Horton Housing Association

Oak Mount Care Home

Inspection report

5a Cliffe Road
Bradford
West Yorkshire
BD3 0JP

Tel: 01274648902

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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

The inspection took place on 09 February 2016 and was unannounced. At the time of the inspection there were eight people living at the home.

There was a change in registration in November 2014 when the service moved to new purpose built premises. This was the first inspection since registration.

Oak Mount offers long-term residential care for men whose lives are severely affected by their chronic alcohol use problems.

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.

People living at the home told us they felt safe and secure. The registered manager and staff were aware of their responsibilities to protect people from harm and knew how to recognise and report abuse. The required checks were done before new staff started work and this helped to protect people from the risk of receiving care and support from people who were not suitable to work with vulnerable adults. There were enough staff deployed and staff were trained and supported to carry out their duties and meet people's individual needs.

We found people's medicines were not always given in a safe way.

The home was clean and well maintained. Risks to people's safety and welfare were identified and measures put in place to reduce or remove the risk.

The home was working in accordance with the requirements of the Mental Capacity Act 2005 and people were not deprived of their liberty unlawfully. People were asked for consent before any care or support was delivered.

People were supported to have an adequate diet and their preferences were catered for. Mealtimes were flexible to take account of people's preferred daily routines. People were supported to access the full range of NHS services.

People were treated with respect, dignity and compassion. People were supported to make choices about all aspects of their daily lives and empowered to be as independent as possible.
People were supported to maintain relationships with family and friends and see their visitors in private.

People were involved in all aspects of assessing and planning their care; this started before people moved in

and continued throughout their stay. People were given clear information about their rights and responsibilities and it was made clear from the outset that behaviour which put other people or staff at risk would not be accepted.

People who lived at the home were aware of how to make complaints and we saw complaints were taken seriously and acted on.

There was an open and inclusive culture and people who lived at the home had nothing but good things to say about the service, the staff and in particular the registered manager.

People who lived at the home and their representatives were involved and consulted about all aspects of how the service operated and the staff and manager were constantly looking at ways to improve the service.

We found one breach of regulation; you can see the action we told the provider to take at the back of the full version of the report.

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.

People told us they felt safe and staff knew how to recognise and report any concerns about people's safety and welfare.

People's medicines were not always given in a safe way.

There were enough staff and all the required checks were done before new staff started work.

The home was clean and well maintained. Risks to people's safety and welfare were identified and managed.

Is the service effective?

Good

The service was effective.

People's rights were protected; the service was working in line with the requirements of Mental Capacity Act and people were asked for their consent to care and treatment.

People were supported to eat and drink an adequate diet and their dietary preferences were catered for. They were supported to maintain good health and access the health care services they needed.

People were supported by staff who were trained and supported in their roles.

Is the service caring?

Good

The service was caring.

People were treated with compassion, dignity and respect and they were involved in decisions about every aspect of their care and support.

Staff were respectful of people's individual needs and supported people to maintain their independence.

Is the service responsive?

Good

People's needs were assessed and they received care and support which was appropriate, met their needs and took account of their preferences.

People were aware of how to make a complaint and complaints were taken seriously and acted on.

Is the service well-led?

Good

The service was well led.

The registered manager had a clear vision for the service and provided strong leadership based on the values of openness, compassion, dignity and respect.

The service had a positive culture and was person centred, empowering and inclusive.

People, their family and friends were regularly involved in a meaningful way to help the service continually improve. People's feedback about the way the service was led described it as consistently good

Oak Mount Care 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.

The inspection took place on 09 February 2016 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case their area of expertise was alcohol and addiction dependency, homelessness and mental health.

Before the inspection we looked at the information we hold about the service which included notifications sent by the home. We usually ask the provider to complete a Provider Information Return (PIR) before an inspection. 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. On this occasion we did not ask for a PIR, however, we reviewed information on the provider's website which included the Statement of Purpose and Service Description.

During the inspection we spoke with four people who used the service, one visitor, two support workers, the cook and the registered manager. We looked at four people's care records, medication records, staff files and other records relating to the management of the home such as maintenance records. We looked around the communal areas of the home and some of the people who lived there invited us the look at their bedrooms.

