Kents Oak Care Homes Limited

Kents Oak Rest Home

Inspection report

Kents Oak
Awbridge
Romsey
Hampshire
SO51 0HH

Tel: 01794341212

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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

Kents Oak Rest Home is a residential care home and provides accommodation for up to 13 people older people and those living with dementia. At the time of the inspection 11 people were living at the home. Accommodation is provided within a large detached house with communal areas, lounge, conservatory, dining area, kitchen and a secure garden to the rear of the property. The home is located in a rural area two miles from the town of Romsey, Hampshire. People's private rooms are on both the ground and first floors. There is a stair lift to the first floor. The service is not registered to provide nursing care.

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

We last inspected this service on 24 April 2017 and found the provider was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued requirement notices in respect of those breaches.

Following our inspection the provider sent us an action plan on 31 May 2017 to tell us about the actions they were going to take to meet these regulations and make the necessary improvements. At this inspection we found action had been taken to meet the requirements of the regulations the service had breached.

The provider had taken appropriate steps to protect people from the risk of abuse, neglect or harassment. Staff were aware of their responsibilities in relation to safeguarding.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests.

People received their medicines safely, accurately, and in accordance with the prescriber's instructions. Medicines were stored safely.

Assessments were in place to identify risks that may be involved when meeting people's needs. Staff were aware of people's individual risks and were knowledgeable about strategies' in place to keep people safe.

People were supported to maintain good health and have access to healthcare services. The home worked in partnership with a local GP practice and received regular visits and support.

The provider operated safe and effective recruitment procedures.

There were sufficient numbers of qualified, skilled and experienced staff deployed to meet people's needs. Staff were not hurried or rushed and when people requested care or support this was delivered quickly.

Staff received supervision and appraisals were on-going, providing them with appropriate support to carry out their roles. Training records showed that staff had received training in a range of areas that reflected their job roles.

People and where appropriate their relatives were involved in their care planning, Care plans were amended to show any changes, and care plans were routinely reviewed to check they were up to date.

Care plans were developed and maintained about every aspect of people's care and were centred on individual needs and requirements. This ensured that the staff were knowledgeable about the person and their individual needs.

Staff responded appropriately to accidents or incidents. Staff recorded all accidents and incidents and the registered manager responded appropriately and further actions were taken to prevent incidents reoccurring.

People knew who to talk to if they had a complaint. Complaints were passed on to the registered manager and recorded to make sure prompt action was taken and lessons were learned which led to improvement in the service.

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 remains safe.

Is the service effective?

Good

The service was effective. Staff were provided with training and support that gave them the skills to care for people effectively.

People's rights were protected because staff were aware of their responsibilities under the Mental Capacity Act 2005.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service remains responsive.

Is the service well-led?

Good

The service was well led. Staff, people and visiting health care professionals told us the registered manager had created a warm, supportive and non-judgemental environment in which people had clearly thrived.

Staff interacted with people positively, displaying understanding, kindness and sensitivity.

There were effective systems in place to monitor all aspects of the care and treatment people received. Audits had been conducted regularly by the registered manager to drive improvement.

Kents Oak Rest 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 April 2018 and 2 May 2018. The first day of our inspection was unannounced and the second day announced.

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

The home accommodates 13 people in one adapted building. At the time of the inspection 11 people were living there. The inspection was carried out by two adult social care inspectors.

Before the inspection, we looked at information we held about the provider and home. This included their Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. Providers are required to send us a PIR at least once annually to give us some key information about the service, what the service does well and improvements that plan to make. We also contacted one general practitioner (GP) and two health and social care professional to obtain their views on the delivery of care.

During the inspection we spoke with the registered manager, nominated individual, three care staff, activities organiser, and two chefs. We also spoke with six people living at the home. We looked at the provider's records. These included four people's care records, four staff files, staff attendance rotas, audits, staff training and supervision records, accident and incident records and a selection of the provider's policies.

Some people were not able to verbally communicate their views with us or answer our direct questions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us the home was a safe place to live and people felt secure. One person told us, "It's alright here, I'm a free agent really, and I can do whatever I want. I feel safe". Another person told us, "This is brilliant; honestly it is 24 hours security".

