Care UK Community Partnerships Limited

Ogilvy Court

Inspection Report

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Overall summary

Ogilvy Court is a nursing home specialising in the support of adults of any age with dementia, mental health conditions and physical or learning disabilities. It is split into three units, one for people with learning disabilities, and two single gender units for people with dementia. It is registered to accommodate up to 57 people, although the registered manager told us that it is considered full when 55 people live there due to some double-rooms no longer being considered suitable for sharing. This was the case during our visit.

We spoke with 11 people living at the nursing home, and four visiting relatives during our visit, the majority of whom were from the units for people with dementia. People praised the service and the care provided. Comments included, “it’s excellent”, “they go out of their way to change things for you” and “the staff work their socks off.” We were told of how the service had improved the quality of life for some people, for example, in their ability to move around independently and recognise people. People told us that nothing needed changing about the service and that they were happy using it.

The home had a registered manager. People spoke positively about the approach of staff and managers. There were enough staff, and staffing cover was provided when needed.

Where people were not able to make decisions about their care, staff worked with their relatives and other professionals to make sure ‘best interest decisions’ were agreed. People whose behaviour challenged the service were safely supported.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We found the location to be making progress towards meeting DoLS requirements.

However, some areas of the service required improvement. Whilst we saw staff treating people kindly, we also saw occasions when people’s dignity and respect was compromised. For example, we saw some staff going into people’s rooms without knocking on their doors, in one instance, surprising the person who was in their room.

In the unit for people with learning disabilities, people were not always treated as individuals. For example, many people were supported to go to bed well before their recorded preferred time. We were not assured that people in the unit for people with learning disabilities received individualised care that was responsive to their interests and preferences.

We found some people who were at risk of dehydration did not have their care and treatment effectively monitored or managed. This was because care planning was not individual enough, and records of being given drinks had some lengthy overnight gaps that started at 1700 hours.

The problems we found breached two health and social care regulations. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

The service had taken steps to identify the possibility of abuse, prevent abuse from happening, and to respond appropriately to any allegation of abuse. The Mental Capacity Act 2005 Code of Practice was being met. People whose behaviour challenged the service were safely supported. There were systems in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). A DoLS application for one person had been granted for a time-limited period. Other applications were being considered in light of recent case-law changes. The service was taking steps to ensure that the Mental Capacity Act 2005 and DoLS were being addressed.

Are services effective?

Care and treatment was planned and delivered in line with individual care plans. People who had dementia were treated considerately and with reference to their individual needs. Staff had been appropriately trained.

However, we found that people at risk of dehydration were not always monitored or managed resulting in increased risk in to their health and wellbeing.

Are services caring?

People living in the home told us staff were kind and caring. Relatives and visitors told us they felt people were well cared for and staff treated people with respect. We saw examples of staff interacting with people in a caring manner.

However, we saw occasions when people's dignity and respect was compromised. For example, we saw some staff going into people's rooms without knocking on their doors. In the unit for people with learning disabilities, we saw instances when people were not treated as individuals. The approach to people did not always promote respectful behaviour.

Are services responsive to people's needs?

People were supported to express their views and be actively involved in making decisions about their care and support. Where people were not able to make decisions about their care, staff worked with their relatives and other professionals to make sure 'best interest decisions' were agreed.

Summary of findings

There was an effective complaints system in use at the service, which helped ensure that people had their comments and complaints listened to and acted on.

The service provided activities and stimulation to people. However, we were not assured that people in the unit for people with learning disabilities received individualised care that was responsive to their interests and preferences.

Are services well-led?

The home had a registered manager. People spoke positively about the approach of staff and managers. Most staff told us they felt well supported by the manager and senior staff. The management team had systems in place to keep staffing levels under review and recruit further staff where needed. The provider had systems in place to monitor standards of care provided in the home.

However, we found overall that the service was not always well-led. This was because of our findings of concern and breached regulations that arose during this inspection. Some people who were at risk of dehydration did not have their care and treatment effectively monitored or managed. People were not routinely treated with respect and recognised as individuals in the unit for people with learning disabilities.

