Barchester Healthcare Homes Limited

Red Oaks DCA

Inspection report

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Date of inspection visit:
24 July 2018
02 August 2018

Date of publication:
11 September 2018

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

Red Oaks DCA is a domiciliary care agency registered to provide people with personal care. The service provides support to older adults and people living with dementia and sensory needs, who are living in their own home within an 'assisted living' arrangement. The service is located within the grounds of a nursing home which is registered with the same provider. At the time of the inspection three people were receiving a service.

At the last inspection in December 2015 the service was rated Good. At this inspection we found the evidence continued to support the rating of good and there was no information from our inspection and ongoing monitoring that demonstrated any serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since the last inspection. At this inspection we found the service remained Good.

Why the service is rated Good

A new registered manager had joined the service since the last inspection. A registered manager is a person who has been registered with the Care Quality Commission to manage the service. The registered manager had continued to promote a person-centred culture at the service. This ensured people's choices and wellbeing continued to be promoted. People and their relatives told us the service supported them to live independently in their own homes. A relative told us, "If my relative didn't have us or the service they wouldn't be able to live in their own home."

People and relatives told us they felt safe and cared for by the service. One person told us, "They are good people, they help." "It's just the fact they are there." A relative told us, "I trust them and they are kind and friendly." People and their relatives were involved in their care planning and their preferences and choices were respected.

Systems and processes were in place to keep people safe. Health and safety and environmental risks were monitored. Risks were assessed and staff received guidance on what actions to take to mitigate risk and ensure people living with dementia and staff's wellbeing in the community. Staff knew how to recognise the potential signs of abuse and what action to take to keep people safe.

Support with medicine was not being provided by the service. There were arrangements in place with people's relatives and GPs, that ensured medicines were made available to people if required. The registered manager told us that this could be reconsidered, if for example there was a significant increase in the number of people they supported. They confirmed in this circumstance staff would receive suitable medicines administration training, and that they would put in place safe systems and processes in line with the provider's policies.

There were sufficient staff available to ensure people's wellbeing, safety and security was protected. One

person told us, "They arrive on time and are good at helping us." People's preference to have support from a dedicated pool of known staff had been respected and introduced. A robust recruitment and selection process was in place, to ensure new staff had the right skills and were suitable to work with people living in their own homes.

Staff continued to work in line with the Mental Capacity Act (MCA) 2005. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People's communication needs were met as staff had a good understanding of people's methods of communication including their sensory needs. People and their relatives told us they could communicate with the service, and receive information in a way that met their needs. One person told us, they always listen, they don't always have to agree with us, but they always listen." "They never say you can't do that." When required, people had access to technology that promoted their independence.

People were supported to maintain good health and maintain a healthy, nutritious diet and had assistance to access health care services when they needed to. Staff understood the importance of supporting people and their loved one's in relation to end of life care, as well as living a full life while they were able to do so. People's important relationships were respected.

People and their relatives spoke positively about the service and how it was managed. The service's leadership and value base continued to be reflected in their staff members actions and motivations. One person told us, "They would do anything you ask them." A relative told us they felt the registered manager had the service 'well in hand' and that, "They do what they do, very well." The service had an open transparent culture, where feedback, complaints and surveys were encouraged and acted on.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Red Oaks DCA

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 comprehensive inspection took place on the 24 July and 2 August 2018 and was announced. It included visiting the site office, speaking to people and speaking with relatives by telephone after the site visit. This was so we could further understand people's experiences. The inspection team consisted of one inspector. We gave the service 48 hours' notice of the inspection visit because the location provides a small domiciliary care service and we needed to be sure the people using the service, the registered manager and staff we needed to speak to were available.

Before the inspection, we reviewed information available to us about this service. This included notifications from the service and information shared with us by the provider. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the site visit we spoke with four staff and the registered manager. We looked at two people's care plans, four staff files, staff training records, policies and procedures, quality assurance documentation and information and policies in relation to lone working and medicines. We spoke with three people using the service and two relatives during the inspection process. We have included their feedback in the main body of the report.

Good

Is the service safe?

Our findings

People and their relatives told us they felt the service was safe and that they knew and trusted staff. One person told us, "They are good people, they help." "It's just the fact they are there." A relative told us they felt their loved one was safe, "Because I have got to know them, I trust them and they are kind and friendly."