The provider had taken appropriate steps to protect people from the risk of abuse, neglect or harassment. Staff were aware of their responsibilities in relation to safeguarding. They were able to describe the different types of abuse and what might indicate that abuse was taking place. Staff told us there were safeguarding policies and procedures in place, which provided them with guidance on the actions to take if they identified any abuse. They told us the process that they would follow for reporting any concerns and the outside agencies they could contact if they needed to.

We asked staff about whistleblowing. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. Staff said they would feel confident raising any concerns with the registered manager. They also said they would feel comfortable raising concerns with outside agencies such as the Care Quality Commission (CQC), local authority or the police if they felt their concerns had been ignored. Staff told us the home had a whistleblowing policy and this was displayed in the office.

There was a clear medication policy and procedure in place to guide staff on obtaining, recording, handling, using, safe-keeping, dispensing, safe administration and disposal of medicines. People's medicine was stored securely in a locked medicine trolley that was secured to the wall. Only staff who had received the appropriate training were responsible for the safe administration and security of medicines. The home used an electronic system for recording the delivery, administration and disposal of medicines to people living at the home and included a photograph of the person. The system reduced the risk of medication errors and ensured that people received the right medication at the right time and in a safe way. Risk to people who were prescribed 'as required' medication (PRN) for pain relief were also reduced. For example, if a person requested prescribed pain relief before it was due the electronic system would alert the member of staff that it was unsafe to administer that medicine. The registered manager told us, "It is a good system and one that reduces any risk of error. The system also gives me a full medication audit 'at any time' and provides 'live' information regarding medicines within the home.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer recruitment decisions.

There were enough skilled staff deployed to support people and meet their needs. Because of the rural location of the home the registered manager told us they did at times rely on 'agency staff' to cover night shifts. The registered manager added, "We use one agency mainly and have regular staff from them. It is important that we have agency staff that know our people well which ensures we deliver consistent care".

Staff were not rushed when providing personal care and people's care needs and their planned daily activities were attended to in a timely manner. Staffing levels had been determined by assessing people's level of dependency and staffing hours had been allocated according to the individual needs of people. Staffing rosters we viewed between February 2018 and the day of our visit confirmed staffing levels safely met the needs of people. It also showed that agency staff covering night shifts were consistently the same people. People said call bells were answered promptly and staff responded quickly when they rang for help. One person told us, "They are pretty quick to come to me when I press the buzzer, usually a couple of minutes".

Appropriate individual risk assessments were in place and these were reviewed and updated regularly to ensure they remained current. These included moving and handling assessments, nutrition support, medical conditions, mobility and environmental safety. Assessments were undertaken to identify potential risk of accidents and harm to staff and people in their care. Risk assessments we viewed provided guidance for staff members when delivering people's care and support to ensure their needs were met safely.

Staff responded appropriately to accidents or incidents. Staff recorded all accidents and incidents and the registered manager responded appropriately and further actions were taken to prevent incidents re-occurring. For example, one person had fallen recently and sustained a minor injury. Staff provided first aid and monitored the person closely after the incident. The person's risk assessment was reviewed and additional hourly checks were implemented to ensure that the person was safe. The registered manager told us that by reviewing these they could put measures in place to minimise future risk and to try to prevent the same thing happening again. A health and social care professional told us, "Recently one of the residents had a fall and all staff quickly responded and dealt with the incident in a personalised way, relevant documentation was completed and follow up care was provided". Incident and accident records we viewed confirmed this. The registered manager knew which incidents and accidents needed to be reported to which regulatory bodies such as and Health and Safety Executive, the CQC and local safeguarding team.

There was an infection control policy in place with information and guidance about outbreaks. Regular infection control audits were undertaken by the registered manager and head of care. All staff had undertaken appropriate training and staff used personal protective equipment (PPE) to undertake personal care task, which reduced the risk of cross infection.

There were various health and safety checks and risk assessments carried out to make sure the building and systems within the home were maintained and serviced as required to make sure people were protected. These included regular checks of the environment, fire safety, gas and electric systems and water temperatures. A fire risk assessment dated April 2017 was in place and regular checks had been carried out to confirm that the fire alarm, emergency lighting and fire extinguishers were in good working order and the fire exits were kept clear and readily accessible.

There were procedures in place to safely evacuate the home in the event of an emergency such as fire. Each person had a personal emergency evacuation plan (PEEP)) should this become necessary. These were individual plans for each person and were kept in a grab bag at the entrance to the home should the need arise. Agreements were in place with nearby school to be used as a place of safety as an interim measure

should an evacuation be necessary.