Summary of findings

What people who use the service and those that matter to them say

We spoke with 11 people living at the nursing home, and four visiting relatives during our visit, the majority of whom were from the units for people with dementia. Overall, people praised the service and the care provided. Comments included, “it’s excellent”, “they go out of their way to change things for you” and “the staff work their socks off.” One visitor explained to us that they had visited six local homes in support of finding the best service for their relative, and had decided Ogilvy Court was the best.

People using the service and their visitors spoke positively of the staff. Comments included, “the staff are excellent, they do a good job”, “they care”, and “the staff are lovely.” One person told us that when they pressed the bell for help, staff came. They said, “they might say, ‘I’ll just finish with someone else first’”, which they found acceptable.

People told us that the home had an assigned doctor who visited weekly and when needed. Most people felt this worked out well for them. A visitor also told us of a physiotherapist who attended to some people regularly.

People and their relatives told us that the manager and deputy were seen around the home regularly and visited at different times including early morning and at night.

One visitor told us of how the service had benefited their relative. They told us that their relative “was not at all well when she came in but she recognises me now and can talk about family and walks about independently.” They felt the care was “fantastic.” Overall, people and their relatives told us nothing needed changing about the service and they were happy using it.

Ogilvy Court

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

This was our first inspection of this service which we registered on 14 March 2014.

Before our inspection, we reviewed the information we held about the service. We visited the service unannounced on 10 April 2014. The inspection team consisted of an inspector, a specialist nurse advisor to help consider nursing care at the service, and two Experts by Experience. These were people who have had experience of services for older people and people with a learning disability respectively.

On the day we visited, we spoke with 11 people living at the nursing home, four visiting relatives, eight staff members and the manager. We observed care and support in communal areas, and used the Short Observational Framework for Inspection (SOFI) in a dining room at lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who were not able to speak with us. We also spent time looking at records, which included people's care records, and records relating to the management of the service.

Following our visit we asked the manager some further questions and reviewed management records that we had asked the manager to give us during and after the visit.

Are services safe?

Our findings

We saw that there were posters about how to report concerns and abuse on display around the premises. Training records indicated most staff had received recent training on safeguarding processes. Safeguarding procedures were robust and staff we spoke with understood how to safeguard people they supported and raise concerns if needed. The manager told us the organisation's whistle-blowing procedures had been sent to each staff member's home address recently. This helped ensure that staff could raise concerns about people's treatment if needed. Staff we spoke with were aware of how to whistle-blow.

We saw records of appropriate referrals of safeguarding concerns to the local authority's safeguarding team. The manager explained to us about investigations in response to safeguarding strategy agreements. She provided documents showing actions taken and safeguards put in place.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). While no applications had been submitted at the time of our visit, appropriate policies and procedures were in place and relevant staff had been trained on the Mental Capacity Act 2005 and DoLS procedures. We saw updates from a senior manager within the organisation on the latest developments in respect of DoLS. As a consequence of this, the manager informed us of a DoLS application following our visit for one person using the service which the local authority had granted for a time-limited period. Other applications were also being considered. The service was therefore taking steps to ensure that the Mental Capacity Act 2005 and DoLS were being addressed.

When people displayed behaviour that challenged others, staff dealt with it effectively and safely. Care plans for people who were assessed as capable of displaying aggressive behaviours, respected people and protected their rights. They were reviewed and updated as a result of incidents. Monitoring took place to minimise the risk of repeated incidents. Appropriate people such as next-of-kin and funding authorities were kept informed of incidents and actions taken.