People remained protected from the potential risk of abuse because staff understood people's needs and the types of abuse people living with dementia experienced. Staff received training and guidance on how to recognise and report abuse and were confident that if they raised a concern with their manager it would be taken seriously and acted on. The registered manager and deputy manager were aware of their responsibility to liaise with the local authority if safeguarding concerns were raised. Staff received training in equalities and diversity awareness to ensure they understood the importance of protecting people from all types of discrimination. One staff member told us, "I would like to think if someone who was gay or from a different ethnic background, came into the company that they wouldn't be discriminated against. It's people's qualities that are important."

Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. This included measures that could be taken to avoid risk in relation to personal hygiene, continence, nutrition and pain management. For example, two people were supported to maintain an active routine, that promoted regular eating patterns. The registered manager and staff told us that this was designed to ensure they were not placed at risk of malnutrition and to promote their emotional and physical wellbeing. Records and staff demonstrated that staff were confident on how to respond if people became unwell while they were supporting them. Staff knew how to obtain support and advice from the ambulance service and the provider through senior manager's on-call systems

Staff were provided with guidance in relation to environmental risk, lone working, infection control and potential hazards such as fire and utilities failure. There was also guidance available detailing what to do if people did not respond when staff attended a visit or staff were delayed. Records demonstrated that allocation was reviewed during daily managers meetings and all visits detailed in daily logs. Staff received infection control and food hygiene training and told us how they would promote people's wellbeing including through safe infection control. Staff were aware of the importance of using personal protective equipment (PPE) to avoid cross contamination when supporting people including with their food and laundry. The provider ensured staff had access to, and used gloves and aprons when needed.

Where accident, incidents and near misses had happened, staff continued to take appropriate action to ensure people's safety. The registered provider had systems in place to spot patterns when accidents occurred and worked proactively to keep people safe. For example, during our visit, one person's access to hot water had been interrupted and staff noted, that they were potentially at risk of dehydration due to their home being hotter than usual. The registered manager investigated the cause of the interruption, and assessed how to ensure the person's safety and the safety of others, while the issue was resolved. This was done by checking other people's living environments, reviewing what happened and taking immediate action to reduce the likelihood of reoccurrence.

The service remained open to learning and to anticipating improvements. For example, the registered manager had identified that as people were living longer in their own homes, the assisted living arrangements would need to adjust with people's mobility needs. In response to this they had involved people and relatives in reviewing how to make the assisted living building more accessible. For example, resident's meetings detailed planned improvements including widening the steps to a garden area and the introduction of handrails.

There remained a sufficient number of staff on duty to meet the needs of the people. Staffing levels were planned around the needs of people and rotas showed these were consistent. People, their relatives and staff confirmed this. One person told us, "They arrive on time and are good at helping us." Staff told us they had sufficient time to meet people's needs and were able to build a rapport with them and their relatives. One staff member told us, "I have enough time to provide support, and always take time to make time. Five minutes can make a big difference for some people." Staff absence, such as annual leave or sickness, was addressed during a daily allocations meeting, and the service had a core group of staff available for short notice cover.

Staff recruitment processes continued to ensure that staff were safe to work with people. Staff files included previous work history, application forms, proof of identity and suitable references. Records demonstrated that checks had been made with the Disclosure and Barring Service (DBS) to ensure staff were suitable to work with people. The registered manager acknowledged they had an established group of workers, who were committed to caring for people in their own community. This was reflected in a low staff turnover and staff feedback surveys that demonstrated people were committed to their work and employer.

At the time of the inspection no one received support from the service to manage their medicines. There were arrangements in place with people's relatives, that ensured medicines were made available at short notice if required, for example for pain management. People and their relatives told us that support was not currently provided with people's medicines. Records including service agreements confirmed this. The registered manager told us that if the need for support with medicines significantly increased, they would review arrangements to ensure staff were appropriately trained to administer medicines.

Good

Is the service effective?

Our findings

People and their relatives told us their preferences, choices and care needs were consistently met by staff that had the skills, knowledge and competencies to do so. One person told us, "You feel it, that they know what to do." A relative told us, "Yes staff have the skills they need, and I am very confident in what they do."

