The Oaks Care Home

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Inspection report

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Ratings

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

Overall summary

The inspection took place on 17 and 20 November 2015 and was unannounced. This means the provider did not know we were coming. We last inspected The Oaks Care Home in July 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

The Oaks Care Home provides care and support for up to nine people who have a learning disability. Nursing care is not provided. At the time of our inspection there were seven people living at the home.

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

We found that people received care that protected their personal safety and welfare. Risks had been assessed and measures were taken to prevent people from being harmed. Staff understood their roles in safeguarding

Summary of findings

people against the risk of abuse and knew how to protect people during their care and support. Relatives confirmed that they felt their family members were safely cared for at the home.

New staff were properly checked and vetted before they were employed to work at the home. There were enough skilled and experienced staff to provide people with continuity of care. The staff were provided with training and support that enabled them to meet people's needs effectively.

Arrangements for the management of medicines were not fully robust. We have made a recommendation about assessing the competency of staff who handle medicines. People were appropriately supported to stay healthy and accessed a range of health care services. Relatives told us that staff were very good at keeping them informed of any changes in their family member's well-being.

Nutrition was assessed and monitored to ensure people's dietary requirements were met. People were offered choices of food and drinks and mealtimes were a pleasant experience where people and the staff dined together.

People and their families were consulted about and agreed to the care and treatment provided. Where people were unable to give consent or make important decisions about their care, formal processes were followed under mental capacity law to uphold their rights.

Staff had a good understanding of people's diverse needs and the ways they preferred to be supported. They treated people as individuals and were kind and caring in their approach.

People and their relatives were satisfied with the care and support provided and had no complaints. A complaints procedure was in place that people were made aware of and could use if they were ever unhappy with the service.

Staff worked well with people in promoting their life skills and independence and meeting their social needs. People were given personalised care which was reflected in extensive and individualised care plans. We have made a recommendation about care planning in relation to Deprivation of Liberty Safeguards.

The registered manager was supportive and provided leadership in the home. They encouraged people, relatives and staff to express their views and influence the service. The quality of the service was routinely checked to ensure that standards were being met.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People received their medicines safely though a system to assess that staff were competent in handling medicines had not been introduced.

Appropriate steps were taken to manage risks and keep people safe during their care delivery.

Staff knew how to prevent harm and abuse and the process for reporting any concerns about people's safety.

A suitable recruitment process was followed to employ new staff. There were enough staff to provide people with safe and consistent care.

Good

Is the service effective?
The service was effective.

Staff were trained and supported to meet people's needs effectively.

People were given care that they had consented to. The service upheld people's rights under the Mental Capacity Act 2005.

People were supported to maintain good health and meet their nutritional needs.

Good

Is the service caring?
The service was caring.

Staff were caring and had developed good relationships with the people living at the home.

People were encouraged to be involved in making choices and decisions about their care.

Staff worked inclusively with people and were respectful of their privacy and dignity.

Good

Is the service responsive?
The service was responsive.

Care plans were comprehensive and focused on each person's individual needs and well-being.

People were well supported to engage in social activities and be involved in the community.

There was a complaints procedure that people understood. No complaints had been made about the service.

Good

Is the service well-led?
The service was well-led.

An experienced registered manager was in post who promoted an open culture.

The staff worked well as a team and were given clear expectations of the standards of care to be provided.

Good

Summary of findings

Systems were in place to seek feedback and monitor the quality of the service that people received.

The Oaks 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 was 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 17 and 20 November 2015 and was unannounced. The inspection team consisted of an adult social care 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 our inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted the local authority that commissions the service and were provided with copies of their latest reports on the home. These highlighted areas of good practice and some issues requiring follow up.

During our inspection we talked with five people using the service, telephoned four relatives, and spoke with a senior care assistant, four care staff, a student and the administrator. We observed how staff interacted with and supported people, including during a mealtime. We looked at five people's care records, three staff files and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

People's relatives told us they felt their family members were cared for safely. Their comments included, "(Relative) has been there more than 12 years. They (staff) are stricter with them outside and that keeps them safe. Staff keep a close eye on them"; "(Relative) loves it, they've been there 20 years"; "Yes it's safe or (my relative) wouldn't be there"; and, "Very safe, (relative) has always had excellent care." One person we talked with said, "Yes it's okay, I've been living here a long time."

