Oliver Court Limited

Oliver Court

Inspection report

Bath Hill Terrace
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Norfolk
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Tel: 01493332552

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Oliver Court is a residential home that provides care, support and accommodation for up to 24 people who have mental health support needs. At the time of our inspection there were 24 people living in the home. The inspection took place on 12 September 2017, and was unannounced.

There was a registered manager in post. 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.

Clear and accurate records were not always being kept of medicines administered by staff. Guidance in relation to 'as required' medicines needed to be clearer to ensure staff knew when to give these. Storage for temperature sensitive medicines required improvement; there was not a designated fridge for these types of medicines.

Activity provision was provided by staff working in the service. However, some feedback suggested this was not always meeting the individual or specialist needs of people on a day to day basis.

When people moved between services, processes for sharing relevant information with others needed to be more robust, particularly in relation to known risks. The registered manager took prompt action to rectify this.

Staffing levels needed to be reviewed to take account of people's changing needs.

Care plans were developed and maintained for people who used the service. Care plans covered support needs and personal preferences. Plans were reviewed and updated at regular intervals and information was sought from appropriate professionals as and when required.

Risk assessments were in place to help protect people from avoidable harm. Assessments contained detailed guidance for staff about how to minimise the risk of harm whilst protecting people's rights and freedoms.

The service acted in accordance with the Mental Capacity Act 2005 (MCA) when necessary. People were supported to make their own choices and this was reflected in their care records.

Staff had been trained in safeguarding topics. The registered manager had a good understanding of safeguarding processes and followed these in practice. Thorough recruitment processes were followed before staff started work. This reduced the risk of unsuitable people being employed.

People were supported by well trained, skilled staff. Staff supervision and meetings were taking place, which

meant staff had the opportunity to reflect on and develop their practice. Training was provided for staff to enable them to carry out tasks effectively.

People were supported to seek and attend healthcare support as required to promote their health.

There was a complaints process in place. Feedback from people, relatives and others was responded to, analysed, and actions taken were logged.

The registered manager and provider had implemented a range of assurance systems to monitor the quality and effectiveness of the service provided. This included an annual assessment undertaken by an independent consultant. Systems were in place to seek feedback from all people who used the service as a means to develop and improve service delivery.

Staff were positive about ways in which the service was managed and the support received from the management team. The registered manager was described as approachable and part of the team; they promoted the values of the service and we saw that they led by example.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The management and administration of medicines required improvement to more fully identify potential risks to people.

Staffing levels required review to ensure people's health and social needs were met.

The likelihood of harm had been reduced because risks had been assessed and guidance provided to staff on how to manage risks and keep people safe. However, when people moved between services, processes for sharing relevant information with others needed to be more robust, particularly in relation to known risks.

Staff knew how to protect people from abuse, and who to report concerns to.

Is the service effective?

Good

The service was effective.

People were supported to make their own choices and decisions. Liaison with other relevant professionals had been sought when required.

Staff had the skills and knowledge to support people who used the service. Staff described feeling well supported and were trained to meet people's needs, choices and preferences.

People received support with eating and drinking when necessary.

People were supported to access appropriate health care to make sure their care and treatment needs were met.

Is the service caring?

Good

The service was caring.

Staff had a good understanding of people in order to deliver

person centred care.

People told us staff treated them with patience and respected their rights to privacy and dignity.

People's independence was promoted.

People's views were listened to and friends and relatives were encouraged to visit.

Is the service responsive?

Good

The service was responsive.

Activities were provided to people by staff. However, some feedback suggested that this was not always meeting the individual needs of all people on a day to day basis.

People's care needs were kept under review and staff responded quickly when people's needs changed. Care plans provided clear guidance to staff on how to meet people's needs.

The service had a complaints system in place, and encouraged feedback from people.

Is the service well-led?

Good

The service was well-led

The quality of the service was monitored to ensure that shortfalls were identified and action taken to drive forward continuous improvement and provide high quality care.

People, staff and relatives all felt they could raise concerns or issues to the management team, and felt listened to.

Areas identified by us as requiring improvement were promptly reviewed during and immediately after the inspection.

Oliver 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 legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 12 September 2017, was unannounced and undertaken 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service: what the service does well and improvements they plan to make. We also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with community healthcare professionals and local safeguarding teams.