People received care that remained responsive to their needs. The registered manager and deputy manager undertook initial assessments of need prior to people receiving a service so that they could ensure they could support them. Care plans were designed around the needs of each person. This included any provision that may need to be made in relation to the Equality's Act 2010. For example, where people had religious or cultural beliefs that may need to be considered when delivering care. Records were accessible, clear and gave descriptions of people's needs and the support staff should provide. One staff member told us, "I read the care plan and always fill in the daily notes, how the person's mood appears, what they've eaten and that I've topped up their drinks to ensure their fluids are monitored."

Staff continued to be well supported and equipped to carry out their roles. Staff received mandatory training and inductions that included, mentoring and shadowing experienced staff who could demonstrate how to work with people with complex needs. Training records confirmed that regular training updates were planned for and provided. Staff also had access to training that was specific to the needs of the people using the service, including dementia, palliative care and the Mental Capacity Act (MCA). One staff member told us, "I enjoy dementia training, as what it helped me understand was that there isn't just one type of dementia, they differ." They told us that this was important as it meant they could deliver the care that was specific to that person's needs through better understanding.

Staff told us they had regular supervisions, appraisals and observational supervisions 'spot checks' of their practice. One staff member told us, that they had always asked for feedback and received helpful feedback from managers. For example, they had started with the provider in a different role, but were encouraged to consider a caring role as a career path. The provider and registered manager recognised the importance of continual professional development and open dialogue with staff to inform best practice. New staff completed the Skills for Care Certificate. The certificate is a set of standards for health and social care professionals that ensure workers have safe introductory skills and knowledge.

The Mental Capacity Act 2005 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 capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

People's rights continued to be protected. The registered manager, deputy manager and staff understood and worked in line with the principles of the Mental Capacity Act 2005. There were policies in place and staff

told us they had completed training, and had access to guidance within their policies to inform when people's level of capacity required assessment.

People told us they were offered choice in an accessible and meaningful way. One person told us, they always listen, they don't always have to agree with us, but they always listen." "They never say you can't do that." We observed staff using a range of communication methods. Staff listened, observed facial expressions and ensured they acknowledged what the people said by repeating their words and checking they had understood them. Consent was always asked for and gained prior to support being given and people and their relatives confirmed this.

People were consistently supported to be as independent as possible in accessing their local community and making their own meals, or accessing meals of their choice. For example, were relatives arranged people's food shopping, staff promoted people's independence, by supporting them to choose their meals daily. Where people chose to eat at the provider's nearby care home, staff ensured they had a copy of the menu to make their selection from. Some people had access to technology and adaptations to their home. Staff encouraged the use of these items including; portable telecare alarms, grab rails and mobility aids to ensure they could live as independently as possible in the community. One person who had a walking aid to improve their mobility told us, "The staff tell me to use it every day if I can."

Staff continued to demonstrate a good understanding of people's health needs and could describe how they ensured they maintained a healthy weight and had access to food and nutrition. One staff member told us they monitored and recorded what people drank because they were aware that the impact of being dehydrated on an older person's health and wellbeing was significant. Health needs were reviewed and planned for with the support of the person's GP and relatives. For example, one person had experienced a period of illness that required them to spend time away from their partner. The registered manager worked closely with the person's relatives and local GP surgery to ensure they had access to respite care, so they and their partner could fully recover.

Good

Is the service caring?

Our findings

People continued to be cared for by kind and caring staff. Throughout the inspection people and their relatives were positive about the care given and the relationships they had with staff. One person told us, "Staff are caring, I notice what they do." A relative told us the staff member who visited their loved one was, "Genuinely a caring person," and that they always felt welcome when staff were present.

People and relatives were comfortable with staff who met their emotional needs. During the inspection one person changed their plans for lunch, due to a maintenance issue in their home. This change of routine could have confused or made the person anxious. However, staff supported the person to eat at the provider's care home at short notice. While supporting the person staff remained reassuring and focussed on the person's emotional and physical needs. For example, they made time to sit with the person and talk with them about what was happening and what choices they had for lunch. Staff were genuine and warm in their conversation with the person, gave good eye contact and adjusted their tone to support the person's hearing needs.