The home had safeguarding and whistle-blowing (exposing poor practice) policies and procedures which guided staff on how to recognise and report any concerns about abuse or unsafe care. The staff we talked with had received safeguarding training and understood their roles in protecting people from harm and abuse. Training was confirmed in staff records. There had been no safeguarding concerns reported since the last inspection.

Records relating to the safekeeping of people's personal finances were not available as only the registered manager had access to them and they were currently absent from the home. We saw people were able to access their money and that staff recorded details of transactions and, where applicable, obtained receipts for purchases. Some people were able to tell us about how their money was handled. For example, one person said their money was in the bank and managed by a relative. Another person had an awareness of and involvement in what happened with their finances. They told us, "I have my purse here. When we went to Benidorm (the registered manager) sorted my money into their notes and when we got back they changed it again so I can use it now."

Rosters showed there were at least two care staff on duty across the day. The registered manager's hours were in addition to these numbers. A third carer was rostered for periods of times during the day to accommodate dedicated one-to-one support. Staff told us six of the seven people living at the home had this additional time funded specifically for support with their living skills and social activities. They told us the allocated staff member worked solely with the person, either in the home or accompanying them to an activity of their choice in the community. During the night people were supported by one waking and one sleep-in staff member.

The care staff had multi-purpose roles which included cooking and cleaning. They told us this worked well with set tasks for day and night staff and a day each week when they supported people with their bedrooms. Staff were able to call upon two senior care assistants for advice or support whilst the registered manager was absent. No use of external agency staff was evident and the administrator told us staff were very flexible in providing cover for one another. This enabled people to have continuity of care from staff who understood their needs.

We talked with relatives about the staffing levels. They told us, "I am happy with the numbers, they get enough attention"; "This is a slightly tricky question as I would always say more is better and it might be tight at times but as far as I know there's always enough"; "There aren't a lot of residents. It's a small home so they get better attention. There are plenty of staff and they all know what they are doing"; and, "Enough staff – yes indeed."

No new staff had started at the home in the period since the last inspection. We reviewed some recruitment information for an applicant who was currently being checked and vetted. An application form with details of employment history, education and health had been completed. The administrator told us the applicant had recently been interviewed and they were sending for references, including one from the last employer. They said that if successful in being appointed, a criminal records check would be carried out. This showed us that a thorough recruitment process was followed to check the suitability of new staff.

Care records showed that people's personal safety had been assessed and steps were taken to reduce identified risks. A range of issues were addressed, including health conditions, moving and handling, distressed and challenging behaviours and vulnerabilities associated with the individual's learning disability. Any accidents or incidents were reported and documented. Staff told us these rarely occurred and the last accident was when a person had fallen and been taken to hospital for treatment. The person's risk management plan had been updated and discussed with staff at a meeting to ensure they were all aware of the close levels of supervision they required.

Servicing agreements were in place to ensure facilities in the building and equipment were safe and fit for purpose. These included tests of electrics and gas safety, the stair-lift, fire equipment and moving and handling aids.

Good

Is the service safe?

Safety checks were carried out and risk assessments were conducted for all areas of the environment, facilities and equipment that was used. The assessments had been reviewed the previous month to check that the control measures remained appropriate.

We looked around the home and found all areas were clean. There were no obvious safety hazards though some of the communal areas were cluttered and staff told us there was limited storage space. A patch of damp was evident on a wall in the main lounge area and we were told a contractor had been out to check on this.

We reviewed the arrangements for managing people's medicines. Medicines were supplied in blister packs for ease of administration and were stored in a locked facility. Care staff who administered medicines had undertaken relevant training in the past year. However, there was no system for periodically assessing the competency of staff in handling medicines. We noted that this matter had previously been raised when the home was visited by local authority commissioners in April 2015.

One person we talked with was aware of the medicines they were prescribed and told us they always received them on time. We saw there were records to support the safe management of medicines. In the Medicine Administration Records (MARs) file each person had a sheet with their name and photograph for identity purposes and information about any allergies. There was a separate sheet with signatures of all staff who administered medicines so that these could be cross referenced to the MARs. Pre-printed MARs were provided by the supplying pharmacy and we saw at times that staff had added further details to make directions for medicines clearer. For example, specific criteria for handling a medicine where contact with skin had to be avoided and for medicines which had to be given 30 minutes before food. Laminated sheets were kept for each topical medicine that people were prescribed with precise instructions for application.