Requires Improvement

Is the service safe?

Our findings

None of the people we spoke with had a bad word to say about the service all of them were very happy and settled at Oak Mount. They told us they were all very well looked after. Family members told us they felt comforted in knowing that even though there family members were troubled in some way they were safe and warm and cared for. There were policies and procedures in place to make sure people were protected from harm. The registered manager and staff were aware of their responsibilities in protecting people and knew how to report any concerns about people's safety and welfare.

We examined the procedures and practices regarding the handling of people's personal money. We found eight people were assisted to manage their own money. All money was securely held in a locked safe. Each person's money, debit cards and receipts was in a separate plastic wallet. We checked the contents of three people's wallets and compared our findings with the written accounts. We found all the accounts to be correct. We were told all money was checked daily at the hand-over of each shift. Records we saw proved this to be the case. We saw further evidence of robust practice through the provider's audit processes. We saw audits in the past had found procedural weaknesses which the provider and manager of the service had acted upon. Whilst the provider's lengthy audit process and our shorter focussed audit were not directly comparable we found the accounting practices in place protected people from potential financial abuse.

Risk assessments were undertaken to identify any possible risks to people's health and safety. Assessments covered areas such as the possibility of fire through smoking, self-neglect, financial exploitation, falling and nutrition. Staff told us if there were changes in a person's care needs then care plans would be reviewed and updated as needed. We saw risk assessments were continually been reviewed and were subject to a multi-agency review each year. All risk assessments had a bespoke risk contingency plan to mitigate risk. For example, one person was known to smoke whilst under the influence of alcohol thus posing a risk to themselves and others. The contingency plan required all bedding and curtains to be flame retardant, for staff to regularly check the person whilst alone in their room and all staff to be trained in fire safety. Our observations and scrutiny of records proved the risk mitigation plan was fit for purpose.

We completed a tour of the premises and found the home was clean and well maintained. The home is constructed on one level. We inspected two bedrooms and various communal living spaces. All radiators in the home were covered, or were of a cool panel design, to protect vulnerable people from the risk of injury. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. We found all floor coverings were appropriate to the environment in which they were used. All floor coverings were of good quality and properly fitted thus ensuring no trip hazards existed.

We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant and within date. We saw that Control of Substances Hazardous to Health Regulations 2002 (COSHH) assessments had taken place to prevent or control exposure to hazardous substances. All cleaning materials and disinfectants were kept in a locked room out of the reach of vulnerable service users.

Medicines were administered to people by appropriately trained care staff yet our observations demonstrated the carers practice fell short of an acceptable standard. No person at the home was self-medicating with care records showing this was through people's choice rather than a lack of proven mental capacity.

We observed a care worker administering medicines which contravened the provider's policy. We saw they administered medicines to five people before signing the medicine administration record (MAR). The provider's policy reflected good practice by stating, "The (MAR) sheets must be signed at the time the medication is administered i.e. sign as you go and not 'en-bloc' after the medicine round". We further saw the care worker had prepared two liquid medicines for two people and walked to the people's bedrooms to administer. This practice placed people at risk of being administered the incorrect medicines.

This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found medicine storage cupboards were secure, clean and well organised.

Arrangements described in the provider's medicine policy for the administration of PRN (when needed) medicines were designed to protect people from the unnecessary use of medicines. Our observations demonstrated the policy was not being fully implemented. We found medicines were prescribed and recorded on the MAR sheet as 'when required' without any description of the minimal interval between doses and no indication of the reasons to administer the medicine. For example, one person was prescribed Promethazine 25mgs to be taken at night when required. Later, during scrutiny of care records we saw a list of current prescribed medicines which indicated the reason PRN medicines could be administered yet this was not readily available to staff conducting a medicine round. Care staff told us they would place a copy of the list with the MAR sheets.

During our observations of the medicine round we became aware some medicines were not available for administration. For example one person was prescribed Paracetamol 500mgs on a PRN basis and was in need of the medicine regularly each day. We found the medicine had been unavailable for three days. We asked care staff and the manager to account for the matter. We saw evidence the prescription had been submitted to the GP practice three days before the supply became exhausted yet six days later we found the prescription had not been dispensed. The manager told us this was a recurrent problem with the GP practice blaming the pharmacy and vice versa. We looked at a record of prescriptions submitted by the home where untimely dispensing had resulted in medicines being unavailable. Our observations showed this to be a regular unwelcomed feature of the service.