Good

Is the service effective?

Our findings

At our inspection in April 2017, we identified staff had not received on-going or periodic supervision in their role to make sure competence was maintained. We also identified that the staff did not act in accordance with the requirements of the Mental Capacity Act (2005) and associated code of practice.

Following our inspection the provider sent us an action plan detailing the improvements they would make. During this inspection, we found that sufficient action had been taken to address these concerns.
Staff were supported in their role and had been through the provider's own induction programme. This involved attending training sessions and shadowing other staff. The induction programme embraced the 15 standards that are set out in the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

There was an on-going programme of development to make sure that all staff were up to date with required training subjects. These included health and safety, fire awareness, moving and handling, emergency first aid, infection control, safeguarding, and food hygiene. Specialist training had been provided to staff in dementia awareness and diabetes. This meant that staff had the training and specialist skills and knowledge that they needed to support people effectively. Staff told us that they received regular training. It was provided through training packages, external trainers and in-house, which included an assessment of staff's competency in each area.

Support for staff was achieved through individual supervision sessions and an annual appraisal. Staff said that supervisions and appraisals were valuable and useful in measuring their own development. Supervision sessions were planned in advance so that they were given priority.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the time of our inspection three people living at the home were subject to a DoLS which had been authorised by supervisory body (local authority).The home was complying with the conditions applied to the authorisation. The home had submitted further applications which had yet to be authorised by the local authority. The manager knew when an application should be made and how to submit one. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

People's legal rights were protected because staff followed the requirements of the MCA. People's records

contained evidence of decision specific mental capacity assessments being carried out to establish people's ability to make decisions. Where people were unable to make specific decisions, best interest decisions were made and documented. Best interest decisions showed evidence of involvement of relatives, healthcare professionals and staff. For example, one person was living with dementia and an MCA assessment had documented that they could not make the decision to consent to their care. A best interest decision was recorded that the person should stay at the home and have their care needs met. Staff involved the person's relatives and health and social care professionals in the best interest decision team. One health and social care professional told us, "The home has a number of people with Dementia and the staff are very aware of the increased care needs of these patients and I have seen numerous examples of the extra effort taken with these residents. The staff have also recently been very helpful in the capacity assessments for a current resident when we were asked as a team to evaluate a patient's capacity with regards to returning home".

People who were able too had consented to their care and this had been recorded appropriately. People told us that staff always asked for consent before providing care to them. For example, a staff member was observed asking for consent from one person to give them their medicines.

People were supported to maintain good health and have access to healthcare services. For example, where necessary people were referred to dieticians and Speech and Language Therapists (SALT). We saw that one person had been put on a regime which required them to be weighed weekly and weight to be monitored. We checked care records for this person and saw they were being weighed, and their weight was consistent. Care plans documented people's specific dietary needs and these were met by staff. For example, one person was living with diabetes and required a balanced diet with reduced sugar to maintain good health. This information was in the person's care plan and was also known to the kitchen staff.

The home worked in partnership with a nearby GP practice to ensure people's healthcare needs were met. They told us, "Working with the staff they are very proactive with their resident's health. A good example I have seen of this is with diabetic residents whom they take extra care to ensure they are on the correct diet plans to minimise deterioration in their condition".

Records contained information of when when people had been visited by the GP or had attended hospital appointments. Health records included information such as allergies, conditions and medicines currently being taken by the person. When people needed to go to hospital staff made sure that they sent all the current information about the person. This would ensure people received the appropriate support and treatment in accordance to their specific needs.

The chef, who was awarded 'Chef of the Year' at the Hampshire Care Awards in 2017, understood people's preferences and used this to guide them in their menu planning and meal preparation. The chef told us they reviewed the menu regularly with people to identify any particular dislikes or requests. They also had a good understanding of people's nutritional requirements, for example people who needed their food to be pureed to reduce the risk of choking. The chef told us, "We always try to accommodate people's wishes as well as trying to ensure they have a varied and nutritious diet. For people who required a soft or pureed diet, food once processed was put into moulds to replicate the food people had asked for. The chef added, "Pureed food can look somewhat bland when it is presented so we try to make it look as good as possible to encourage people to eat. I do use moulds but I also mould food to look like 'the real thing'. I try to ensure that people have the best quality foods and presented in a way that means they feel included and it's appetising".

