Oxford House Community Care

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Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out this inspection on the 27 November 2014.This was an announced inspection. We gave the provider 48 hrs notice of our visits to make sure we could access the people and information we needed to.

When we inspected Oxford House Community Care in December 2013 we found they met all the regulations inspected.

Oxford House Community Care provides care and support to approximately 215 adults and older people in their own homes. This includes adults with physical disabilities and older people living with dementia. Oxford House Community Care does not provide services to children.

Oxford House Community Care has a registered manager. A registered manager is a person who has registered with

Summary of findings

the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Whilst people were positive overall about the quality of the care they received, a number told us they did not always get their visits at the time they expected. They were satisfied care staff stayed for the time they were supposed to. However when there were changes in their regular care staff they were not always told of this beforehand. Care staff reported that whilst in most cases they had full details about people they provided care for, in cases where they went at short notice, this had not always been the case. In those circumstances they had to ask the person concerned or consult the care plan in the home before they were able to provide care effectively.

People's safety was maintained and protected. Staff received regular training and support they required to provide a high standard of care to meet people's needs. Care plans set out clearly how people preferred their care to be provided. People were involved in making decisions about their care.

People were supported to eat and drink and take their medicines. Staff received the appropriate training to enable them to do this safely and effectively.

Staff said they felt well supported by the provider and management team. The provider sought feedback from staff, people who received care, their relatives and from professionals responsible for arranging care. They were very proactive in looking at new ways to provide care and were involved in a number of innovative pilot projects in partnership with other providers and local authorities.

Summary of findings

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.

Risks to people's health, safety and welfare were assessed and then eliminated or managed to protect them from avoidable harm.

People were protected from abuse because staff received safeguarding training to ensure they could recognise abuse if they saw it, knew what action to take and how to report it.

People were protected from the employment of unsuitable people to provide their care. This was because before staff started work, they were subject to a rigorous recruitment process.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Whilst people received the length of visit they expected, their visits were not always at the time they expected and their care was not always provided by a consistent team of care staff. People were not always informed when care staff changed or were running late.

Staff understood the implications of the Mental Capacity Act 2005 for the way they supported people to make decisions for themselves wherever possible

Staff received the training and support they needed to provide effective care. This included assisting people to eat and drink, manage their medicines safely and provide the help required with their personal care.

Is the service caring?

Good

The service was caring.

People were very positive about the way their care was provided. They told us their dignity was protected and that they were always treated with respect.

People were involved in decisions about their care and staff supported them to maintain their independence.

People told us they had no concerns about staff discussing their care and support inappropriately with other people.

Is the service responsive?

Good

The service was responsive.

Care plans were in place to give care staff the information they required to identify people's needs and how they liked them to be met.

People said whilst care staff were busy, they still enjoyed their visits and felt they were friendly and interested in them as individuals.

Summary of findings

People and their relatives knew how to make complaints if they had need to do so. Most people said they were more likely to deal with any problems informally and were confident they would be listened to.

Is the service well-led?

Good

The service was well-led.

People who received care and those responsible for arranging it for them benefitted because the provider actively sought improvements in service delivery and ways of working.

There were a range of audits and performance measures in place to enable the service quality to be assessed.

People who received care, staff who provided care and those individuals or organisations responsible for people who received care benefitted because the management and systems of the service were well-resourced to provide effective support for them.

Oxford House Community Care

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.

The inspection was carried out by one inspector 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. In this case older people, including those living with dementia.

Before the inspection we reviewed the information we held about the service. This included information the provider had sent us in their Provider Information Return (PIR). The PIR asks the provider for some key information about the service; what it does well and any improvements they plan to make. We reviewed notifications the provider had sent us since the previous inspection in December 2013. These were about significant events affecting people who used the service, including safeguarding referrals.

We sent 183 questionnaires as part of this inspection. These went to people who used the service or their relatives, staff and community health and social care professionals including GPs and local authority commissioners who arrange care for people from Oxford House Community Care. We received 38 responses, including 28 from people who used the service or their relatives, six members of staff and four community health or social care professionals. We directly contacted 20 professionals who worked for three local authorities as commissioners of social care or who were care managers responsible for individuals receiving care from Oxford House Community Care. We received four responses on behalf of the 20 people contacted.

During the inspection visit we spoke with the registered manager, two senior administrative staff and four care staff, we looked at three staff training and recruitment records and three care plans for people who had recently started to receive care and two for people who had done so for longer periods. Following the inspection we contacted 12 people who used the service and two relatives, with the service users' agreement. We received additional feedback from two social care commissioners as well as from the provider in response to requests we made for clarification or to provide further evidence where that was needed.

