Oxton Manor Ltd

Oxton Manor

Inspection report

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Tel: 01516536159

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced inspection of Oxton Manor on 12 June 2018. Oxton Manor is a detached house providing care for up to 15 people with complex learning disabilities. The home is situated in Oxton on the Wirral. At the time of inspection there were 12 people living in the home and two people who were respite.

Oxton Manor is a 'care home' for people with learning disabilities. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care service had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy

Registering the Right Support gives guidance surrounding the maximum amount of people a home providing support to people with learning disabilities should have. Guidance states this should be six however Oxton Manor had been registered since 2014 to provide a service to 15 people. We saw that the home itself was situated in a residential area and that people with learning disabilities who were using the service were able to live as ordinary a life as any citizen.

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. The service had a registered manager in place.

We previously inspected Oxton Manor in October 2016. We found the home was Inadequate and enforcement action was taken by CQC. This was followed by an inspection carried out in April 2017 where we found improvements had been made and so we cancelled the proposed enforcement action. During this inspection we found that Oxton Manor continued to improve however we identified that further improvements were needed.

For services rated Requires Improvement on one or more occasions, we will take proportionate action to help encourage prompt improvement. Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires a provider to give us information – when we ask them to do so - about how they plan to improve the quality and safety of services and the experience of people using services.

We found that risk assessments were not always fully completed and did not give full information about the level of risk. However, staff monitored people regularly.

We found that recruitment processes continued to improve. However, we found that although the culture of the service had significantly improved with changes that had occurred to staffing, the recruitment process needed to be more robust to show the registered manager had followed procedures appropriately to ensure the safety of the people living in the home.

We saw that the environment continued to improve with clean, open and cheerful areas. However, we identified that some fire doors were wedged open and that this had not been reported for the maintenance person to fix. We identified that other doors had been reported and fixed.

Care plans did not always reflect the needs of the people living in the home. We saw improvements continued to be made in people's care plans and the registered manager was in the process of reviewing all care files. There were varying levels of information held in each care plan and staff gave differing examples of how to support a person in certain situations.

Staff received training appropriate to their role. They told us that they felt well supported and effective in their roles. We saw that trained staff administered people's medication safely and we saw that the service had appropriate safeguarding policies in place.

We saw that the home's environment and their rooms were nice, clean and well kept. There were ongoing improvements being made to the home's communal areas. There was also a series of health and safety checks in place to ensure the building was safe.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. We saw the quality and variety of activities available at the home. During mealtimes there was a relaxed and unhurried atmosphere and people could access food whenever they chose to throughout the day.

The manager at the home undertook a series of daily and periodic audits and checks of the quality of the service provided to people. People and their relatives were consulted in a variety of ways.

The registered manager and staff understood the requirements of the Mental Capacity Act 2005 (MCA). This meant they were working within the law to support people who may lack capacity to make their own decisions. We saw that people were supported to make their own decisions and their choices were respected.

There continued to be sufficient staff employed at the home to meet people's support needs. The staff were friendly, welcoming and we observed good relationships were maintained with people living in the home and a kind and respectful approach to people's care. The manager continued to be a visible presence in and about the home and it was obvious that she knew the people who lived in the home well.

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 always safe.

Some risk assessments had not been fully completed.

Recruitment processes needed to be more robust.

Some fire doors had not been monitored for safety.

Medicines were managed safely.

Is the service effective?

Good

The service was effective

Staff had undertaken relevant and appropriate training.

The service was working within the principles of the MCA and DoLS.

The care and support for people living in the home had achieved some good outcomes.

Is the service caring?

Good

The service was caring

People were supported to express their views. We saw that people's privacy and private confidential information was respected.

We observed that people's privacy, confidentiality and dignity was maintained.

We observed staff to be caring, respectful and approachable.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans did not always reflect the needs of the people living in the home.

A range of social activities was provided and the staff took time to build positive relationships with people.

Staff were using person-centred knowledge to support people's behaviours that challenge.

Is the service well-led?

Requires Improvement

The service was not always well-led

Some audits had not recognised issues that were identified during our inspection.