We saw that people had up-to-date and individualised risk assessments that were clear for staff to follow. These focussed on, where appropriate, night care, nutrition, bed rails, manual handling, and pressure care management. These had been reviewed regularly and were up to date. Staff we spoke with were aware of risks relevant to individuals, and showed knowledge of generic risks to people needing nursing care such as dry lips and red marks on their skin. They all indicated that they received training appropriate for their role. We saw staff safely supporting people to transfer using hoists

One person told us that when they pressed the bell for help, staff came. They said, "They might say, 'I'll just finish with someone else first'", which they found acceptable. We saw call-bells to be functioning during our visit, and staff responding to them. We saw evidence of an annual professional check of the call-bells to ensure that they were functioning properly. However, a recent complaint included that a person had experienced their call-bell not working. On discussion with the manager, we established that there were no recorded internal checks of the call-bells in the premises. This meant there was a risk that people would not be able to call for staff help due to their call-bell becoming faulty. Immediately after the inspection, the manager contacted us to inform us of a full audit of call-bells throughout the premises, from which minor shortfalls in the efficiency of the system were identified. The manager informed us that there would now be daily recorded checks of call-bell effectiveness.

Recent professional checks of the environment had taken place to certify the safety of the premises, for example, for gas and electrical wiring systems, and lifts and lifting equipment. A fire safety risk assessment and action plan had been developed by a fire safety professional, and there was evidence of addressing this. There were records of ongoing fire safety checks within the service. A designated health and safety audit of the service took place at the end of 2013, from which most action points were recorded as addressed. For example, environmental risk assessments had now been reviewed and updated, first aid equipment had been replaced where out of date, and more staff had attended the three-day first aid at work training course so that there was always someone with that training present at the service if needed.

We checked equipment and furnishings in some people's rooms and found it was appropriate and met their individual needs. For example, where people were using pressure-relieving mattresses, these were set correctly for

Are services safe?

their weight. Window restrictors were in place so that people could not fall from windows. Doors were propped open using fire-alarm release devices, so that people would be protected from fire if the alarm went off.

Are services effective?

(for example, treatment is effective)

Our findings

We found overall that that people at risk of dehydration were not always monitored or managed resulting in increased risk to their health and wellbeing. This meant there had been a breach of the relevant legal regulation (Regulation 14(1)(c)). The action we have told the provider to take can be found at the back of this report.

Where people had a high risk of poor nutrition or hydration the amount they ate and drank was monitored on specific charts. However, our checks of these records for four people found only one person with a clear plan on the amount of fluid staff should have been supporting them to drink throughout the day. Most fluid charts for these people across the previous week identified that an appropriate amount of fluid was provided. However, for three people who were dependent on staff support, there were three days when no fluid was recorded as provided between 1700 hours and 0900 hours the next day, whereas on other days there was an additional 2100 hours entry. We spoke with a nurse and the manager about this, but we were not assured that these people received support with drinks later than 1700 hours on those days. There was a risk that people were not provided with adequate hydration for too long overnight.

We noted that management team audits paid attention to people's nutrition and hydration. For example, night-time checks considered the availability of drinks and snacks for people. The recent senior manager audit of the whole service noted a number of actions needed for the effective support of people's nutrition and hydration. This included establishing and monitoring daily fluid intake targets for individuals via community health professionals. As we found that this had not been set-up for three of the four people we checked, and because of the lengthy gap in three people's overnight fluid charts, we were not assured that people's hydration needs were effectively monitored and managed so that people were protected from the risks associated with dehydration.

People and their relatives that we spoke with were happy with the care and treatment provided. For example, one person told us, "I'm well looked after here." Some visitors told us that the service had improved their relative's quality of life. One visitor told us that their relative "was not at all well when she came in but she recognises me now and can talk about family and walks about independently." They felt the care was "fantastic." A person using the service told us of being ill when they moved in, but that they were much better now through the care and treatment provided which they described as "excellent."

We saw documents that supported people and their families to explore what their needs, preferences and aspirations were. Care plans were developed based on this input and assessments of need and risk, and were detailed and individualised. They stated the person's needs and preferences and the support required from staff on, for example, personal hygiene, eating and drinking, mobility, sleeping, communication, end of life and wound care. Plans and risk assessments were reviewed on a monthly basis. There was evidence of plans being updated where people's needs had changed, for example, in acquiring community health professional input or adjustments to how the person needed staff support and monitoring.