Good

Is the service safe?

Our findings

All the people who responded to our questionnaires agreed they felt safe from abuse or harm from the people who provided care. Fourteen other people we contacted said they felt safe with care staff and could rely on them. One of them said; "I used Oxford House when I cared for (a relative) and I was happy with them, now I use them for myself." People also confirmed their care was provided by the correct number of care staff.

Staff confirmed they had received safeguarding adults training. Training records confirmed this was the case, showing initial training during induction for new staff and periodic refresher training thereafter for all staff. Staff were able to explain to us what constituted abuse, how it might be recognised and they knew what to do if they saw or suspected it.

During the course of the previous 12 months we had received details of safeguarding referrals made to the local authority because of concerns staff had identified. We saw copies of the provider's safeguarding policy were readily available to staff. As the provider's area of operation covered more than one local authority area, we confirmed specific procedures were in place in respect of each one. The contact we had with local authorities about safeguarding was positive. The provider had informed the Care Quality Commission (CQC) about any safeguarding referrals and had kept CQC informed of progress and actions taken in each case.

People told us they thought the service was sometimes short-staffed and staff had to contend with adverse traffic at peak times of the day. One commissioner of care said whilst they had no current issues or concerns with Oxford House Community Care, they were aware there had been recent staffing capacity issues which had led to visits being late and not always by regular care staff. The provider also acknowledged difficulties in recruiting additional staff locally was a problem for all care providers. The provider had less problem retaining staff and had introduced incentive schemes to promote loyalty and reward good practice.

People received the help they needed with their medicines. They did not raise any concerns with

CQC about how this was done. Six people had pre-filled daily medication containers which they said care workers helped them with. Staff confirmed they received medicines training and training records supported this. The provider had a detailed medicines policy and procedure in place. Although people were satisfied with the support they received with their medicines, in the Provider Information Return (PIR) the provider reported there had been 14 medicines errors in the previous 12 months. Where this was the result of staff error, additional training was provided and enhanced supervision put in place. There was also a review of medicines practice undertaken.

People were protected from identifiable and avoidable risk. Risk assessments were undertaken when initial referrals for care were received. Risks to the person or to staff were identified and plans put in place to manage or eliminate those risks.

Care plans included risk assessments for moving and handling, environmental risks, health and safety and medicines. We found risks were reassessed at regular intervals or when any change in risk became evident. The PIR included evidence that where risks had changed appropriate action was taken. This had included additional equipment being provided to help people move, an increase in staff numbers and in rare cases determining care could no longer be provided safely by care staff in the person's home.

The provider had a business continuity or disaster recovery policy. This identified those people who received care and who would be at greatest risk if care was not provided. This allowed the available resources to be prioritised. It also set out what procedures would be followed in the event, for example, if a large number of staff were incapacitated by illness or in the event of very severe weather.

All computer systems were protected by passwords where they held confidential information. The systems were protected by the use of robust servers, with main, back up and remote capability to ensure important data would not be lost in the event of any foreseeable emergency. Staff received training in first aid and we were given examples where support had been provided for people in an emergency, for example following a fall in their home.

When staff were recruited, appropriate checks were made to safeguard people who received care and support from the employment of people who were not suitable to do so. This ensured people had the right skills, experience or potential to provide safe and effective care. Staff

Good

Is the service safe?

recruitment files included evidence of previous employment and education with any gaps identified. Checks were made with the Disclosure and Barring Service (DBS) to identify any previous criminal convictions.

References as to character and competence were also obtained from previous employers, together with confirmation about the applicant's physical fitness for the role.

Requires Improvement

Is the service effective?

Our findings

People said they felt care staff were able to meet their specific needs. "I tell them what I need and they can all do it. I have been living with this (disability) for so long I know exactly what I want." One person thought care staff; "Struggle with my stockings, they could give them some training, the nurses do it." One relative thought training in the use of walking aids and competence when showering would be helpful as they thought it was sometimes unsatisfactory.

The people who responded to our questionnaires agreed care staff had the skills and knowledge needed to provide their care and support effectively. This included people who used the service, relatives and friends and community health and social care professionals, for example commissioners of care.