During the inspection we spoke with eight people living at the service. We spoke with the registered manager, deputy manager, medicines champion, and five members of care staff. Following the inspection we spoke with two relatives and three social care professionals. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met we reviewed five people's care records and other information, including risk assessments and medicines records. We reviewed maintenance files and a selection of records which monitored the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

We reviewed the processes in place for the administration of people's medicines and found that improvement was required. Where people were prescribed 'as and when' (PRN) medicines, guidance was in place, but did not always contain sufficient information to instruct staff on the intended purpose of the medicines and when they should be administered. For example, one person was taking a medicine for agitation. The PRN guidance did not describe what signs the person may display when they were agitated, or what other strategies could be tried before giving the medicines. Another person had PRN medicines prescribed for pain relief. However, there was no information on when this might be needed. This information was important to ensure staff in the service gave people the correct medicines when they needed them and as prescribed.

The majority of medicines administration records (MAR) we reviewed were consistently signed by staff to show they had been given. However, we found two MAR charts where it was not always clear who had signed, as the entries were illegible. Therefore we could not see if the person had received their medicines, or if the medicines had been refused. Where people had refused medicines, staff were not consistently recording why they had refused the medicine on the back of the chart. This is important as it helps staff to ascertain if people are routinely refusing their medicines, and whether a review is required. We checked stock levels and found that two stock checks were incorrect. This was partly due to staff not signing correctly, and partly due to the stock level amounts not being carried over correctly, or in some cases, not at all. This meant we could not determine what medicines had been administered in accordance with the prescriber's instructions.

One person was prescribed a topical application cream. However, there was no body map to indicate where the cream should be applied. Having this information is important to ensure staff who may not regularly work in the service gave people their medicines as prescribed.

We saw that medicines were stored securely, and there were appropriate facilities for controlled drugs. However, there was not a designated fridge for temperature sensitive medicines. The medicines champion told us that at present one person had medicines which required cold storage and they kept them in a fridge in their room. However, staff were not monitoring that the medicines stored were within the correct temperature range. Additionally if a person came to live in the service who was not able or safe to have their medicines kept in their room, then there would not be suitable facilities available. We brought this to the attention of the registered manager.

Room temperatures were being taken where medicines were stored, however, we found gaps in the recording of this over a period of three days. The room was small and during warm weather staff told us it could become very hot. This meant the effectiveness of medicines could be compromised if the temperature was not monitored daily. Additionally staff were recording temperatures differently, some in centigrade, and some in fahrenheit which meant it was not immediately clear if temperatures were correct. The monitoring sheet did not give the correct temperature range for staff to ensure it remained within safe limits. Following the inspection the registered manager informed us that they had purchased an air cooler for the medicines

room.

Some people living in the service required staff to administer their medicines, and we saw that people had signed to consent for staff to do this. One person said, "I get help with medicines, they [staff] make sure I take them." Other people independently managed their own medicines. In these circumstances the registered manager told us that discussion with the person's care team always took place to ensure people were safe to do so. Stock checks were also monitored by staff to ensure compliance with medicines and identify any issues early. One person said, "Here I get help to self-medicate which I like."

Following our inspection we were made aware of an incident that had occurred where a person moved between services. The risks associated with their behaviour had not been shared with other professionals and a serious incident occurred. The registered manager took immediate action to rectify this by implementing a 'consent to share' risk assessment which will be passed to third parties providing care or treatment. This will help to ensure that relevant information is known and people and others are kept as safe as possible.

People's care records contained a comprehensive range of risk assessments relating to situations which could affect their daily lives. For example, medicines, finances, nutrition, and personal care. Risk assessments were very detailed, individualised, and included diverse needs, such as the risk of exploitation, self-harm, harm to others, suicide, absconding, and neglect. Risks were regularly reviewed and updated to reflect changing needs. It was also evident that people had been involved in creating these, as their views were also considered and documented.

People's views about the staffing levels varied. One person told us, "I think they might need more staff to take people to appointments, sometimes appointments are re-arranged or cancelled." Another said, "Staffing is ok, but I'm independent so I see to myself." A staff member said, "It's been demanding lately, two staff have left so we are covering shifts. We work very well as a team, and we all pitch in."

Oliver Court comprises two linked Victorian style houses. One side houses people who live independently in flats, the other side is for people requiring a higher level of support, and therefore staffing levels are calculated on the basis that some people live independently. The registered manager told us that two experienced staff had recently left the service, and they had recruited two more staff but were awaiting recruitment checks prior to them starting. As a result existing staff had been covering shifts, but the number of staff on shift had not dropped. On the day of our inspection we were told that the cook was on holiday, and we observed that a member of care staff spent most of the morning working in the kitchen covering the workload of the absent cook. There was therefore little spare capacity to deal with any issues that might arise.

