the day of the inspection to adequately meet the needs of the people who used the service. Although some agency staff were used, the service tried to ensure the agency staff were regular to help ensure consistency for people who used the service. We saw evidence of induction and supervisions for agency staff.

The staff recruitment process was robust. Each staff file we looked at included an application form two references, proof of identity, new starter forms, a health questionnaire and interview questions and notes. Checks had been carried out with the Disclosure and Barring Service (DBS) or the Criminal Records Bureau (CRB). These checks identify people who are barred from working with children and vulnerable adults and inform the provider of any criminal convictions noted against the applicant.

There was an appropriate safeguarding policy and procedure in place. Staff we spoke with demonstrated an understanding of the issues and the procedure and had undertaken training in safeguarding. All safeguarding issues had been followed up appropriately.

There was a health and safety policy and procedure and staff undertook training in infection control. They used personal protective equipment (PPE) such as plastic aprons and gloves, when carrying out personal care, to help prevent the spread of infection. Regular audits of cleaning and infection control were undertaken and action plans completed for any issues identified.

General and individual risk assessments were in place to help ensure people's safety. There were personal emergency evacuation plans (PEEPS) in place for each individual. These set out the level of assistance each person would require in the event of any emergency.

The service had up to date gas safety and electrical certificates. There was a business continuity plan to be used in the event of an emergency, such as disruption to electricity, gas or water. The floor was slightly uneven on one of the corridors, but appropriate signage was in place to warn people of the risks.

There was a fire risk assessment in place which had been reviewed on 30 June 2017. Fire exits were free from obstructions and we saw a fire safety system for periodic testing of equipment and alarms. These were documented in a printed book, however there was no space for dates to show when tests had been completed. We discussed this with the registered manager and provider and they agreed to add dates. There was evidence of a fire drill having taken place on 13 September 2017.

Water testing was undertaken monthly and records of shower temperatures and baths checks were complete. The maintenance file included certificates for legionella testing, maintenance of hoists and slings and profiling beds and regular servicing of the passenger lift.

Accidents and incidents were logged and followed up appropriately. Analysis of accidents was undertaken to look at any patterns or trends and these were addressed by the service.

The service had an appropriate medicines policy in place and guidance around medicines errors. Medicines systems were robust, medication was in blister packs and the drugs trolley was clean, tidy and securely locked to the wall as required. Medicines were given as prescribed and correctly recorded and there was no overstocking. There was a controlled drugs cupboard and register. Medication administration records (MAR) were audited by the nurse and the audits had picked up on a missed signature, which had been addressed. Fridge temperatures were monitored and were correct to the manufacturers' requirements.

The recording of thickening agents put into drinks for people who experienced swallowing difficulties needed tightening up. Drinks were only being recorded four times daily, as per the MAR sheets, other drinks were not recorded. We discussed this with staff and a fluid sheet was actioned immediately for those people on thickeners.

Good

Is the service effective?

Our findings

The induction process was robust and was a 12 week programme which included mandatory training and working under the supervision of a more experienced member of staff to begin with. Staff were regularly supervised during this period to help ensure their competence and confidence with regard to carrying out their role.

We saw evidence within the staff files we looked at of regular one to one supervision sessions, approximately six per year for each staff member, and annual appraisals. These gave staff a forum to discuss their training and development needs and any issues or concerns around their work.

Staff had access to e-learning and on-site training conducted by an external training company. Staff we spoke with told us they were happy with the training programme. One said "We have lots of opportunities to complete training, I have done lots, I enjoy it". Another said "I think I am up to date with everything". There was evidence of mandatory training within the staff files we looked at and in the training matrix. Mandatory training included safeguarding, moving and handling, health and safety, infection control, dignity in care, MCA and DoLS and fire safety. There were other courses, such as equality and diversity, confidentiality, medication, dementia awareness, record keeping, communication and food safety, undertaken by some staff as appropriate.

The environment was pleasant and well appointed. There was a welcoming reception area, a coffee lounge for people who used the service and relatives to have refreshments in and a nice outdoor space with patio area for people to use in good weather. There were no unpleasant odours detected within the home and there was some signage to help people orientate around the home.

Care plans included appropriate information about people's health and support needs. Separate care plans for issues such as catheter care were up to date and appropriate. There was a log of professional visits and professional correspondence was kept within the files. New care plans were implemented as required when people's support needs or health had changed. A visiting health professional had made the comment, "Care plans are really good. Information is up to date, relevant and easy to access. Made the process of obtaining necessary information easy". Another health professional had commented, "Had a good assessment review of patient [name] with [staff name]. She has good knowledge of residents. Nursing documentation thorough. Good atmosphere in the home".

Food hygiene assessors had been in to the home and were returning in three weeks to check that some minor requirements made had been addressed. We looked at menus and saw they were in the process of changing over to winter menus, incorporating some suggestions from people who used the service. On the day of the inspection we saw there was a choice of cooked breakfast or cereals, toast and preserves. Mid-morning drinks and snacks were offered. Lunch, which was the main meal, consisted of roast turkey, creamed potatoes and vegetables and other choices were available. Tea was soup and sandwiches or alternative choices and for supper people could have tea, coffee, hot chocolate or Horlicks and sandwiches, toast or cereals.