People said the timing of calls could sometimes be inconsistent. Two thirds reported their care staff arrived on time whilst one third said they did not. "Carers are very good, very good about timing" and "Yes they are very reliable, I've been using them for about 10 years now." Six people told us that if they could make one improvement it would be the timing of their visits. Three people said there had been a recent improvement in the consistency of timing of their visits whilst two people gave examples of how the timing of their calls remained unsatisfactory to them. One partner of a person who received care said they had to go to bed at 8.30 pm which suited neither of them as "all the good television programmes are after 9pm." One person told us three weeks before we spoke with them, their 8.45 pm call had been at 4.30pm although that was not usually the case.

There were different experiences recorded by people about the consistency of staff who provided care and support for them. Some reported a difference in their experience as between staff during the day and the evening or weekend. Those people who enjoyed consistent care from a regular team of care staff were most positive "I love my carers and they love me… (care worker's name) has been coming to me for ten years." Others were less so; "At times the carers are very different

and then I have to explain it each time." Another person noted "They are always changing, lots of new staff."

The challenge of recruitment within the local care sector impacted directly upon the service's ability to provide staff consistency for people who received care. To address this staff had been canvassed about a move towards more fixed hours of work to provide greater stability and consistency for them. There had been a detailed consultation process about this to ensure staff could make their views known and influence any decision about potential changes to their terms and conditions.

Two people told us they experienced difficulty understanding some care staff because of their accents. "Sometimes I have difficulty understanding some of the carers, initially it is difficult" another person said; "I wear myself out trying to talk to them, a lot have language difficulties and it is very tiring." We were told by the provider that recruitment of staff included competency checks in respect of spoken English. Support was given when required to improve verbal communication of staff where English was not their first language. The provider also noted that having care staff able to speak languages common within the local population, as well as English, could also be an asset, as it enabled people they provided care for to communicate in their preferred language.

There were mixed experiences about communication of changes to care staff or when visits were delayed. One person said they were always notified if there was to be a change of care worker. Three other people said this seldom or never happened. In the responses to our questionnaires only 40% of those who responded said they were always introduced to their care worker before they provided care or support and only 50% of care workers said they were. People also had different views about communication when care workers were 'running late.' Most said they now expected there to be a delay because of traffic and the number of calls and distance care workers had to contend with. One person, who said they had often needed to ring to find out when their care worker was coming, also noted that in the previous three weeks things had improved.

The majority of people we contacted by telephone said they did not feel care staff were rushing them whilst providing their care although one person noted; "You know they are in a hurry." Another person said; "Sometimes the carers are good but some not so good. Sometimes they rush me;" and another noted; "Some are very good, some can't get in and out quickly enough."

Requires Improvement

Is the service effective?

One commissioner of care said whilst they had no current issues or concerns with Oxford House Community Care, they were aware there had been recent capacity issues which had led to visits being late and not always by regular care staff. The provider also acknowledged difficulties in recruiting additional staff locally was a problem for all care providers. The provider had less problem retaining staff and had introduced incentive schemes to promote loyalty and reward good practice.

One person reported a call had been missed and one commissioner of care also reported being aware of one missed visit. In both cases, contact had been made by the provider at the time the visit was missed to address this and offer an apology.

Staff told us they were supported by extensive training. We saw training records which detailed what training was required and when it had been undertaken. Training was provided both in house and through external training organisations. For example, end of life care training was provided through the provider's associated care home. Staff were aware of the implication for their care practice of the Mental Capacity Act 2005 (MCA). This is important legislation which establishes people's right to take decisions over their own lives whenever possible and to be included in such decisions at all times. We confirmed with staff, the provider and from training records that training on the MCA was included for all staff within the safeguarding training they received at their induction and through subsequent updates.

Staff who responded to our questionnaire stated they understood their responsibility under the MCA. Staff told us how they approached people who may not be able to make all decisions for themselves. They were able to describe how the person's best interests were safeguarded and how they would support people, wherever possible, to make choices about care for themselves. Senior care staff and the provider worked together with local authority care and commissioning services to ensure appropriate mental capacity assessments were in place and these were included, where applicable, in care plans.

We saw records of regular staff supervision, appraisals, team meetings, newsletters and other information provided to staff. These highlighted specific issues and areas of care and supported and encouraged the development of the staff team. Staff who responded to our questionnaire also confirmed they had received induction training before they worked unsupervised (100%), received regular supervision (67%) and received the training they required to meet people's needs (83%). we saw records of unannounced checks carried out by senior care staff to monitor the effectiveness of care staff in people's homes.