The registered manager was clearly visible and staff said communication was open and encouraged.

The service had a manager who was registered with the Care Quality Commission and who was aware of their roles and responsibilities in relation to the service and to registration with CQC.

Oxton Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 June 2018 and was unannounced. The inspection was carried out by an adult social care inspector and an assistant inspector.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also asked for information from the local authority.

We examined a range of documentation including care files belonging to four people who lived at the home, three staff files, staff training information, a sample of medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the home and were able to visit some of their bedrooms.

We were able to speak to four people living in the home and one relative. We also spoke with the registered manager and three staff.

Requires Improvement

Is the service safe?

Our findings

Staff showed a good awareness of safeguarding processes and the staff we spoke to told us they had no concerns about how this was managed at the service. Staff said, "I am not worried about anything. If there were problems, I would go to [registered manager name], but I never had to. If I was concerned about the safety of people, I would be on the phone to the local authority or CQC after speaking with [the registered manager]." We saw that policies where in place, records where well-maintained, evidence of appropriate action taken and CQC notifications had been sent as required regarding an safeguarding incidents.

One relative we spoke with told us, "Yes [person] is safe there, they're brilliant." A person living in the home told us, "They're (staff) are very nice to me."

We found that people had risk assessments in place, however some of these needed to be completed in more detail. Risk assessments appeared as short support plans and the risk had not always been scored. This meant that the likelihood of a risk had not been scored and that risk assessments described the hazard but did not tell the reader how often or how likely it was to occur. We saw this was the case for things such as epilepsy risk assessments or those around behaviours that challenge. We saw however, that staff completed epilepsy monitoring charts and records related to people's behaviours that challenge and these had been acted on appropriately.

We found that foot releases on two of the fire doors within the home were not working and fire doors were open, although they carried a sign stating, "Fire door, keep shut". We found that this appeared not to have been picked up by maintenance or in audits. The maintenance person told us, "Usually staff tell us if there is something wrong; the foot releases also make quite an annoying noise if the battery is empty." The foot releases were not making any sounds when we found doors open; however, once the maintenance person had changed batteries, they started sounding again. Other doors were working normally. We raised this with the registered manager as we questioned the staff awareness about the importance of reporting issues.

We looked at the recruitment processes and found that the majority of the systems were in place. We found that recruitment files included photographic identification of the member of staff. We saw completed application forms, although one person had completed it after their start date. The manager explained that was because she had known the applicant for a long time. We appreciated this was the case. The registered manager was recruiting people known to her to positively influence the culture of the service; however, checks and evidencing of safe recruitment decisions to protect people using the services needed to be improved.

We saw that all staff in the home had a Disclosure and Barring Service (DBS) check completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. The registered manager had in one case not completed a risk assessment based on the DBS results. Such risk assessments document how the decision was reached to employ the applicant considering previous convictions. This was brought to the managers

attention who acted on this immediately.

We saw the premises were safe. We looked at a variety of safety certificates that demonstrated that utilities and services, such as gas, electric and small portable electrical appliances had been tested and maintained and we saw that the fire alarm system had been checked regularly. Firefighting equipment and emergency lighting was checked. A recent fire risk assessment had been undertaken and each person had a personal emergency evacuation plan (PEEP) in place. The home had an emergency grab box at the entrance of the home that contained equipment that may be needed, such as torches and the PEEP file. The registered manager also had comprehensive contingency plans in place to manage unexpected emergency situations. For example, if the kitchen was out of order and people living at the home were unable to access food. These plans gave clear guidance on actions to take.

The administration of medication was safe and medication was stored securely at the home. The medication room was temperature controlled and medications requiring additional cold storage were stored in a medication fridge. Regular checks were made of the storage temperatures. Each person had a medication profile, which included a photograph for identification and a record of their known allergies. There was appropriate guidance for staff for people's time sensitive and as and when required medications (PRN). One person told us "I get my medicines morning and night fine."

Staff told us, "The pharmacist comes and does our medicine competency assessment. The pharmacy has changed now. The pharmacist comes in and checks whether you are checking if it is the right person, the right drug, the right time and so on. I last had mine about 12 or 13 months ago."