We saw the MARs were appropriately completed to verify medicines had been given correctly, though there were two gaps where night staff had not signed the records. A staff member told us these medicines had been given and that the gaps to the records had already been identified and followed up with night staff. We were shown an entry to the staff handover and communication book that confirmed this. A senior care assistant told us weekly checks of medicines were carried out. These ensured there were sufficient supplies and that the stock levels corresponded to the amounts administered. A daily checklist was also completed by staff to confirm all signatures were entered into the MARs and that medicines had been administered as directed.

We recommend that the provider reviews the competency of all staff who handle medicines.

Good

Is the service effective?

Our findings

Relatives felt their family members were effectively cared for and said that staff promoted people's independence with daily living skills. They told us, "(Relative) is retired from day services now and doesn't want to go any more now they're older. Staff support them to make their bed, clean their room and dust. There's a stair lift so they can still have their room upstairs which they like"; "They encourage independence as far as they can. If (relative) doesn't want to do things they won't, they've always been like that"; "(Relative) loves ironing and staff encourage them to do it"; and, "The staff are well trained."

Records confirmed that care staff had undertaken induction training when they first started working at the home to prepare them for their roles. A senior care assistant told us any new staff employed in the future would be required to complete the 'Care Certificate'. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.

A training matrix, with an overview of the courses completed by the staff team, was not kept. We therefore looked at a sample of individual training records. Each staff member had an agreed personal development plan that included the training they would complete throughout the year. We saw the plans had been followed and staff had received a range of training. They had updated training in safe working practices such as fire safety, moving and handling theory and practice, safe handling of medicines, infection control, and food hygiene. Some staff had undertaken certificated training in 'understanding dignity and safeguarding in adult health and social care' which included their duty of care to protect people. Courses relating to the needs of people living at the home had been provided. Topics included working with individuals with learning disabilities, dementia awareness, nutrition and hydration and end of life care.

There was evidence in records that staff were provided with individual supervision and annual appraisals to review their performance and identify any support and training needed. The staff we talked with were very positive about the support they received. One staff member said, "We get plenty of training and supervision." A senior carer told us all staff had achieved nationally recognised care qualifications.

We saw care documentation included sections where staff had recorded people's abilities to understand and make decisions about their care and treatment. Records showed that people were asked to give informed consent to different areas of their care. Records specified the information staff must give in advance, for instance, explaining about medicines and the reasons they were prescribed before seeking the person's consent to them being administered. Consent was also obtained for any disclosure of personal information.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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).

We found the service worked within the principles of the MCA. For example, a person's mental capacity had been assessed and a best interest decision made, enabling measures to be put in place for their safety. A formal process had also been followed to seek authorisation for DoLS for one person living at the home.

There was a four week cycle of menus with a variety of main and lighter meals. Although sandwiches featured regularly for lunch on week days, we were told these were often replaced with other hot or cold alternatives. We saw staff kept daily records of the meals each person had taken, including packed lunches. No-one currently needed a special diet or assistance with eating and drinking. Nutritional needs were assessed and, where necessary, care planned, for instance supporting a person with weight management.

One person told us, "We have nice dinners. I like lots of different things." Relatives told us, "My (relative) never complains about the food. I have seen their Sunday dinners and they look adequate", and, "They are well fed. (Relative)

Good

Is the service effective?

enjoys their food." Another relative had been concerned about their family member's weight gain and said that staff had encouraged healthy eating. They said, "(Relative) has a monthly weigh-in and they are keeping on top of it now."

We observed that mealtimes were a relaxed and pleasant experience. At lunch, people were asked in turn which sandwich filling they would like from a choice of four and if they would like additions such as pickle. Everyone chose what they wanted and some people asked for items such as tomatoes and beetroot to be added. The sandwiches were nicely presented with a side salad and looked appetising. Staff had their lunch with people and engaged them in conversation. Everyone ate independently and one person was given discreet help to cut their food up into smaller pieces. Pudding was a choice of yoghurt or fruit and when fruit was requested it was served in a bowl and had been prepared. One person asked for a biscuit and wasn't happy with what they were given, telling staff, "I can't eat that; it's proper dry, like rubber." Staff explained the texture was because it was a rice cake and offered the person an alternative which they accepted. The staff said they would note for future reference that the person did not like rice cakes. People were offered tea, coffee or other drinks and these were placed on the table in pots so they could help themselves and add milk and sugar. The drinks were replenished during the meal.