Each of the care staff we spoke with confirmed they had opportunity and felt able to discuss their own performance or any issues or concerns they had about their role with senior care staff and the provider/registered manager. One member of staff said; "Best job in the world, support is so good, they are there for you." They cited the support given to them following the death of a person they provided care and support for, as an example.

Care plans we saw included contact details for family and health services relevant to the person. Staff told us they would support people to attend appointments, for example by calling earlier than usual to help them get ready. They were able to give examples of how they passed on concerns about people's health to family carers or health professionals to ensure people had access to the specialist health support they required.

Care plans and care staff programmes of work included details of any support people needed with food and drinks. Staff received training in food hygiene to ensure they maintained safe and effective practice when doing so.

Good

Is the service caring?

Our findings

People who received care and support were overall very positive about the standard of care they experienced. People told us they were happy with the care and support they received and six relatives said the same about their relatives' care. Comments included; "They are very good"; "They are very caring;" "They do a good job and look after (name of relative) very well; most of the staff are lovely." One relative wrote to the provider; "Mum was not well this weekend and I wanted to thank you for looking out for her. As usual the carers were both so caring."

All the people we contacted by telephone said they were treated with dignity and respect. One person noted; "They always treat me with respect when they visit, all of them." One person gave a positive example of how they were supported; "They are very respectful, they help me onto the bedpan and then leave the room and wait until I call them back in." All of the relatives we contacted said they felt their relative was always treated with respect. All four of the commissioners of care we received information from said people were treated with respect and that the staff they met were all 'kind and caring'.

Care plans included contact details for family and professionals involved with the person's care. People told us they were able to discuss their care with their care worker and that they felt able to ask them to do things in the way they preferred. Care plans included details of people's preferred routines.

Staff told us they always asked people how they wanted their care provided. They had a good understanding about how independence and choice could be promoted although they acknowledged pressure of time sometimes made this difficult to achieve. People who received care and support told us they felt staff helped them retain independence and control over their own care as much as was possible for them.

There were currently two people receiving advocacy support (This is independent support provided to ensure the person's view is heard and understood). This was usually arranged by or through the local authority, however the provider confirmed they had appropriate information and contact details available for anyone who required it.

Where people had specific cultural food or care requirements these were noted in care plans so that care staff were aware of them and could provide care and support sensitively. The provider tried to match staff with particular insight or language skills to appropriate people to achieve this.

The provider had an associated care home and was able to access nurse led palliative care training where that was required. We saw an e-mail from one relative praising care staff for the care provided when their relative had a heart attack. Care staff were aware there was no instruction in place from the person about resuscitation and under supervision by phone from the emergency services administered cardio pulmonary resuscitation successfully until paramedic support arrived.

Good

Is the service responsive?

Our findings

People said the timing of calls could sometimes be inconsistent. Two thirds reported their care staff arrived on time whilst one third said they did not. "Carers are very good, very good about timing" and "Yes they are very reliable, I've been using them for about 10 years now." One relative said: "The fact that our mother had a regular, almost dedicated group of carers, worked extremely well for her as they were all able to understand her likes and dislikes and tailor their care accordingly."

Six people told us that if they could make one improvement it would be the timing of their visits. Three people said there had been a recent improvement in the consistency of timing of their visits whilst two people gave examples of how the timing of their calls remained unsatisfactory to them. One partner of a person who received care said they had to go to bed at 8.30 pm which suited neither of them as "all the good television programmes are after 9pm." One person told us three weeks before we spoke with them, their 8.45 pm call had been at 4.30pm although that was not usually the case.

People said the length of their visits was usually what they expected and required. One person said; "I don't think they give them long enough to do the job, but they do it anyway."

People told us they were involved in decisions made about their care and support needs. Relatives also told us they were consulted, with their relatives' consent, in the decision-making process relating to their care and support.

People were very satisfied with the care they received from their regular and familiar care staff. They told us they had a good relationship with them and that the care staff knew how they liked things done. Where there were short-notice changes in care staff or where visits were outside of the expected time people were less satisfied although they told us they knew the service was short-staffed and staff had to contend with adverse traffic at peak times of the day.

Staff were able to tell us about the care needs of the people they provided care and support to. They spoke of them as individuals and knew, in the case of those they supported regularly, how they preferred their care given. They were aware of people's family circumstances and important events and people in their lives. They acknowledged this was not always the case when they went at short notice to a person who was unfamiliar to them. However, they told us they always read the care plan to get the basic details they required and would also ask the person themselves about how they wanted their support provided.