We looked at a sample of medicines dispensed in liquid form. We found the bottles were not dated upon opening and on two occasions it was likely the medicine was out-of-date. For example, a person had been prescribed Gaviscon with the label indicating a dispensing date of 22 October 2014. The bottle had been opened. We opened the bottle to find the medicine had developed a grey hard crust around the rim of the bottle. A care worker said they would remove the medicine and if appropriate arrange for a new supply.

Scrutiny of MAR sheets showed some people regularly refused their medicines. Care staff understood these refusals may not be based on an informed decision and may be influenced by the use of alcohol. We saw daily care records demonstrated care staff frequently checked with people whether they were prepared to take their medicines following initial refusal. Records showed this approach to be beneficial.

The registered manager told us there were enough staff to ensure people received the support they needed.

Staffing levels were kept under review and changed in response to changes in the level of support and care needed by people who lived at the home. People living at the home were very complimentary about the staff and were satisfied staff were available when needed. Staff told us they enjoyed working at the home and there were no problems with staffing because they worked as a team to cover any absences. For example, one of the staff said, "Sometimes, I volunteer for the night shift I like it here that much."

The provider had robust recruitment procedures in place to make sure the required checks were done before new staff started work to reduce the risk of appointing staff who were not suitable to work with vulnerable adults. This included background checks such as references and criminal records checks with the Disclosure and Barring Service, (DBS). This was confirmed by the staff files and the staff we spoke with. At the time of the inspection the provider had just carried out an audit of their recruitment policies and procedures and was in the process of updating the policies and procedures.

The registered manager told us they were involved in the recruitment of staff at Oak Mount and said their focus was on getting staff with the right approach, they said, "When I interview someone for a job here I look at they're background and experiences first before anything else because to me having an open empathetic and none judgemental attitude to work here is more important than a degree in social care."

Good

Is the service effective?

Our findings

We saw evidence the provider sought the consent of service users in order to carry out any proposed care and treatment and to follow specific procedures in line with the Mental Capacity Act 2005 (MCA 2005) where people were unable to give their informed consent. Care plans demonstrated service users were empowered to lead their own lives and enabled them to exercise choice and maximise their independence, whilst offering them the support and care they need. We saw all plans or proposals for people's care were fully recorded.

The MCA 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack 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 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We spoke with the registered manager about the Mental Capacity Act 2005 and DoLS. We found their knowledge of the legal frameworks to be sufficient to safely and legally carry out care. One person had recently been assessed to be lacking in mental capacity which made it appropriate to submit an application for authorised DoLS. This application had been preceded by an application for urgent authorisation which had subsequently been extended for the maximum period in total of 14 days. The outcome of the standard authorisation was awaited. Our assessment of the environment, other people's care plans and our observations through the day indicated no further people were being deprived of their liberty.

People were supported to maintain good health and access the health care services they needed. We saw appropriate referrals were made to healthcare professionals such as opticians, specialist nurses and dieticians. We saw evidence staff worked with other agencies such as NHS mental health services to ensure people were cared for and supported in an appropriate manner.

Some people had varying degrees of cognitive impairment due to prolonged and excessive use of alcohol. We saw evidence the provider was ensuring people were treated with dignity and received care and support based on individual need, rather than assumptions about the condition. We saw some people had declining health which potentially may result in an increase in falls. Adaptations had been made to people's bedrooms and toilet and bathing facilities to ensure they were protected from harm. This demonstrated the provider was recognising their responsibilities as defined in the Equality Act 2010 and had made "reasonable adjustments" to ensure people with disabilities were not disadvantaged.

