Hightown Housing Association Limited

Oakmead

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

Summary of findings

Overall summary

This unannounced inspection took place on 29 and 30 January 2018. Oakmead is a care home for adults with learning disabilities. The service is a converted residential house situated on a main road. Five people were living in the service at the time of our inspection. Support is provided over 24 hours, seven days a week. Each person had their own bedroom with communal facilities such as kitchen areas, lounge and bathroom.

As a requirement of registration the service had a registered manager in place. 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 been previously owned by a different provider. Hightown Housing Association Limited took over the ownership of the service in October 2016. This is the first inspection since the change in provider.

Oakmead is a 'care home'. 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 has 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

People's consent was sought for aspects of their care. Where people were not able to make decisions for themselves, their mental capacity was assessed and the best interest process was followed. 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.

People were involved as much as possible in planning their care. Their opinions were sought as to the effectiveness of the care they received. The provider considered where improvement could be made these and where appropriate these were actioned.

People were well cared for. They were provided with an environment that met their needs. Maintenance checks and health and safety audits had been completed to ensure the environment was safe for people and staff. Risk assessments and care plans were devised to ensure care was safe and appropriate.

Staffing levels were based on people's needs. Staff recruitment was carried out safely. This was to prevent unsuitable people from working with the people at Oakmead.

Staff were trained and received support to ensure they had the skills and knowledge to carry out their roles. They were encouraged to feedback ideas to assist with the improvement of the service, through supervision, meetings and general discussion

Staff were trained to identify signs of abuse and how to report concerns. Medicines were administered by trained staff. Records showed people received their medicines in a safe and appropriate way. Health professionals such as psychologists and GPs were referred to when people required additional support.

People were supported with their nutritional and hydration needs. This included providing food and drink that was safe for them to consume in line with their preferences and dietary needs.

We observed staff supported people with their care in a dignified and sensitive way, by speaking discreetly to them and asking permission to access their room and property. People's communication needs were identified and staff had the skills and knowledge to work in an inclusive way with each person.

People were supported to remain as independent as possible and involvement in the community was encouraged. Activities were available to people to protect them from the risk of social isolation.

Staff and people living in the service responded positively when discussing the registered manager and the senior staff. Staff supported each other and worked well as a team. Quality assurance checks and feedback from people, relative's, staff and professionals was used to drive forward improvements to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Systems and practices were in place to protect people from the risk of infection.

Staff understood how to identify abuse and how to report concerns, to protect people from harm.

Medicines were stored and administered in a safe way by staff who were trained.

Is the service effective?

Good

The service was effective.

People's health was monitored and when necessary external professionals were contacted to provide support to people on maintaining good health.

Staff were supported to provide effective care to people through induction, training, supervision and appraisal.

The service was working within the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). This protected people's human rights.

Is the service caring?

Good

The service was caring.

People were able to communicate with staff in a way that was meaningful to them.

People were supported by staff who demonstrated a caring nature and who were knowledgeable about people's needs and the care required.

Staff knew how to protect people's dignity and privacy and demonstrated this throughout our visit.

Is the service responsive?

Good

The service was responsive.

People participated in activities both in the service and in the wider community. This encouraged inclusion and protected people from social isolation.

Systems were in place for the registered manager to obtain feedback and complaints from people on the quality of the service. They had acted to improve the service to people.

Is the service well-led?

Good

The service was well led.

There was a shared philosophy of person-centred care between the registered manager and staff team. This enhanced the service to people.

The registered manager and senior staff provided effective leadership and management. This was valued by the staff and people using the service.

Oakmead

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 checked 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 29 and 30 January 2018 and was unannounced. It was carried out by an inspector.

Prior to the inspection we reviewed the information we held about the service. This included notifications we had received from the provider. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information during our inspection.

During the inspection we spoke with five staff including the regional manager, the registered manager, the deputy manager, a care assistant and an agency staff member. We spoke with four people who lived in the service. We used simple sign language to speak with one person.

We reviewed documents associated with two people's care and medicine records for three people. We reviewed records associated with the employment of two staff. We read records related to health and safety, incidents and accidents and audits connected to the running of the service.

Good

Is the service safe?

Our findings

One person told us the staff made them feel safe living in the service. On the two days we visited the service we were greeted at the door by a person living in the service. On both occasions we were asked to show our identification badge and to sign the signing in book. This enabled people to maintain the security of their home.

We were shown around the service, we found it to be clean and well maintained. Staff received training in infection control. Systems were in place to prevent the spread of infection. Colour coded equipment was used for cleaning of specific areas. A poster was available in the laundry room to remind staff of what coloured equipment was used where. Staff understood the importance of hand washing and the use of protective equipment such as gloves and the need to change these when moving between tasks. Weekly infection control sheets recorded checks on refrigerator and freezer temperatures and stock control of gels and equipment, necessary to maintain a safe and hygienic environment.

Staff had received training in how to protect people from abuse. They were clear about how to identify indicators of abuse, and what action they would take if they had concerns. The process for reporting concerns to the local authority was clearly visible on the wall in the office. There had been no safeguarding concerns at the service since the new provider took over the running of the service.

We reviewed how people's medicines were stored, recorded and administered to people. Staff administered medicine. Their competency was assessed prior to them taking on this responsibility. Medicines were stored in a locked cupboard in people's bedrooms. Stocks of medicines were checked and recorded on an audit sheet that was completed weekly. This was a record of what medicines had been delivered, what had been administered and what the balance of stock should be. We randomly checked some medicines and found the recorded balance was correct for each medicine. Medication administration records were completed correctly by staff.