People received care from staff that knew them well and that they were compatible with. Schedules of visits were organised so that the support was provided by a small number of staff. Staff could describe people's, likes, dislikes, background and routines. For example, one staff member knew that one person had been a keen gardener and had arranged floral displays in their local church. They engaged the person in conversations about their outdoor plants and how they could spend time outside later in the day. Staff remained well motivated and promoted people's wellbeing and ability to live independently in their own homes. For example, one person was being encouraged to increase the amount of walking they did, so they could improve their mobility and visit their local community more regularly.

People were consistently supported to make informed choices. One person told us, "They come and give a little help, we are independent, we do what we want." Another person had recently had a respite stay to help them recover from a health issue, before returning home. They had spoken with their relatives, the staff and their doctor and told us, "We agreed it was for the best." Staff told us they always ensured people gave consent on entering homes, supporting personal care and offering food. Staff told us they encouraged people living with dementia to take positive risks and to do as much as they could for themselves. For example, where people needed support with personal care, staff would encourage people to wash as much of their own body as they could.

People's diversity and important relationships remained respected and promoted within their day to day experience and care planning. For example, people's religious beliefs and how these were expressed, were detailed in care plans, and where they practiced their faith they had access to multi denominational faith services within their community or at the adjacent care home. Staff were respectful of maintaining people's important relationships and understood that established couples may still want to carry out some part of each other's care. For example, one person liked to lay out fresh clothes for their loved one while they were bathing.

People's human rights were continually protected. Staff understood the importance of respecting expressed views. We observed staff responding to peoples wishes during the inspection. Relatives confirmed that people were always included and involved in making decisions about their care. Where people did not have relatives involved, the registered manager was aware that people had the right to have an advocate involved and knew of local advocacy providers. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

People's privacy continued to be respected, staff understood their responsibilities in maintaining people's dignity while supporting personal care and privacy in relation to confidential information. Care plans and electronic records were kept secure and access limited to people who needed to know.

Good

Is the service responsive?

Our findings

People were supported with personalised care that continued to respond to their needs. People were involved in making decisions about their care and support needs, by staff who listened to them. One person told us, "I would ask if I wanted something changed, it doesn't hurt to ask." A relative told us that as their relative's needs changed the service adjusted to meet the changes.

Staff remained knowledgeable about people's life histories and expressed wishes. Staff understood people's needs and had positive relationships with them and their relatives. One staff member told us that one relative was very involved with their relation's care and worked closely with the service. They told us, "They pick up the phone when we call, and always leave a note if they have any concerns they feel we should know about."

Initial assessments of need were completed by the registered manager and deputy manager to ensure the service was able to meet the person's needs. Care planning considered people's and their relative's expectations for their life and future goals. The registered manager was aware that this process needed to be managed sensitively to support people and their relatives to make the accurate decisions about their care and support needs.

Care plans remained personalised and detailed people's life experiences, interests, activities, preferences including what name they preferred to be called and who or what was important to them. For example, one person had key memories and interests detailed including; the birth of their first grandchild, golfing holidays and that they really enjoyed horticulture and puzzles. This was recognised within their care planning and assisted staff to promote the person's interests and build a rapport with them. For example, the person enjoyed being outdoors, kept pot plants in their garden space and regularly completed puzzles. Their relative told us, "The outdoor space is like a little oasis. They still dead head their plants"

Care plans continued to provide guidance on how people's needs were to be met including; physical, emotional and communication needs. Staff we spoke with found the care plans to be informative. Staff were knowledgeable about the emotional and physical care needs of the people they supported and had a good awareness of their relationships with their wider family networks. The registered manager told us, and staff demonstrated in their conversations with us, and people, that they remained non-judgemental of people and their relationships. Staff were conscious of what adjustments they needed to make to ensure people at risk of isolation received personalised care. For example, when people moved to the assisted living service, they were always encouraged to participate in resident's meetings and spend time in the communal spaces and local community.

People benefitted from telecare equipment that ensured they had someone external to the service to contact in an emergency, which further ensured their independence. Relatives spoke positively about how the service had promoted independence. One relative told us of the progress their loved one had made since moving to their home, "My relative is still independent, they still put themselves to bed, get up and take part in the day."