People were encouraged and supported to eat and drink sufficient amounts to meet their needs. Most people took their meals in the dining room and this was encouraged to enable people to socialise. Tables

were arranged to seat between two to four people. During the lunch time meal the atmosphere was relaxed and people sat with other people talking. The meals looked plentiful and appetising. People were enjoying the social occasion of the mealtime experience. There was laughing and talking between people, some of whom were being supported and encouraged by staff to eat their meals.

We looked around the building and found it was appropriate for the care and support provided. There was a stair lift that serviced the second floor to ensure it could be accessed by people with mobility problems. Each room had a nurse call system to enable people to request support if needed. Lighting in communal rooms was domestic in character, sufficiently bright and positioned to facilitate reading and other activities. Aids and hoists were in place which were capable of meeting the assessed needs of people with mobility problems.

Good

Is the service caring?

Our findings

People were positive about the care and support provided by staff. One person said, "I'm fine and well looked after". Another added, "I like the staff, I think they are all lovely", whilst a third person told us, "I love it here. It's the next best to your own home. You can have a good laugh with them. The staff are very caring". A GP told us, "The staff at Kents Oak are in my opinion, very caring of their residents and from a health perspective which is naturally my focus, they are very good to work with". A health and social care professional told us, "Whilst being in service the registered manager and the team always talk to the residents and include them in decisions, all are approachable and offer a high level of support to the resident and their family members. The service is clean and welcoming and from observations I noted all rooms are personalised and well decorated. The residents seem to like the activities in service and like the inclusion and the social aspect that this brings".

Staff cared for people in a relaxed, warm and friendly manner. Non care staff who worked in the home such as kitchen and maintenance staff took time to sit with people and chat. Staff sat talking with people and engaged in lively conversations about their families, social events and sharing memories. There was a lot of laughter and we noted staff took every opportunity to engage with as many people as possible. For example, by bending down to ask if a person would like more tea, by touching a person's hand to ask if they were ok, and by frequently popping in and out of bedrooms to check on people.

People told us people's privacy and dignity was respected. Staff knocked on people's doors and asked them if they would like to be supported. People were able to make choices about how they spent their time and were able to spend time in their rooms if they wished. Staff respected people's need for privacy and quiet time. Staff told us how they maintained people's privacy and dignity in particular when assisting people with personal care. Staff said they felt it was important people were supported to retain their dignity and independence. Staff used their knowledge of equality, diversity and human rights to help support people with their privacy and dignity in a person centred way.

People were able to spend private time in quiet areas when they chose to. Some people preferred to remain in a quieter sitting area when activities took place in the main lounge. This showed that people's choices were respected by staff. There were other areas within the home to allow relatives opportunities to speak with staff privately about the care provided to their loved one.

People were supported to express their views whenever possible and be involved in any decisions about the care and support they received. Staff were seen communicating effectively with people. This helped to ensure people were involved in any discussions and decisions as much as possible. Interactions we observed whilst staff supported people were good. Staff understood people's communication needs, for example if they were able to verbally respond or if they were distressed. People had information on their communication needs recorded in their care plans.

Staff showed concern for people's wellbeing. People confined to bed due to deteriorating health were observed to be well cared for by staff with kindness and compassion while maintaining people's dignity. The

care people received was clearly documented and detailed. For example, turning charts and food and fluid intake records.

Good

Is the service responsive?

Our findings

People told us their care and support was delivered the way they wanted it to be. One person said, "I am cared for exactly how I want it". Another person told us, "I like to be on my own sometimes and just sit in the conservatory. They (staff) are very good and let me sit on my own". A third person added, "I can't fault it in any way. The staff are very good here. They let me be me but are on hand if I need help".

Each person's physical, medical and social needs had been assessed before they moved into the service and communicated to staff. Pre-admission assessment of needs included information about people's likes, dislikes and preferences about how their care was to be provided. They clearly recorded what a person could manage independently and areas of daily living where they required support from staff. For example, one care plan detailed how a person could wash their hands and face and front body but needed assistance from staff with all other aspects of personal care.