The registered manager told us that usually staffing levels were more than sufficient, but the past two weeks had been more difficult due to two staff leaving, and one person who was presenting with increasingly challenging behaviours which had impacted on staff time. As a result, people's appointments had been re-arranged in the last two weeks, but said this was a very rare occurrence. We advised the registered manager to implement a dependency tool to support them to determine staffing levels more accurately in the future, and in line with people's changing needs.

There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria. However, the risk assessment needed to be more robust. For example, the roles and responsibilities of the staff monitoring the water temperatures, including how often this should be done, target water temperatures, and who was responsible if issues were identified. Following the inspection the

registered manager informed us that they had promptly contacted a water company and requested they visit the service and assist with creating a more comprehensive risk assessment.

Where people required support, personal emergency evacuation plans were in place which outlined the support people would need in an emergency situation.

Staff working in the service had received safeguarding training and were aware of what constituted abuse. One staff member said, "We [staff] are very aware of abuse and what to look out for. People can be at risk of financial abuse, sexual abuse, theft, and there are also dangers from strangers in the community." Another said, "People we work with can be quite vulnerable so we [staff] look out for signs of changes in their manner. We know people well here so notice if something is wrong." The registered manager had also notified us when people had reported potential cases of abuse, and we saw they had taken appropriate actions. This included reporting incidents to the police, care teams and other agencies involved in people's care.

Recruitment processes were in place to ensure staff working with people were suitable for their role. This included Disclosure and Barring checks, which identify people who may be barred from working with vulnerable people.

People commented on how safe they felt living in the service. One person told us, "It's a safe place to be, most people are quite independent and look after themselves. Another said, "Once or twice a week I hear shouting, staff separate people and calm them down. It always gets sorted".

Good

Is the service effective?

Our findings

People commented on the care that staff provided. One person said, "I was suffering with [condition] I talked to them [staff] about that and they reassured me." Another said, "Staff are very helpful, lovely really, very understanding, they do all they can." A relative said, "Overall they [staff] are a lovely bunch."

Systems were in place to ensure that staff were provided with training and support, and the opportunity to achieve qualifications relevant to their role. Staff received training in areas such as safeguarding, moving and handling, Mental Capacity Act and Deprivation of liberty safeguards, medicines, first aid, drugs and alcohol, and behaviour de-escalation. Other relevant training was also provided when needed, for example, specific mental health conditions, so staff could understand more about how certain conditions could affect people in their daily lives. One staff member said, "The training here is good, I've been supported to do training in a way that supports my [learning needs]."

New staff received an induction period prior to working independently in the service. This included shadowing of experienced staff and completion of the Care Certificate. The Care Certificate is a set of standards that care workers are assessed on to ensure they are providing good quality care, and standards that should be covered as part of induction training of new care workers. One staff member told us that their induction had included reading people's care plans, undertaking shadow shifts, and completing the Care Certificate.

Staff received supervision sessions which provided staff with a forum to discuss the way they worked, identify training needs, and receive feedback on their practice. One staff member said, "I had supervision a couple of weeks ago, and I get to say how things are going." Another said, "I'm asked for my views, feedback and concerns. An open talk, you can get it off your chest and it's documented. They're about every six weeks but you can stop [registered manager] and chat anytime".

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 decision made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

The registered manager informed us that all people living in the service at present had mental capacity. We saw that in the past the service had made applications for DoLS if they felt this was necessary, but currently there was nobody who was subject to a DoLS authorisation. We found that where people's capacity had been in question, or where it fluctuated, appropriate social care professionals had been contacted. The

registered manager had a good knowledge of when people might require a DoLS and the importance of best interest decisions. We saw that one person had an advocate in place to support them with specific appointments they found stressful.

People's records made reference to their mental health and how people should be supported with their emotional needs. This included reference to their wishes in the event that they were detained under the Mental Health Act. Where legal representatives were in place, these were documented, including what legal authority they held, for example, to manage a person's finances.

People's freedom was promoted, and care plans made reference to how people liked to live their lives. Where there were potential risks, for example, people absconding, care plans described what factors increased risk, and how to reduce them. One person said, "I can come and go as I like, I don't feel restricted." Another said, "I have a lot more freedom here. I'm allowed to drink here in my room and there's always someone here to chat to." A staff member said, "Its person-centred planning here. They [people] decide how they want to live their lives. We support that."

Where required, people were supported to eat sufficient amounts and maintain a balanced diet. Lunch time was flexible between the hours of 11:30am to 1:30pm, to support what people were doing during the day with a similar flexible regime for supper. The food available to people was varied and well prepared by staff. Drinks were constantly available. Most people had cooking facilities in their flats and could self-cater. Some people required prepared meals which offered alternatives. One person said, "I have what I like, I have a microwave in my kitchen and I keep a lot of ready meals in my freezer and they cook them for me". Another said, "[Staff member] baked me a diabetic cake for my birthday." We also saw that a 'menu survey' had been completed, asking people what their food preferences were and their general opinion of the food, which we saw was mainly positive.