We saw six recent e-mails from the service to local authority care managers or commissioners of care. These reported specific circumstances which related to changes in people's care needs. For example, one requested height-raisers to be fitted to one person's chairs as they were unable to see out of their window. Some were about changes in family or financial situation which impacted on the person's health or well-being. We also saw requests for reviews to be carried out made to local authority care managers as well as responses from the service to requests from local authority care managers.

We saw examples where people's care had been temporarily rescheduled to take account of health appointments or social engagements, for example family celebrations. This showed the provider was able to offer flexible care and support to people.

Community health and social care services told us they were very satisfied with the responsiveness of the service to any instructions or advice they gave. They said the service co-operated with them and other related care services and shared relevant information appropriately. Examples were provided about changes in people's care and how information had been shared to ensure changes in the care and support provided were put in place without undue delay.

The care commissioners who provided information about Oxford Community Care were positive overall about the level of communication with the provider, for example in providing updates on, or requesting reviews of, individuals' support packages.

Care plans included variable amounts of personal information. Those for people who had received care for longer included more information about the person and their care, much of this was obtained during regular reviews of care which took place. This enabled care delivery to be changed and better focussed on both the assessed needs of the person and also on how they wanted their care provided and by whom.

We saw copies of the compliments and complaints policy. This was provided to all people who received care and support. It included contact details for the service and local

Good

Is the service responsive?

authority commissioners of care, the Local Government Ombudsman and the Care Quality Commission (CQC). People said they knew how to make a complaint. Relatives said the service responded well to concerns or complaints.

People had mixed experiences of the response they received to any concerns they raised. One said; "I can telephone the agency if I need to grumble and they will sort it" another said "I know the woman in charge, she is always helpful and came herself the other morning." Other people said they did not bother to complain or complete surveys sent to them by the service as they felt it was "a waste of time."

In the PIR we were told there had been 13 complaints in the previous 12 months. Of these, 12 had been resolved and one recent one was being followed up. In the same period there had been 86 compliments about individual care staff or the service in general.

Good

Is the service well-led?

Our findings

There were a range of different views expressed about communication with the service. Care staff said they were confident about reporting concerns about care or poor practice to their line manager or to the senior management direct.

Relatives knew who to contact at the service if they needed to. However, only a few people who received care told us they knew who to contact whilst those people who spoke with us had contrasting experiences; One said; "There is one person in the office who always responds but the other never phones back, so I'm wasting my time." People told us they would get in touch if they needed to.

We saw copies of recent surveys of satisfaction sent to people who received care. These covered a range of areas of the service's operation and care support including timing of calls and reliability of care. We saw the statistical analysis which had been carried out on these surveys to identify areas of strength and where improvements could be made.

The feedback we received from community professionals, including those who arranged services for people was positive about communication and responsiveness. The fact there was a dedicated member of staff monitoring carers' activity as it happened through the call monitoring system was said to be very effective and helpful.

Administrative roles within the service were well-staffed and equipped. For example key personnel had access to data and records through the computers and systems provided for their use. This enabled the service to operate effectively, twenty four hours, seven days a week.

Staff told us they received regular supervision by their line manager. Records of supervision planned and those which had taken place confirmed this. We saw minutes of team and whole staff meetings as well as copies of the weekly newsletter , which included a feature; 'Star of the week'. This recognised individual staff members' special contribution during the week based on feedback from people who received care, colleagues, office and management staff as well as external bodies who arranged care for people.

The management of the service had been proactive in seeking new and improved ways of commissioning and delivering care to people in their own homes. This included pilot schemes, for example to evaluate outcome based commissioning. This is where care is provided to achieve a specific outcome, rather than just for a given period of time. This work was carried out in collaboration with local authority services responsible for arranging people's care in the community.

To address and improve medicines administration and support, the provider undertook a review of medicines in response to what they identified as increasing complexity of medicines and an increase in medicines queries. They were taking part in a local pilot project which was intended to improve medicines delivery and care, increase consistency and reduce medicines errors. The management were active within local forums, events and networking activities with other providers and commissioners of care, for example, local authorities.

The provider's values and mission statement were clearly set out in newsletters, on company documents and training material as; "Quality, Dignity, Choice, Respect" with a vision to be; "The very best care provider in Berkshire and South Bucks." We saw these values were included in staff training and meetings. Staff told us they were aware of them and sought to put them into practice.