We identified that the process for when covert medications were needed to be administered were not always followed. Confirmation had been gained from the persons GP however there had been no input from a pharmacy. This guidance was in the homes own policy however this had not been followed in practice. This was brought to the manager's attention who immediately acted and rectified it.

The registered manager had a process in place that monitored accidents and incidents. Staff told us, "If there is an incident, we report it on paper. It goes to [registered manager] and she looks at it, then she goes onto the computer to record it." This was monitored and actions taken if needed, examples of this included behavioural incidents.

It was clear that staffing continued to improve in the home. Staff turnover was now low and feedback from the local authority supported our findings that staffing was sufficient to support people safely.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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. The service was working within these principles. We saw the manager had a tracker in place that identified all DoLS authorisations that were in place and all that had expired had been reapplied for prior to them expiring.

The registered manager had placed an 'easy read' version of the mental capacity act for the benefit of the people living in the home and their visitors.

The care and support for people living in the home had achieved some good outcomes. The sharing of how these had been achieved, to learn from and develop, needed to be more effective in records. For example, a person had been referred to the GP, because they had lost a significant amount of weight. The home was concerned about this; however, the GP saw it as a positive. As an outcome, the person was no longer deemed as having a certain type of diabetes. We looked at care plans and spoke with staff about how this had been achieved. We saw that the resident's diet was not different from that of others or particularly "healthy".

Staff explained, "It was more about working with [person] and family, to make sure they did not have all their sweets in one go. We worked with them to have things in portions." Staff explained this was also true for meals. "We just worked with [person] to still have seconds if they wanted, but maybe not thirds or fourths. That really made a difference."

We saw that both staff whose records we looked at had completed an induction on the first day or within the first month of their employment. The induction included introductions to residents and staff, a tour of the building pointing out important things such as fire exits and fire procedures. The induction also covered peoples support plans and risk assessments, the key worker role and documents, people's finances and petty cash receipts, writing in support plans, the communication book and handover book. Staff were also appointed a 'mentor' during their induction. This is someone who is more experienced, who can help the new starter to settle in and learn.

Mandatory training for staff during their induction included food hygiene and safety, fire safety, health and safety, Control of Substances Hazardous to Health (CoSHH), infection control and manual handling. Other training, we saw had taken place, included learning about equality and diversity, learning disability

awareness, medication training and competency assessment, challenging behaviour, safeguarding adults, falls safety, record keeping, dignity and respect, as well as a level 2 training in diabetes awareness and care. Staff we spoke with had National Vocational Qualifications in Health and Social Care or were in the process of completing a higher level.

Staff told us, "The training [we have here] helps you to refresh your memory. It is now 'paper-based', it was e-learning before."

Staff spoke highly about the registered manager's drive to ensure staff learning was developed. "[Registered manager] is always looking for new courses for us to do. For example, autism awareness is next. It is good to understand about it. None of our residents have a diagnosis, but it will still be good for us to learn about it." Another staff member said, "With other managers we did not have the support [to our learning]. With [registered manager], we can ask for training and she will do it. She is introducing dementia awareness training."

Staff told us that learning had helped them to achieve good outcomes for people. "Because of our diabetes training, we were more aware of what is not good for [person]. So we made some changes, only giving [person] so much at a time. They are ok with having portions rather than everything at once."

We saw and staff told us that regular supervision meetings took place. The home also operated a probationary period. Yearly appraisals took place to manage staff performance. Staff told us, "We have supervisions every one to two months. They are very open and I feel confident to speak to [registered manager]."

We saw that the registered manager used a "Good practice improvement record" to address staff conduct, for example where it may put people at risk. This included for example what staff should do if they had to bring their own medicines into the home.

We saw that people had GP visits and access to health professionals. We saw for one person, their medicines had been increased to help with sleeping problems and incidents during the night. In the care plan, there was no further record of how the person's physical and mental health would be promoted to support good sleep. However, staff told us about increased activity for this person.

We saw in people's care files that they had had a health passport, which had recently been reviewed. People's hospital visits and appointment summaries had been recorded. Monthly chiropodist visits had been recorded with "checks and actions". We saw that staff had recorded eye doctor and dentist appointments for people. We also saw that the home had been working together with specialist community learning disability nurses.