Care plans made reference to people's dietary needs, for example, one person's care plan showed they were on a low fat diet and that staff were supporting them to attend a weight loss club. Another person had a small appetite and had previously been prescribed 'build-up' drinks to increase their weight. We saw these had been stopped as the person had subsequently gained weight.

People's general health and wellbeing was reviewed on a daily basis and their care records were kept up to date regarding their healthcare needs. People had access to a range of health care services and received on-going health care support where required. This included health professionals, psychiatric services, speech and language therapy, cardiology, audiology and continence nurses. We saw that referrals to relevant professionals were done so in a timely manner, and where needed, further advice had been sought.

Staff supported people to attend professional appointments and meetings when requested. The registered manager told us that they had made sure they were available to take one person to an appointment as they had been supporting the person who was apprehensive about attending. A social care professional told us, "They [staff] are fantastic at communication. They are always updating me about people. I come in and I get all the information." A relative said, "They [staff] always call me if [relative] has been unwell. They involve me."

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. One person said, "Staff know me very well and know what I like". Another person said, "It's the best place I've been to, staff are very nice, very open". A relative said, "Staff are always friendly." A social care professional told us, "They [staff] are very kind and caring. They are very understanding."

We observed and spoke with staff who demonstrated a good knowledge of people living in the service, such as their health care needs, personal likes and dislikes, and the various interactions between people living in the service. We observed warm relationships between people and staff. This included the registered manager, who we saw received a hug from one person living in the service, and who also told us that they were, "Fantastic." One staff member said, "I like people, I care about people, I was in [different career] but wanted greater contact with people." During a conversation with us, when a person reported that someone needed assistance, they immediately went to take care of the matter.

There were regular 'residents meetings' and also one-to-ones meetings with key workers which provided an opportunity for opinions to be expressed by people. Relevant items were discussed during these meetings such as smoking areas, holidays, activities, and requests for new furniture, such as communal sofas. We also observed that staff and management were constantly around and were approachable. Throughout the day, we saw people coming in to see the registered manager with different types of questions and queries, which were responded to patiently. People were comfortable and relaxed entering the staff and management office for advice and sometimes just to sit down and have a chat. One person said, "Very good here, very flexible with a bit of a family atmosphere."

Care plans were signed by people to show their involvement and agreement to their care. Where people did not agree to sign, or where they had declined to take part in creating or reviewing their care plans, this was noted to show the person was asked. We saw one person come to the office and said to the registered manager, "I would like to discuss a couple of things in my care plan later if that's ok, I'd like to change some things in it." This demonstrated that people were aware of, and involved in, their care planning.

Some people living in the service were there for a period of rehabilitation and living independently in their own flats. Care plans included a section on 'independent living and recovery' which included what goals they would like to achieve, such as managing their own finances, shopping, laundry, and managing household chores. Aims were listed, in addition to how they would achieve their goals.

People's privacy and dignity was respected, and at several points during the day we saw that staff, when speaking about people, did so in a discreet manner so others close by were not able to hear. When we were discussing people's care, staff closed doors, or asked people to wait outside to ensure that no confidential information was overheard by others. One person said, "Staff always knock, shout, if no answer they enter and shout again, they [staff] only go in the flat if asked."

There were no restrictions on visits by family members and friends to the service. One person said, "They

[staff] let my [friend] stay over and have no problem with that if I let them know in advance".

Good

Is the service responsive?

Our findings

Staff told us they felt that the majority of the time they could be responsive to people's needs, although at times recently this had been more difficult. One staff member said, "We can meet people's needs, but if something happens between [people] and there are only two staff around it can be more difficult." Another said, "Staffing is ok, today I took four people to [location] for a trip out. Trips out can be random, but for some people that works better, some people don't want structure, it stresses them out."

People's records included care plans which guided staff in the care that people required and preferred to meet their needs. This included personal care, mobility, physical health, emotional needs, social inclusion and mental health. Care plans were detailed and contained relevant information which related to people's mental health history, and assessments carried out by other professionals. This provided staff with information to help them understand people's experiences, and how they could best support them. One staff member said, "The culture here is assisting people to do everyday things, promoting independence and not judging or labelling people."