People's care records showed they regularly accessed a range of health care services. Health action plans were drawn up for meeting needs and there was close monitoring of particular medical conditions, such as epilepsy. People confirmed they were supported to stay healthy. For example, one person told us they did exercises to strengthen their legs and had recently had a fitting for new specialist footwear. Another person told us they attended an external health focus group to give their opinions. Relatives also told us, "Anything medical and (relative) is straight to the doctors and they always ring and let me know"; "A few years ago (relative) decided to give up smoking. Staff helped them and they've never smoked since"; and, "They call me straight away if there's any accident or illness. (Relative's) health is well monitored."

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring and they were happy with the support provided. Their comments included, “The staff are always brilliant. (Relative) is very content. Whenever I take them out they’re always keen to go back – you can’t say fairer than that”; “All the staff are good”; and, “They give (relative) all the care and attention they need.” Relatives told us they were always made to feel welcome when visiting the home. One relative said, “They (staff) are always polite and offer me cups of tea.”

The home had a philosophy of care in place to promote people’s privacy, dignity, choices, independence, rights, fulfilment and security. Staff told us the registered manager set high standards and expected care practices to be applied consistently. A range of procedures had been developed that reflected these standards for the delivery of personal care. The procedures covered areas such as support with bathing and going to the toilet and specified the ways in which staff must maintain people’s privacy and dignity.

We observed that staff were caring in their approach and respected people’s privacy by, for example, asking permission before they entered bedrooms. Staff spoke calmly to people and listened to what they had to say. We saw they offered people choices and where necessary explained things in a way they could understand. There was a homely and inclusive atmosphere. Staff were attentive without being intrusive and encouraged people to be involved in everyday life in the home. For instance, taking their dishes to the kitchen after meals and having a day each week when they were supported with cleaning and tidying their bedrooms.

Everyone appeared comfortable with one another and it was evident that good relationships had been formed. For instance, people told us they were looking forward to going to a staff member’s birthday party at a local club. This staff member said they had invited people as, “They are like extended family.”

We found that some staff practices within the environment were not always mindful of people’s dignity. In the entrance to the home our initial view was of people’s underwear that had been hung up to dry in the doorway of the laundry; this was attended to when we informed staff. In the lounge areas we saw that armchairs and sofas were covered by continence sheets which are meant to be used for bed protection. These were removed and staff told us they would be looking into more discreet and appropriate coverings for the furnishings.

Staff told us most people were well able to make their needs and wishes known and no-one used an advocacy service to represent their views. Where a person had limited communication, the staff gave accounts of how they interpreted the ways people expressed themselves. People were asked to give their feedback about the home through meetings and surveys, enabling them to influence the service they received.

Staff demonstrated that they were committed to upholding people’s rights. For example, one staff member told us about an occasion when they felt people were being discriminated against whilst attending an event at a popular music and arts centre. They had raised this as an issue with staff at the venue and achieved a positive outcome. Another staff member told us, “We know we’re here for the people and make sure everyone is treated fairly.”

The age range of people using the service was 45-73 years old. Staff told us they aimed, wherever possible, to provide a home for life where people received the level of care they would want for their own families. They were proud of the fact that they had managed to care for some older people until the end of their lives.

Good

Is the service responsive?

Our findings

People using the service told us they made choices about their support and took part in a variety of social activities. Their comments included, "I choose what I want to do"; and, "I like knitting, dancing and music." One person told us about a recent overseas holiday and showed us the souvenirs they had bought. They said they had stayed in a nice hotel, went out to different places during the day and had enjoyed the evening entertainment. The person said they liked making things and showed us Christmas decorations and 2016 calendars they had made. On the first day of our inspection, people went out to a leisure centre in the morning, came back for lunch, and then most went out again in the afternoon to a tea dance. A staff member told us, "They're really busy this weekend with two parties and one person is going on a ghost walk."

We saw information had been gathered about people's backgrounds, lifestyles and interests. Care plans for meeting social needs and activities timetables were in place. Records were also kept which showed people routinely took part in numerous activities, both within the home and in the community.