People's communication needs were anticipated and met as staff were given guidance and had a good understanding of people's methods of communication, their sensory, psychological and cultural interests. For example, one person living with sensory needs and memory issues found it difficult to process spoken information. One staff told us, "I adjust my communication with one person due to their hearing needs, I check they have their hearing aid in, I use smaller words, shorter sentences, speak slowly and give them the time they need to respond." People and their relatives told us they were able to communicate with the service, and receive information in a way that met their needs. This included information provided in the service welcome pack, the use of emails and texts. People and relatives who were potentially seeking information about the service prior to choosing a provider had full access to information made available through their website.

People and relatives remained confident that complaints would be taken seriously and were happy to raise anything they were unhappy about with the registered manager. One person told us they spoke to staff when anything went wrong and it was always sorted. A relative told us, "The registered manager would be my first port of call," and that any problems they had were always sorted. We looked at the complaints policy and the registered manager told us there were systems and processes in place including; weekly coffee mornings where people and relatives could discuss any concerns. An example of this was where people had requested more regular staff to provide the domiciliary care service. The registered manager had ensured a dedicated group of community skilled workers was made available in response to this feedback.

The registered manager acknowledged the service had a focus on people who were able to live in their own homes independently. However, they recognised that it was important to encourage people and their relatives to consider end of life care planning and ran a session on this in a resident's meeting. Staff told us they had received training and could describe how they would support people to experience a comfortable, dignified, pain free end of life that including their wishes and those of their relatives.

Good

Is the service well-led?

Our findings

People and their relatives told us the service was well run. One person told us, "It's very good they keep a check on you." Another person told us, "They would do anything you ask them." A relative told us they felt the registered manager had the service 'well in hand' and that, "They do what they do, very well."

There had been a change in the registered manager since our last inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager, deputy manager and regular staff continued to promote a person-centred culture at the service. There were systems and processes in place that ensured staff were clear about their responsibilities. This included clearly defined schedules, tasks and access to policies and senior staff when advice or assistance was required by staff. In addition, staff were also supported to attend regular staff meetings that promoted team work. One staff member gave an example where the registered manager had taken on board and acted on some staff concerns that uniforms were not being maintained in a good condition, and this was addressed. This ensured people's choices and wellbeing was promoted. One staff member told us, I want to make a difference to people living in the later stages of their lives, I want to them to have a happy life." The service's culture and value base of supporting people to live in their own homes remained embedded in the service. Staff, people and their relatives told us the service supported them to live in their homes as long as they could. A relative told us, "If my relative didn't have us or the service they wouldn't be able to live in their own home."

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). The registered manager had submitted notifications to us, in a timely way. This meant we could confirm that appropriate action had been taken. There was a policy in place in relation to the Duty of Candour and the manager was aware of their responsibilities under the Duty of Candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment of people.

People and their relatives told us they were engaged and involved in making improvements. Regular coffee mornings, resident's meetings and surveys were held and people and their relatives were encouraged to have their say on how their day to day care and the assisted living building could be improved. Action had been taken when improvements were suggested. For example, in December 2017 people fed back that they wanted a dedicated staff member at the assisted living service. In response, the registered manager delegated one staff member a day to the service and reduced the pool of staff working with people. To enhance people's support further, they designated a lead staff member who had community work experience. People have fed back that this has improved the consistency of the service. This demonstrates that the service is responsive to feedback from people.

Quality assurance arrangements were in place to manage the overall quality of the service, and identify areas for learning and improvement. These checks included making sure that care continued to be provided in the right way. Ensuring care plans were reviewed and surveys and feedback were learned from. In addition, managers had oversight of staff training and monitored practice through observed supervisions. This ensured the quality of the service was maintained and staff had the knowledge and skills they needed to support people. The service worked in partnership with their local GP surgery, a local hospice and dementia groups to support people and their relative's awareness about dementia and end of life care planning.

People and their relatives told us that they could would discuss any concerns they had with the managers and were confident they would be heard. One relative told us they would be confident approaching the registered manager about any concerns or suggestions as, "Nothing's ever too much trouble for them." Another relative told us, "It's all about the relationships between, the service, people and their families, we work together." People, relatives and staff told us they were involved in community events that took place on a regular basis; including a local garden and arts festival, and garden parties.