We saw monthly audits of care plans and supporting risk assessments, which helped ensure that people's support was kept under review and updated as needed. These also included checks on the involvement of the person or their next-of-kin. Actions were set for unit managers where appropriate, for example, to recheck some individuals' weights and adjust nutrition plans if weight loss was confirmed.

People told us that the home had an assigned doctor who visited weekly and additionally when needed. Most people felt this worked out well for them. A visitor told us of a physiotherapist who attended to some people regularly. People's care plans and records indicated the appropriate involvement of community professionals where needed. For example, one person's needs had recently increased, and it was clear that the doctor had consequently reviewed them. Community chiropody needs had also been identified and addressed for them. This assured us that the service supported people to have access to appropriate community healthcare services.

Staff we spoke with had understanding of how to work effectively with individuals who have dementia. Records indicated that most staff had received dementia training. Some staff told us of completing a three-month course on dementia, and the manager informed us of further opportunities for staff. Our checks of people's care records indicated that people's life histories and preferences were

Are services effective?

(for example, treatment is effective)

considered, to help understand the needs of the individual with dementia. We saw people who had dementia being treated considerately and with reference to their individual needs.

Staff we spoke with knew people's individual nutritional needs and how to spot signs of dehydration. People's care plans included an assessment of their nutrition and hydration needs and individualised support plans where appropriate. One person had a comprehensive section on diabetes within their care plan. It included, for example, how this person might show signs of low or high blood sugar and the action for staff to take to address that. Nutritional assessments including checks of people's weight were completed and regularly reviewed. Adjustments to care and referrals to community professionals such as dieticians were made when needs changed.

When meals and drinks were being served to people in the units for people with dementia, we saw staff sitting with the person to support them, and staff noticed when people needed encouragement. People were helped into an appropriate position when needed, for example, sitting up in bed or sitting closer to the dining table, to allow them to eat and drink safely and effectively. People were offered a choice of food, and staff sought alternatives that people liked when individuals did not eat.

Are services caring?

Our findings

We found overall that that the service was not always caring. We saw some staff going into people's rooms without knocking on their doors. In the unit for people with learning disabilities, we saw instances when people were not treated as individuals. This meant there had been a breach of the relevant legal regulation (Regulation 17(1)(a)(2)(a)(g)). The action we have told the provider to take can be found at the back of this report.

We saw some occasions when people's dignity and respect was compromised. Whilst some staff knocked on people's doors before entering their rooms, we saw two different staff failing to do this. One was surprised to find the person in their room, although they were then apologetic about it. Our observations matched some feedback we received in advance of the inspection visit, that staff did not always knock on people's doors before entering rooms.

In the unit for people with learning disabilities, although staff showed care towards people, the approach was not always respectful and appropriate. We heard a few occasions when staff used language that was not age-appropriate, for example, telling someone to be quiet when engaged in an activity, and asking someone to "be a good boy." We saw one person who was asleep during an activity being touched underneath their chin to make sure they woke up, rather than respecting that they were not interested in the activity. Another person was being supported with eating during lunch. They fell asleep for a short time, but when awake again, staff forgot to put their glasses back on so that they could see properly.

Many people with learning disabilities did not get individualised support to eat. We saw people left waiting in the dining area for up to an hour before being provided with a hot lunch. This was because either the meal or the staff support was not immediately available. We also saw one person finishing their meal but unable to leave due to seating arrangements that meant they were blocked in unless some other people, who were still being supported to eat, moved out of the way. This caused the person anxiety which had an impact on others nearby. These approaches to people with learning disabilities did not always promote respectful behaviour and treat people as individuals.

People living in the home told us staff were kind and caring. Relatives and visitors told us they felt people were well cared for and staff treated people with respect. Comments included, "the staff are excellent, they do a good job", "they care", and "the staff are lovely."

We saw records in support of value being placed on staff showing concern for people's well-being. A senior manager's recent quality audit visit included observations of the care and support provided at lunch, and coaching of staff where needed on their approach to people. Most staff had received customer care training and many had had training on equality and diversity. Specific dignity training was being planned for, so that some staff would become Dignity Champions in the service.