We saw there was an activity schedule in place, which showed when activities would be taking place. This included swimming, cooking, table tennis, film nights, and arts and crafts. There was also a good sized games room with large sofas offering a pool table, piano, arts and crafts, television and laptop. People's views of the activity provision varied. One person said, "Plenty to do", another said, "We used to do quite a lot; pleasure beach, sea-front, but stopped this year, cutbacks". A third said, "it's rare to get walks." A relative told us, "My only criticism of Oliver Court is that I wish there were more activities for people. My [relative] is not getting enough exercise or walks, and it is this that keeps [relative] mentally well. Things get cancelled at short notice."

The registered manager told us, and we observed that people's ability to join in with activity varied. Whilst some people independently sought activity for themselves, others preferred their own company. Some people however did rely on activity being provided. The minutes from the resident meeting in February 2017, showed that people had requested more days out. A staff member said, "Sometimes it's difficult. We have to cover appointments and activity. Obviously it's important that people attend appointments, so that's usually the priority. This impacts on staff numbers, so sometimes activities are harder to provide. We need staff to be able to cover outings more."

The registered manager told us that they did try to ensure activity was covered, and in most cases they felt this was the case. They also supported people to take part in bigger activities, such as snowboarding and go-carting, which we were shown photos of. They acknowledged that the past two weeks had been more difficult with two staff having left the service and one person requiring more support from staff. We advised them to review the provision of activity to ensure it was meeting the individual and specialist needs of all people living in the service.

People were supported to find employment, or undertake voluntary work or education in the community. This ensured people were able to maintain links with the wider community which provided meaningful

activity and purpose.

There was a complaints procedure in the service. All complaints and compliments had been logged, which included any actions taken. They were then analysed to identify any recurring themes. People we spoke to felt confident that they would be able to make a complaint if they wanted to. People felt confident that they would be listened to.

Good

Is the service well-led?

Our findings

There was a registered manager in post. They were supported in their role by a deputy manager. Both were knowledgeable about the service and the importance of ensuring a high quality of care for people. The registered provider visited weekly, and was present during the inspection. They were very involved with what was happening in the service, and we saw them receiving feedback about each person living in the service. The approach of the registered provider and manager was open and transparent, seeking feedback to further improve the provision of care.

Where we had identified areas for improvement in the service, the registered manager acted promptly to resolve these. For example, where medicines procedures needed improvement, they planned to arrange for a pharmacist to visit the service and review their procedures. They had also purchased an air cooler for the medicines room to ensure medicines were stored safely. A water company had been contacted to review the legionella risk assessment, and a 'consent to share' form had been implemented as a result of a recent incident, demonstrating that lessons had been learned, and action taken as a result. This included discussion with the registered manager at the provider's other location, to ensure the learning was shared.

The management team had systems in place to monitor the quality of the service and to identify areas for improvement. Audits included care records, complaints, medicines, health and safety, and incidents and accidents which had occurred in the service. These had been analysed to identify trends and recurring themes. Actions had been taken to reduce risk or risk of recurrence.

The registered manager told us the provider commissioned an external consultant annually to carry out a quality monitoring audit which focussed on ensuring that documentation and quality checks met the expected standards. This had been done so that an independent person could establish how well the service was being managed and could give advice about any improvements that may be necessary. We were given the quality report carried out in February 2017. We saw that where improvement had been identified, that actions had or were being taken.

There was an open team work culture and staff told us they enjoyed their work, caring for and supporting people. Staff told us that if ever they identified or suspected poor standards of care or harm they would have no hesitation in whistle blowing. Whistle-blowing occurs when an employee raises a concern about a dangerous or poor practice that they become aware of through work. One staff member said, "The culture is very open here, nothing is hidden up, if it was staff would whistle-blow."

Staff gave us their views about the management team. One staff member said, "[Registered manager] does a superb job. They lead by example, and knows about everything that is going on." Another said, "The home is very well run. [Registered manager] has a relaxed approach, you can speak to them about anything." Professionals we spoke with all praised the work of the staff and management team. One social care professional told us, "[Registered manager] is very helpful, very supportive and a lovely person." Another said, "Very good, very bright I'd say." We saw from people's records that relevant care teams and other professionals were regularly contacted for advice and support where necessary.

People's views were important to the management team, and we saw that surveys were issued annually to people living in the service. Relatives and professionals were also asked for their feedback, which we saw was positive. Actions were listed on each survey following feedback, to show it had been listened to and where needed, changes made as a result.

The registered provider was fully involved in the service. They told us about work that was underway to convert six rooms into three flats. The registered provider told us they were excited by the project which will mean they can offer people a more independent style of living in their own self-contained flat. They had also arranged for CCTV (closed circuit television) to be installed outside of the building to ensure people's safety.

The management team and registered provider demonstrated a commitment to providing a high standard of care, with a view to continually improving the service provided.