One person who lived at the home said, "The food is really good the chef will cook me anything I asked for and its proper food as well none of that cheap **** here ''

We spoke with the cook who knew about people's likes and dislikes and dietary needs. There was a list in kitchen of people's likes and dislikes so this information was available for other staff when the cook was not working. At the time of the inspection none of the people living at the home had any special dietary needs but the cook told us they could cater for special diets if the need arose. The meal times were flexible and people had their meals when they wanted. The cook worked to a four weekly menu and cooked a main meal around lunch time every day; people were then able to have the meal reheated when they wanted to eat. The cook told us people could have more or less what they wanted at breakfast and tea time and we saw the fridges and cupboards were well stocked. We saw the main meals were cooked from fresh ingredients and the use of frozen foods was limited. The cook kept a record of what people had eaten and this along with people's care records showed people were able to choose what they wanted to eat and when. For example, in one person's records we saw they had asked for scrambled eggs at 9.30pm one evening and this had been cooked for them.

A recent audit of the service by the provider had identified the need to carry out nutritional risk assessments and monitor people's weights are more regular intervals. The registered manager was in the process of implementing this at the time of the inspection.

The registered manager told us all new staff completed a 12 week induction and had monthly supervisions for the first six months of employment. The records we looked at confirmed this. The provider had a an online training academy where records of all staff training and development were maintained. There was a training plan which identified mandatory training and how often this should be updated, for example, safeguarding training was updated every two years. There was a planned programme of supervision and appraisal and the records showed these were up to date. The registered manager carried out staff supervisions and appraisals and they were reviewed by their line manager. Staff we spoke with told us they felt supported to carry out their duties and develop further skills and knowledge.

Good

Is the service caring?

Our findings

People who lived at the home had nothing but praise for the service and the staff. These are some of the things people said to us about the service:

"You know what the staff here are amazing and the manager will do anything she can for you if you ask her ''

"It was my 40th the other week and I fell asleep in the afternoon but when I woke up and went into the dining room there was balloons up and cake and all kinds set out it was amazing I honestly couldn't believe it I haven't had a party like that since I was 10 years old , Fantastic ''

"I'm in bed bound because I broke my pelvis , I was on the toilet and drunk and reached out for my wheelchair but I forgot to put the brakes on it and slipped , the staff are in and out of my room every few hours checking on me they are amazing here can't fault them at all ''

"I feel sorry for the staff here sometimes when the meds are late and some lads are drunk they get a bit nasty with staff but it's not their fault it's the doctors and chemist they haven't got a clue".

A relative of one of the people who lived at the home said, "Now that he's here I sleep better at nights I know he's got a long way to go yet but he's safe and I visit him every other day. The staff here will do anything for you they really do go out of there way ''.

Staff supported people to maintain their independence as much as possible. Care plans demonstrated staff helped with a range of daily living tasks, from shopping to cleaning to helping with the preparation of meals, but this was with the explicit consent of individual people. The home was within walking distance of local shops and other facilities which people took advantage of.

People were able to decide when to get up and go to bed, when and where to eat their meals and whether they wished to spend time on their own.

Whilst people at the home had close friends or relatives a common feature of this care group is isolation with loss of contact with families. We spoke to the manager and care staff about advocacy. There were systems in place to request support from advocates for people who did not have families. Advocates are people who are independent of the service and who support people to have a voice and help them to make decisions.

Everyone living in the home had their own bedroom with an en-suite shower and toilet area. This meant they had private space where they were able to relax and have privacy. People were supported to maintain their privacy because they were supported to lock their bedroom doors if they wanted. People were able to meet friends, relatives or professionals in their bedroom or in the quiet lounge which meant they were able to maintain their privacy. Staff referred to people by their preferred names and waited to be invited in after they knocked on bedrooms doors.

We looked at two people's care plans and saw they contained comprehensive information about people's needs and preferences. The information was clear and there was sufficient detail to enable staff to provide consistent care.

Good

Is the service responsive?

Our findings

The registered manager carried out a detailed assessment before people moved into the service. The specialist nature of the service meant some people originated for well outside the home's natural catchment area. The manager told us of an assessment recently carried out over 100 miles away yet stressed to us the importance of a personal assessment to ensure an appropriate placement. The registered manager gave us confidence they knew of how disruptive an inappropriate placement could be for vulnerable, fragile people.