We saw examples of staff interacting with people in a caring manner that promoted people's dignity. A staff member attended to a person whose skirt was caught up and compromising their dignity. Staff respectfully intervened when someone impinged on another person's personal space. Staff explained to people before assisting them with manual handling transfers, and reassured them during the process. We noted that the radio in one lounge was set to an appropriate channel which engaged some people. Staff made sure one person who could not see well had a good grip of a warm drink before leaving them.

Our discussions with staff indicated a positive, caring attitude towards people. For example, a staff member told us of the importance of going around greeting everybody at the start of their shift. However, we were concerned overall that in the unit for people with learning disabilities, the care provided was linked to the routine of the service rather than how people would like to receive it.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found overall that that the service was not always responsive to people's needs. This was because people in the unit for people with learning disabilities did not always receive individualised care that was responsive to their interests and preferences. This meant there had been a breach of the relevant legal regulation (Regulation 17(1)(a)(2)(a)(g)). The action we have told the provider to take can be found at the back of this report.

The service provided activities and stimulation to people. We were told of, and saw photos of, staff supporting some people to access the community, for example, for meals, the zoo, and the British Museum. Some visitors provided stimulation, for example, a visiting pet service and monthly exercise sessions through Mobility London.

We saw that staff engaged people in activities, for example, knitting, ball-throwing and karaoke. They also chatted with people from time to time. A bingo session was organised before lunch. Some people engaged in this, but we also saw some people from the learning disabilities unit being moved into the room without making a clear choice to join in. Some people's behaviour showed they were not interested in the session, including one person who fell asleep.

Records showed that the service employed three people for activities co-ordination for 57 hours in total across weekdays. Discussions with staff and the manager highlighted that there had been little training on activity provision and that nothing was planned. We were concerned that the service did place enough value on enabling people to undertake individualised activities that they enjoyed.

We returned to the unit for people with learning disabilities at 1830 hours. We found most of the 13 people were in bed in their rooms. We checked four people's care plans, and in the three that recorded preferred bed-times, all were between 2100 and 2130 hours. We also looked at records of engagement for these three people. For three of the previous seven days, there was nothing recorded beyond watching television. These three days included the weekend. A person whose care plan recorded them as liking church attendance on Sundays had no record of that occurring the previous Sunday. We were not assured that people in this unit received individualised care that was responsive to their interests and preferences.

People commented positively on being asked about their care and responded, for example, "they go out of their way to change things for you." We saw examples of this taking place in the units for people with dementia. Whilst we were talking with someone, staff reminded them that it was lunchtime but respected the person's decision to finish the conversation first. Another person asked to be assisted to their room and was supported with this. We saw people being asked about what to eat for lunch and staff providing individual responses.

People and their relatives told us they were consulted about the planning and reviewing of their care and treatment. Care plans had evidence of discussion with people about their care. One person told us about the 'This Is Me' document they had been involved in, which helped record their preferences and life history so that their care could be more individualised.

We saw capacity assessments in place for two people for their medicines, from which best interest decisions had been made for covert medicines to be administered. These had been reviewed since the initial decision. One person's relative did not agree to bed-rails for their bed, and so crash-mats were instead placed on the floor by their bed.

People said that they received the individual care and support they needed. One person told us about a broken television in their room being replaced within 24 hours. We saw that staff knew people's preferences when drinks were being served mid-afternoon. During lunch, only those people who needed aprons were asked to wear them. Staff knew people as individuals and could give us examples of how they had supported people to meet their particular needs. Where people could not verbalise, staff described how they read people's body language and facial expressions. We also found that the individual preferences and precautions listed in people's care plans were being addressed in practice. For example, one person had their hair in plaits as per their plan, and another person did not have any sharp objects in their room as per a risk assessment.

Information on making a complaint was available to people throughout the service. There were complaint

Are services responsive to people's needs?