We spoke with the chef, who was aware of people's likes and dislikes, special diets and fortified meals. There were information files for the kitchen and rules for the kitchen included what should be on food trolleys, chef's routing, the role of the kitchen assistant, cross contamination, cleaning, storage and chilling of food. The chef told us there were ample supplies of fresh and dried food and weekly deliveries of meat, milk and bread.

Both staff and people who used the service felt there had been improvements with the food choices. People who used the service were happy with the food and the choices given and commented. "The food is very nice. There is always a choice"; "I enjoy my meals the food is good". A relative told us, "The food is good, there is plenty of choice".

We observed the lunchtime meal and saw five members of staff assisting. Two were serving food to people sat at the two tables, one was behind a food counter and two were giving out tea, coffee and juice from a small trolley. We noticed that all the people who used the service had the same meal. The mealtime experience was lacking in conversation and interaction and we discussed this with the manager. She agreed to review the mealtime experience with a view to improving the atmosphere and communication.

We saw information about nutrition and hydration within people's care files. Weight records were completed where there had been an issue identified and continuing weight loss was addressed via appropriate referrals to other agencies. There had been a recent environmental health inspection and the service had been awarded a 4 Star rating in food hygiene, which is good.

People were asked to give their consent to their care, treatment and support. Care plan agreements and consent for issues such as access to care notes were signed by people who used the service, or their representatives where appropriate.

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 so that they can 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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw evidence of best interests decision making in some of the care plans. For example, a person's capacity had been considered and a best interests decision had been made around the consent to use photographs of an individual for reasons of health and well-being. However, the mental capacity of one individual had been difficult to ascertain due to a language barrier. The service had relied on interpreting body language and facial expression, but not used an interpreter for this person, as required by the MCA to help ensure the individual was given all the tools required to make decisions. We spoke with the registered manager about this and she agreed to access an interpreter to fulfil this requirement

Staff had undertaken training in MCA and DoLS and we saw that DoLS had been applied for appropriately and documentation was kept in people's care files for reference. There was a DoLS file which included the DoLS status on each floor, when the DoLS had been approved, whether it was standard or urgent, when the

relative had been informed and the expiry date. This helped the service keep a check on review dates. We saw that restrictions on individuals were kept to a minimum in line with the legislation. Staff we spoke with demonstrated an understanding of DoLS and MCA.

Good

Is the service caring?

Our findings

People who used the service felt the care was good and staff were kind and caring. One person described how they had been supported by staff through a difficult time in their personal life. Another told us, "They [staff] don't rush me. They help me choose my outfit every day". A third said, "The staff have encouraged the family to visit anytime".

Relatives' comments included; "Beautiful, really nice, gorgeous, can't fault the staff. They are pleasant. My [relative] is happy and settled. They manage him well, I can't fault them" and, "Staff are friendly and they do look after [relative]".

We observed staff interactions with people who used the service throughout the day. Staff were pleasant and friendly and offered care with compassion and respect. We heard friendly exchanges, such as staff members commenting favourably on people's clothes. People were encouraged to be as independent as possible and support was given in a way that facilitated this, for example, cutting up food so that an individual could eat independently.

Privacy and dignity were maintained by staff knocking on people's bedroom doors and waiting to be invited in. Staff were mindful of keeping people's dignity when offering care and spoke discreetly to people about their care needs. However, we saw that a podiatry clinic was held during the day in the coffee lounge. This did not afford privacy for people who used the service and would not be a pleasant experience for others who wished to use the lounge to spend time with relatives and friends. We spoke with the registered manager about this and she agreed to have the podiatrist use alternative facilities in the future.

People's bedrooms were furnished to their taste and had their personal belongings in them to help them feel at home. All rooms were single occupancy and people were able to spend time in their rooms if they wished to have some privacy.

We saw evidence within the care plans that people who used the service and their relatives, where appropriate, were involved with care planning and reviews of care. One relative we spoke with told us they were always involved with their loved one's care and attended meetings at the home. We saw evidence that independent advocates were sourced by the service for those people who had no relatives to represent them.

We saw that there were regular scheduled meetings for relatives and friends to attend. There were regular satisfaction surveys sent out to relatives and friends and feedback was collated, analysed and used to inform improvements to the service.

There was a residents' handbook and service user guide. This included the philosophy of care, information about the staff team, admission criteria, home's facilities, policy on pets, services offered and sample menus. There was information about additional services, such as hairdressing and chiropody, and the cost of these, policy on visiting times, health and safety, complaints procedure and some information around

finances.

There were end of life care plans, where people had expressed their wishes, within people's care records. We saw that, where people did not have capacity to make choices, best interests decisions had been made about where they would stay. Staff we spoke with were not all knowledgeable about end of life care, but support was sourced from the district nursing service when required.