Care plans also included a history of people's upbringing, early life, education, teenage years, career and work, social and recreational interests and personal achievements. Care plans were developed and maintained about every aspect of people's care and were centred on individual needs and requirements. Some people had advance decisions in place. For example a do not attempt resuscitation (DNACPR). These had been made by people when they had full capacity or their relatives and health care professionals where they were unable to do so. This meant staff were clear about the people's wishes, and could inform other appropriate bodies of this, for example if the person was admitted to hospital. This demonstrated people were supported to have a planned ending to their life that reflected their wishes.

The home employed an activities co-ordinator who told us they planned activities in advance however as people's needs changed there was a need for flexibility and activities changed accordingly. The activities co-ordinator told us, "We follow the principles of the seven Montessori care activities developed for people living with dementia, based on their cognitive skills which can be performed in a variety of different exercises depending on the individual's abilities. For example, movement, sensory, music, art and socialization. Some people chose not to take part in activities or some people, because of the level of dementia benefit from one to one interaction. For those people I will take time to sit and talk with them and try to engage with them through board games, pampering and sensory activities such as smell and touch".

The provider kept a complaints and compliments record. The complaints procedure gave people timescales for action and who in the organisation to contact. The service had not received any formal complaints since our last inspection. People told us that if they were unhappy they would not hesitate in speaking with the manager or staff. The provider's complaints procedure was on display at various points around the home.

Good

Is the service well-led?

Our findings

People told us that the service was well-led. One person said, "I am very satisfied with the service, I have no complaints – the home is not luxurious, it is homely and comfortable and the staff are wonderful, all of them". A health care professional told us, "The registered manager supports the staff to give a very high standard of care".

Staff interacted with people positively, displaying understanding, kindness and sensitivity. For example, we observed one member of staff smiling and laughing with one person when playing a board game. The person responded positively by smiling and laughing back. These staff behaviours were consistently observed throughout our inspection. Staff spoke to people in a kind and friendly way. We saw many positive interactions between the staff and people who lived in the home.

Systems were in place that ensured audits were carried out regularly. For example, infection control, care plans, medicines and health and safety and environment. Audits were robust in identifying improvements. Any areas for improvement were identified and there was a record of when these had been actioned. The provider had oversight of the service and carried out regular audits to satisfy themselves that the home was being operated in accordance with the policies and procedures in place.

The provider carried out regular repairs and maintenance work to the premises. On the day of our inspection the stairway and reception area was being repainted. Action plans to refurbish, repaint and redecorate other parts of the building were on-going with a programme of improvements planned throughout the year.

Equipment such as moving and handling aids and wheelchairs were regularly serviced to ensure they were safe to use.

Staff told us that there was a clear expectation by the management team for them to deliver high quality care and support. People knew the management team and staff very well and told us that communication was good. Staff were very positive about the registered manager and told us there was good communication within the team and they worked well together. Staff and people told us the registered manager was visible leader who created a warm, supportive and non-judgemental environment in which people had clearly thrived. One member of staff told us, "She (registered manager) does not hide in the office. She is very hands on and not afraid to get her hands dirty". The home had a clear management structure in place led by an effective registered manager who understood the aims of the service. Staff told us that they felt supported by management and morale was excellent and that they were kept informed about matters that affected the service. One staff member said, "It's really good working here, great team and lovely residents". Another staff member told us, "I love working here, I feel like I belong here".

Staff told us that team meetings took place regularly and they were encouraged to share their views. They found that suggestions were warmly welcomed and used to assist them to constantly review and improve the service. We looked at staff meeting records which confirmed that staff views were sought and confirmed

that staff consistently reflected on their practices and how these could be improved.

The provider sought the views of relatives, staff and visiting health care professionals regularly. Feedback was consistently complimentary. We looked at nine completed relative questionnaires that had been returned in February / March 2018. Most relatives indicated the service was 'good' or 'very good' with comments including, 'Room is excellent' and 'Yes I would recommend this home'. Visiting health care professionals were also complimentary. Comments included, 'Very friendly and welcoming', Courteous and respectful…..with a bit of fun', Excellent communication skills' and 'Wellbeing and quality of care important aspects that are promoted at Kents Oak'. Staff feedback was mostly complimentary and generally staff felt supported and valued and indicated they worked well as a team. However some staff felt the general ambiance of the home could be improved to make it more 'homely'.

From April 2015 it became a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Kents Oak Rest Home was displayed prominently in the home for people to see and on the provider's web site.