Relatives confirmed their family members led full and active lives. They told us, "(Relative) is always out, I have to ring before I visit to make sure they're in. They go out to music concerts, keep fit and they did a computer course"; "(Relative) does more in a month than I do in a year. They go to local churches, tea dances and have holidays. They like music, knitting and books about the Royal Family"; and, "They are very stimulated, they do all sorts, even been out on a rescue craft. They have holidays and have been to Benidorm and Scotland this year." One relative added, "When they go away I'm given an itinerary with a picture of the hotel, pool and rooms and an emergency number, and they always send a postcard."

Each of the staff we talked with had a very good understanding of the needs of the people they supported. A senior carer told us they had previously worked in a health setting with people with learning disabilities. They said in comparison the home had much more flexible routines, people were actively encouraged to make choices, and they felt the care provided was personalised to each individual.

We checked care records to see how people's care was planned. An extensive range of assessments were completed and all needs identified were set out in detailed and specific care plans. The care plans were tailored to the individual, covered all aspects of daily living and stated the person's routines and preferences. They addressed areas of support including physical health and psychological well-being, communication, and personal care. Each of the care plans gave clear guidance to staff about the level of support to be provided and took account of what the person could do independently. There was evidence that care plans had been updated as people's needs changed. However, we noted one person, who had Deprivation of Liberty Safeguards authorised three months ago, did not yet have a care plan developed in relation to the safeguards and protecting their rights.

Relatives told us they were consulted about care planning and involved in care review meetings. They said, "I get invited once a year and we discuss it all. My feeling is if there's nothing wrong, if it's not broken - don't upset the apple cart"; "We have an annual meeting to discuss (relative's) care and social services come"; and, "I can't always get to it but they send me the report so I can add comments."

People were given the complaints procedure in an easy read format with pictures. We saw the procedure had been discussed at a resident meeting and everyone had confirmed they were aware of how to make a complaint. Staff told us there had been no complaints about the service in the period since the last inspection.

We recommend that the service seeks guidance from a reputable source on Deprivation of Liberty Safeguards care planning.

Good

Is the service well-led?

Our findings

The service had an experienced registered manager who had been in post since the home opened. They were supported in their role by a well-established staff team, including two senior carers and an administrator. The senior carer for day duty told us they took responsibility for leading shifts and had lead roles for disseminating information to staff about infection control and communication methods.

We saw the registered manager held meetings for staff where they had opportunities to air their views and discuss practice and employment issues. Staff spoke highly of the support they received. They told us, "I've never had a more supportive working environment"; "We get listened to at meetings and fill in surveys"; "(Registered manager) is very supportive and always there for you to ask anything"; and, "(Registered manager) is fierce about this being the residents' home, it being a haven for them." Staff told us the registered manager was approachable and openly communicated with them. We observed that staff worked well as a team and ensured the service was running smoothly during the temporary absence of the registered manager.

Relatives told us they felt the service was well-led. Their comments included, "We have never had any concerns or complaints and (relative) has been there for 12 years"; I can't fault (the registered manager). I'm pleased with the care and attention (relative) is getting"; "The manager's very good, very helpful"; "I've had no complaints in 20 years. (Relative) would let me know if there was a problem and they've never raised anything"; and, "I have no qualms whatsoever, they are just lovely people."

A checklist was in place for monitoring the quality of the service throughout the year. This ensured that checks were kept on issues including staff training and supervisions, any complaints and safeguarding concerns, accidents, updating of care records and reviews of policies. A quality audit was carried out every three months that incorporated observations of people's care experiences and checking standards such as the meals and arrangements for healthcare, medicines and social activities.

Resident meetings were held and surveys were conducted with people living at the home, their families, staff and external professionals involved in people's care. The surveys enabled all concerned to rate and comment on different areas of the service. For example, people were asked about their accommodation, meals, activities, privacy, dignity and independence and whether staff were polite and respectful and provided the support they required. This showed us that a range of methods were used to keep checks on the quality of the service.

We viewed the findings from previous surveys which showed a high level of satisfaction with many positive comments and no suggestions for improvements. These included, "I think the home does a marvellous job and (relative) is very happy and content", and, "I feel The Oaks provides a high standard of care and are very caring towards the residents who seem happy in their environment."