The registered manager told us, "We changed all the furniture and changed the dining room. We have updated the décor and the garden is more accessible." We found the lounges had been updated and felt welcoming. The home felt lighter, in particular in stairwells that had been dark in places at the last inspection. Staff said they were hoping to make the kitchen more accessible at some point, to help people develop their cooking skills.

A person we spoke to told us, "I would like to go home soon. I feel really better. I am here until I am better." The registered manager told us they were working with the person and social workers around this.

Good

Is the service caring?

Our findings

We observed that staff engaged with people in caring and supporting ways when they appeared to need it. We observed kind and caring interactions between staff and people using the service.

We saw there was a "Service User Guide" in people's care plan files. This talked about, "What can we do for you?", "Our Goals", "Meeting Your Needs – Rights, choice, inclusion, fulfilment, independence, privacy, dignity, security, support packages", "What you will have to pay for" and "Complaints and Compliments". The information gave the number of the Care Quality Commission, if people had concerns about their care. This document was also stored at the enterance of the building. The guide was available in pictoral form but it was not always clear how they supported people's understanding of the information, this was raised with the registered manager who told us this would be actioned immediately.

We saw that as part of staff's induction, managers gave new starters a "Dignity Do's" leaflet and talked about respecting people's privacy and dignity. We saw that people's right to confidentiality was respected throughout the home.

We asked people if they had choices in the way they lived and if they were respected. One person told us "I can choose what I wear, I have favourite cafes. I like living here." We saw that staff throughout the day where respectful and discreet when supporting people. During our visit people moved about freely and communicated with us and staff. We found that people could get out of bed in the mornings when they wished and staff attended to them when they were ready.

During our tour of the building we saw that there was a notice board in the entrance area that had information displayed for the benefit of people living in the home as well as visitors. This included complaints, advocacy, and any courses that were available for people who may want to achieve them.

We saw that the registered manager held regular resident's meetings where topics such as menus, safeguarding, activities and health. We saw how suggestions from people living in the home were acted on, for example outings and menu changes. One person told us "They [staff] listen to me, I love them."

The service was working to develop people's independence, for example through supporting more independent community access and budgeting. An example of this was where a person was able to access the community independently through working with staff, manager and by accessing resources such as travel passes. People told us how they were able to attend disco's and other social gatherings that encouraged positive interactions. One relative told us how the staff encouraged their family member to do things for themselves.

People and their relative told us that the communication was good within the home. A relative told us "The home is brilliant, they communicate really well."

Requires Improvement

Is the service responsive?

Our findings

We found overall that there was more structure in people's care plans. However, there were different formats in use. The registered manager was in the process of reviewing all care files. The different formats gave varying levels of information. In some places the information was not clear or detailed enough. We found this was the case even where the person had resided at the home for some time and they had the new care plan format.

We found that some of the care plans were personalised in places and there was generally good person-centred information in the main. This included insight into the person, for example through a brief life story. We found that the focus on what people could do, as opposed to merely describing what they could not, was varied across plans. Some people' care plans stated they had only lived at the home for a short time, when they had lived there for a number of years.

When we spoke to staff, they told us about some slightly different approaches for the same person. Some staff also told us that residents presented physical behaviours that challenge, while other staff said they did not. This needed clarifying, so that there would be consistency and to ensure the person's care was safe and responsive to their needs.

People using the service that we spoke to, as well as staff and the registered manager told us about different activities on offer. This appeared to be an area where the home had made good improvements. On the day of our visit, people were going to a weekly "disco" over in Liverpool. A person told us about a trip to London for a charity walk they had been part of that they were very proud of and excited about.

The registered manager told us, "Everyone is going on holiday to Presthaven Sands. We have been to the zoo, Llandudno, Blackpool to see the lights, people go swimming and play football." A person we spoke with told us they very much enjoyed going swimming. They were keen to be supported by a specific member of staff to do this. Staff also told us that residents also went to a social club event held by a learning disabilities charity at a local night club.