Good

Is the service responsive?

Our findings

People who used the service that we spoke with felt they were listened to. One individual said, "Even when the staff are very busy they will make time for my concerns".

We looked at six care files and they included information about people's backgrounds, interests, significant events and things that were important to them. There were risk assessments in place for issues such as falls, nutrition and skin integrity. We saw body maps and monthly weight recording where required. People's religious and spiritual beliefs were respected and individuals were supported to continue to follow their beliefs. People's preferences for going to bed and getting up, night time routines and requirements, were documented and followed. We saw evidence of regular care file audits, with actions to address any shortfalls.

One care file, where the person was of a different ethnic origin, was not complete. Some signatures had not been obtained, for example for agreement to the care plan and access to notes. There was an issue with the language and the service had some communication cards in place to aid interactions. They also relied on a member of staff who was able to speak the particular language required. Due to the language barrier there were some documents which were incomplete, such as the life history and the end of life plan. We saw that this person liked to stay in their room a lot and did not join in with activities. We discussed with the registered manager the obtaining of music or videos in the person's first language for them to use in their room.

There was an activities coordinator employed full time, who provided activities tailored to people's individual needs. Group and individual sessions were facilitated, and these included arm chair exercises, table top games, film afternoons, shopping trips, arts and crafts, sewing, relaxation hand and arm care, dominoes and card games and one to one chats with people. There was a Halloween party planned with a buffet, face painting and entertainment. We observed the activities coordinator spending time with people in their rooms and saw good, positive interactions
Individual activities were recorded for each person.

There was a monthly newsletter which included events, birthdays, thank yous and dates to remember. There were recipes, stories, poems, puzzles, song lyrics and pictures included within the newsletter.

Questionnaires were completed regularly throughout the year by people who used the service, relatives and professionals. Recent questionnaires completed by people who used the service were positive, with some suggestions for improvements such as less agency and more regular staff. This was being addressed by the registered manager.

On a questionnaire sent to relatives, one person had written "I would not hesitate to recommend Oakbank to anyone who is looking for care or their relative". One professional, within the professionals' questionnaires, had rated the service as excellent and commented, "Made very welcome, files and room to read and write provided without having to ask. Staff very friendly and aware of purpose of visit". Another

wrote, "Working with [staff name] was a pleasure and allowed for an accurate assessment of the service user's needs". A third commented, "I have always found staff to be professional, knowledgeable and happy to help".

Comments written in the comments book included "A very big thank you for everything you did for [relative]. Your care was much appreciated and was second to none"; "Thank you for your care, compassion and kindness". "Words can't convey our thanks to you all for your loving care of our dear friend".

There was an appropriate complaints policy which was displayed within the home. There had been six complaints or concerns recorded for 2017 and these had been responded to and actions taken. One person who used the service told us, "No complaints , everything is fine". A relative we spoke with said, "I have no complaints, if anyone complains there is something wrong with them".

Good

Is the service well-led?

Our findings

There was a registered manager in place. 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.

A health professional we contacted told us, "We have visited Oakbank quite a few times this year. I did not identify any issues of concern". We asked staff if the management were approachable. Staff we spoke with felt supported and said management were approachable. They told us the new registered manager was making improvements and had a clear vision of leading and improving the facility.

People who used the service that we spoke with told us the management were approachable. A relative said, "You can speak to any of them, they are lovely people". Another told us, "[Manager's name] is approachable. She is always in or will give you a phone call".

There was a statement of purpose which outlined the aims and objectives of the service and the values. These values were being revisited by the provider and the intention was to involve staff, people who used the service and relatives in this process. The service had an Investors in People award, which had been renewed in July 2017.

There were systems in place for monitoring and assessing the service and a number of audits were completed regularly. These included care plans, medication, complaints, accidents and incidents. Complaints and accidents were monitored and analysed for patterns and trends so that these could be addressed and outcomes improved. We saw evidence of falls monitoring, including documentation of times, locations, injuries and risk assessment reviews. People were referred to other agencies, such as the falls team, if appropriate. The registered manager had oversight of all incidents at the home. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

Results of questionnaires were analysed and actions taken to address any suggestions or concerns raised. Residents' and relatives' meetings were held regularly and feedback from these meetings was also used to drive improvement. We saw that the results were positive from recent questionnaires and meetings, but the issues raised around agency staff had been addressed by trying to ensure consistency when agency were used, whilst making efforts to recruit regular staff.

Staff supervision sessions and appraisals were undertaken regularly to help ensure staff were supported. We saw evidence of group supervisions to address particular issues, for example, the mealtime experience.

There was evidence of a number of staff meetings, including domestic staff, kitchen staff and care staff. Issues discussed included fire awareness, relatives' meetings, belongings, audits and staff issues. We saw that a quick staff meeting had been convened following an incident that happened within the home, where an individual had left the premises. This demonstrated a quick response to an issue and prompt action to

ensure there was no repeat of the incident. Minutes of staff meetings were recorded and made available to staff who were unable to attend.