People living at the home told us about they had been involved in the initial assessment. For example one person said, "I came here from the south of England , my social worker arranged it all, I had to complete a lengthy form and sit an interview but after that was done the process went so fast and I moved here within a few weeks ''

Following this initial assessment, care plans were developed detailing the care, treatment and support needed to ensure personalised care was provided to each person. This assessment identified choices of life-style so this could be integrated into the care plan. Because of the nature of the service the foundations of care planning was derived from an in-depth risk assessment. This approach was to protect the individual from harm and to ensure no harm came to others.

People contributed to the assessment and planning of their care and signed to say they had understood. People routinely discussed their needs and preferences with staff and this was recorded in people's care plans under the daily activity notes. People's key workers reviewed the daily notes and where necessary updated the person's care plan accordingly. Key workers had particular responsibility for ensuring people's needs and preferences were understood and acted on by all staff.

Whilst care was positively influenced by people receiving care there were responsibilities placed on people to ensure a harmonious environment existed. People were aware they might face exclusion from the home if they continued to exhibit either verbal or physical aggression to staff or other residents. We saw evidence of written agreements between the provider and people. We also saw clear guidelines for staff to rigidly follow should exclusion be a possible outcome of untoward behaviour. We saw these guidelines were closely linked to other guidelines which informed staff of appropriate non-physical interventions designed to manage untoward behaviours.

We saw any physical intervention on the part of staff was forbidden with staff instructed to involve the police in such circumstances. Staff with whom we spoke had a thorough understanding of the written guidelines. Our discussions showed staff were trained and experienced in dealing with aggression and potentially violent behaviour. During our inspection we witnessed one person who was having difficulty expressing their feeling which was manifested in shouting and threatening behaviour. We saw staff take immediate action and bring a potentially aggressive situation to a peaceful conclusion.

There was a complaints procedure in place. People who used the service told us they would not hesitate to

speak to a member of staff or the manager if they were unhappy about anything. When we looked in people's care records we saw evidence people's complaints were recorded and investigated and they received a written response.

Good

Is the service well-led?

Our findings

Staff told us how much they enjoyed working at Oak Mount. These are some of their comments:

"This is a great place to work it's kind of a lifestyle more than employment I love it here and this new building makes it even better."

"Have you met our manager? She's great."

"We are like a family here, good communication and empathy all around."

There were monthly team meetings to help make sure staff were kept informed about any changes and had an opportunity to make suggestions about how the service could be improved.

We saw written evidence in the form of compliments received at the home that people, relatives and care professionals were complimentary about the service provided. We saw a comment from a paramedic who recorded, "How clean and welcoming this home is; how happy and welcoming staff are".

We saw people were comfortable in the presence of the registered manager and staff. Discussions with the registered manager and staff showed they were caring and interested in the welfare of people who lived at the home and staff.

The provider had a quality assurance system delivered by a dedicated team to check their policies and procedures were effective and to identify areas for improvement. We looked at the process and outcomes of four recent audits. We found audits came to clear conclusions with identified areas for improvement and who should affect the improvements over what period of time. Whilst we found the audits had improved the quality of the service there still remained some long-standing matters to resolve. For example the medicines audit of July 2015 identified inadequacies in the storage facilities and our observations showed this had still not been addressed.

Care files and other confidential information about people were kept in the main office which remained locked when not in use.

People living at the home were given a say in how the service was run by means of house meetings and consultations on specific points. For example, in January 2016 people were asked for their views on 'client involvement'. People were asked what they liked about the service, what could be improved, what activities they would like to take part in and if they felt the house meetings were worthwhile. There were a lot of positive comments about the service, for example, one person said, "I feel secure and well looked after. It's a nice home, nobody gets neglected." There were some suggestions for improvements, for example one person said they would like to see more organised activities. Following consultations feedback was provided by means of a 'You said, we did" posters displayed in the communal areas. The posters showed what action was being taken in response to suggestions, ranging from 'we can do this or already have' to 'we are sorry

we can't do this but we'll explain why'.

Accidents and incidents were recorded and reported to the providers head office where a Health, Safety, Welfare and Risk group reviewed all accidents and incidents to identify trends or patterns and identify actions to reduce the risk of recurrence.
The provider had a number of external awards in recognition of good practice, these included Investors in People, Investors in Diversity and the Mindful employer awards.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always administered safely. Regulation 12(2)(g)