Staff told us about activities they did with people, based on their life history. We were told about a person, "[Person] walks around the home more. We are waiting for a piece of walking equipment to go outside, but they have their wheelchair for now. [Person] likes one pub but we are not sure of the name, we are trying to find out."

We acknowledged to the registered manager that we could see that she and staff had worked hard to make improvements where there had been concerns. We found that key worker meetings now took place between people and a dedicated staff member. Staff signed for their awareness of care plans. We saw that some staff had signed on different dates, which showed they kept up to date with information.

We discussed with the registered manager that although staff may provide care in the right way in practical terms and that records just need to be updated.

The registered manager gave us examples of how they were using person-centred knowledge to support people's behaviours that challenge. For example, this had an impact on a person needing medicine during the night if they had an incident. The registered manager explained that the person would come to the medicines room, but then select an object they liked, instead of needing 'as required' medicine. This was not in the person's care plan. We discussed that care plans help share approaches that lead to good outcomes with everyone. We saw how people and their relatives were involved with care planning. One relative told "Oh yes, I'm involved with [persons] care." We asked if they thought the staff knew about people's likes and dislikes and everyone we spoke with said yes. One relative told us "Yes, they've learnt about [person]."

The home had a complaints policy that was on display for people to access, this was up-to-date and had been reviewed. This was displayed at the entrance to the building making it easily accessible for everyone. We asked people if they felt they could raise concerns and everyone said they could. One relative told us "I'd tell them straight if I had a problem but I'm happy with [person] there".

Requires Improvement

Is the service well-led?

Our findings

The service was clearly continuing to improve however, we identified issues surrounding risk assessments, fire doors, care plans and audits during the inspection. When these were discussed with the registered manager we were able to see how they immediately acted on our findings and developed additional processes to improve.

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. The manager had been registered since May 2017. The registered manager understood their responsibilities in relation to the service and to registration with CQC.

From April 2015, providers must clearly display their CQC ratings. This is to make sure the public see the ratings, and they are accessible to all of the people who use their services. The provider was displaying their ratings appropriately in a clear and accessible format at the entrance to the home.

The registered manager had different methods in place to monitor the quality of the service being delivered. These included quality questionnaires, reviews, meetings and audits. The registered manager had completed care file audits monthly. We discussed with the manager that the audit had not picked up on some things such as information that needed updating. Medication and finance audits were also carried out an we saw that these were acted on. An example being a medication error, we saw the actions that had been taken.

The local authority and staff spoke very highly of the registered manager and the difference they had made to the home.

Staff said, "[Registered manager] has made such a difference. Before she came, all the residents were 'mixed and matched' and not really compatible. Everyone gets on well and we are freely willing to talk about it." We were also told "Over the last 12 months, the culture has changed. It has been a big change since [registered manager] came. Staff are good, the manager is good, we got furniture for people. There are so many positives since the new manager came."

Staff told us they felt really listened to by the registered manager. Staff said their supervision meetings were open and honest, "We are all on the same page here. We might get told by the seniors, 'This is what we will do'. But staff get to have a say for people what they would like to do instead." Staff told us, "I look forward to coming to work. I am not worried, improvements are happening." We also saw that team meetings took place in the home.

We saw that staff had a signed contract and a job description that outlined their accountabilities and responsibilities. As part of their induction, staff received a staff handbook and a code of conduct. The induction also told staff about the structure of the company, as well as policies, such as whistleblowing,

grievance, safeguarding, health and safety and complaints.

We saw how the registered manager and staff continued to work in partnership with other professionals. People continued to have prompt access to medical and other healthcare support as and when needed. There were documented visits from district nurses, dieticians and GPs.

Registering the Right Support gives guidance surrounding the maximum amount of people a home providing support to people with learning disabilities should have. Guidance states this should be six however Oxton Manor had been registered since 2014 to provide a service to 15 people. We saw that the home itself was situated in a residential area and that people with learning disabilities who were using the service could live as ordinary a life as any citizen. This was discussed with the registered manager who had full awareness of the guidance and was able to demonstrate to us throughout the inspection how the manager and the staff in the home supported people to fully engage with the wider community and achieve their full potential.