(for example, to feedback?)

records at the service which included details of matters raised and the action taken for resolution. Where a person using the service had made a complaint, there was evidence of informing the person's next-of-kin, taking staff statements, and recognition by the management team on what needed improving. Records indicated responses by the management team to each complaint that were thorough, questioning and objective. For example, the response to a complaint about standards of care at night included unannounced night checks by the management team. Whilst those checks did not corroborate the complaint, records indicated detailed checks and actions being taken to make service improvements in response to findings.

We also saw records of quarterly relatives' and residents' meetings that gave people the opportunity to raise concerns. For example, the last meeting included comments about more stimulating activities being needed from which plans were made.

Are services well-led?

Our findings

We found overall that the service was not always well-led. This was because of our findings of concern and breached regulations during this inspection. In particular, the standard of care provided in the unit for people with learning disabilities was not sufficient because people were not routinely treated with respect and recognised as individuals. For example, many people were supported to go to bed well before their recorded preferred time, and the support provided to people at the lunch we saw was disorganised.

We also found some people who were at risk of dehydration did not have their care and treatment effectively monitored or managed. This was because care planning was not individual enough, and records of being given drinks had some lengthy overnight gaps that started at 1700 hours. Although audits had taken place which identified improvements needed in these areas, insufficient improvement been made at the time of our visit.

People spoke positively about the approach of staff. People and their visitors told us that the manager and deputy were seen around the home regularly and visited at different times including early morning and at night. The atmosphere throughout the home was calm and staff were approachable. One visitor told us of making complaints in the past but that this was no longer needed under the current management arrangements.

Most staff we spoke with felt supported by their line managers and the management approach of the service. Their comments included, “managers have time for me” and “it’s the best home I’ve worked in.” The manager told us of encouraging staff to champion different aspects of the service. For example, there were now infection control and manual handling leads for the service, with an aim for dignity champions to shortly be in place. Records indicated that staff were receiving additional training for those roles.

The service’s manager has been in post at the service since the previous summer. It was evident that she was well-known to people using the service and staff. Stakeholder information in advance of the inspection indicated good communication from the manager. Suggestions for improvements that we put to the manager were welcomed. We received feedback of actions taken in response to some suggestions, which demonstrated an open culture in support of aiming to provide an effective service to people.

Records showed that the results of a relatives’ satisfaction questionnaire from the autumn of last year were shared at a meeting. Strengths included staff knowing people as individuals and how staff spoke with people. Weakest areas were food choice and nutrition. The manager told us of improvements being made in this area, and the action plan arising from a senior manager’s recent quality audit visit indicated that this area was being kept under review.

We saw many audit tools were being used across the service, for example, on medicines, infection control, people’s nursing care, and health and safety. Whilst these demonstrated many positive points, actions plans were set up to address any areas identified for improvement. For example, some medicines audits identified staff competency assessments were out of date but which had since been signed off as addressed. Action plans showed good attention to detail, for example, to the extent of implementing matching crockery at the service. The manager told us that a new computerised care planning and recording tool had just been introduced to the service. There were a number of audits to ensure that the tool was working effectively overall and for individual people, from which we could see that improvements and minor additional actions had been identified.

The management team had systems in place to keep staffing levels under review and recruit further staff where needed. We reviewed staffing levels across the ten days prior to our visit, and checked with the manager when there appeared to be shortfalls. The manager was able to demonstrate, with corroborating evidence, that on most occasions, staffing levels had in fact been maintained at the usual levels despite unplanned staff absence.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 14(1)(c) HSCA 2008 (Regulated Activities) Regulations 2010.** **Meeting nutritional needs** The registered person did not ensure that service users were protected from the risks of dehydration by means of the provision of support, where necessary, for the purposes of enabling service users to drink sufficient amounts for their needs.

Regulated activity	Regulation
	Regulation 17(1)(a)(2)(a)(g) HSCA 2008 (Regulated Activities) Regulations 2010. **Respecting and Involving Service Users** The registered person did not make suitable arrangements to ensure the dignity, privacy and independence of service users. Service users were sometimes not treated with consideration and respect, and were sometimes not provided with appropriate opportunities, encouragement and support in relation to promoting their autonomy and independence.