For people who were prescribed "as required" medicines a PRN protocol was in place. This informed staff of when a person required the medicine, for example pain relief. This was important for people who could not verbally express when they may require this medicine. The PRN protocol explained to staff what signs or symptoms the person may display when experiencing pain or discomfort.

Medicine risk assessments were in place. These were linked to information sheets supplied with each medicine. This enabled staff to be aware of any side effects or contraindications related to the medicine. Where creams were used for people, these had labels on to indicate their opening date and ensure they were not used beyond their shelf life.

People's care files included risk assessments which included areas such as nutrition, community safety, behaviour that may challenge, medicine and finance. One person lived with an illness, we found there was insufficient information in the care plan and risk assessment to support the person with this illness. Although the person was receiving adequate support from their GP the records did not reflect in depth

knowledge of the illness and the health considerations associated with it.

We signposted the provider to the guidance provided by the local Clinical Commissioning Group on supporting people with this illness. This was immediately implemented by the registered manager. The registered manager and staff were due to attend a training course on the condition in the days following our inspection. They were keen to establish good practice in this area of support.

Systems were in place to minimise the risk of employing unsuitable staff to work in the service. Applicants completed application forms, gaps in employment histories were identified and explanations were recorded. Reference checks were completed with previous employers. Disclosure and Barring Service (DBS) checks had been obtained. The DBS helps employers make safer recruitment decisions through the disclosure of criminal records. Identity checks were undertaken. These ensured candidates were fit and safe to work with people.

The allocation and numbers of staff on duty were aligned to the needs of the people living in the service. Staff told us there were sufficient numbers of staff to support people safely. Recruitment was underway to fill staff vacancy hours. Bank staff and agency staff were used to fill any staff shortages. Where possible these were regular staff to ensure consistency of care was provided. This ensured people were kept safe as staff were available to support them when needed.

Environmental risks had also been considered. For example there was a vehicle seating plan in place for people who may get anxious or distressed and may affect their journey. . This enabled staff to maintain the safety of the driver and the passengers, by reducing the risks people's behaviour may have on the welfare of others.

Other safety considerations included the maintenance of fire equipment and the gas and electricity supplies to the service. Legionella checks had been completed. This protected people from the risk of harm from unsafe utilities and equipment.

Good

Is the service effective?

Our findings

People told us the food was good, one person used sign language to indicate the food was very good. Another person told us the food was "alright". They said there was plenty to eat and drink and they enjoyed a healthy diet. People had access to food and drinks whenever they wished.

People chose what food they wished to eat on a weekly basis. If someone did not like the choice on offer alternatives were available. Where people required support with eating or drinking this was provided by staff. We observed how people were supported with their lunch. Food was prepared in line with people's care plans. For example, where people required food to be cut up this was done. Where people had difficulties with food and drink, specialist advice was sought and their advice was being followed. Where appropriate care plans highlighted the risks of choking for people and what action staff should take to prevent this from happening.

People were assisted to access the healthcare support they needed when they required it. A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. For example, psychologists, GP and dentists. Where specific guidance was given to staff by external professionals, this was documented and acted upon. One person told us how they had been supported by staff to attend regular hospital appointments for the treatment of a skin condition. Significant improvements had been made. They told us they felt their skin was "much better now." This had been a huge commitment on behalf of the person and the staff to ensure all treatments were kept up to date and appointments were attended. This demonstrated how people were supported to maintain or improve their physical and mental health.

People indicated to us staff were trained and knew how to support them. One person told us, "The staff know what they are doing. [Named staff member] is very good." New staff attended an induction prior to working in the service. During their induction they started to complete the care certificate. The care certificate is part of induction training and covers the minimum set of standards that social care workers adhere to in their daily working life.

Records showed staff training was up-to-date. Where staff required additional training because of their role, this was provided. For example, diabetes and epilepsy. Competency assessments were carried out on staff in areas such as medicines. This ensured staff were safe to carry out this aspect of care.

Staff were further supported throughout their employment by receiving supervision and appraisals from senior staff. Staff told us they found this useful, and one staff member told us, "It is quite nice to talk about things you are not sure about." They said they worked well as a team receiving support from each other as well as from the registered manager.

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 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. People's mental capacity had been assessed, and records showed where they lacked the capacity to make decisions these had been followed up through the best interest process.

Where people had been deprived of their liberty, an application had been made to the local authority for authorisation, and these had been approved. The DoLS we viewed had conditions attached which were being met by the provider.

Good

Is the service caring?

Our findings

People affirmed they were happy living in the service. We observed their needs were being met by staff. We could see they were happy to live at Oakmead as they interacted together and with staff in a positive and fun way. There were lots of smiles and people looked relaxed. It was clear people were able to join each other in the communal lounge or spend time in their bedrooms.

We observed positive interactions between people and staff. Staff were discreet and respected people's wishes. People answered the door and telephone and the house was treated as a home by the staff and people living there. A sign in the entrance hall pointed out that people did not live in the staff's work place but staff worked in the home of people. This was evident throughout the inspection.

Staff knew how to protect people's dignity and privacy. We observed throughout the inspection staff knocking on people's bedroom doors and asking permission to enter. Whilst people were out of the house, no one was allowed to enter their bedroom. One person told us, "They show me respect by knocking on my door." They went on to tell us how they were treated kindly by staff, and when they needed support this was provided. We observed staff were patient and kind. One person had sustained an injury from a fall. This limited their ability to manoeuvre their arm and to eat comfortably. On their return from hospital staff were immediately aware of their physical limitations and offered to move furniture to assist them to eat their meal.

Not everyone who lived in the service could communicate verbally. One person used sign language to assist their verbal communication. This was used predominantly to express themselves as their understanding of speech was good. Another person expressed themselves both verbally and through facial expressions and body language. The Accessible Information Standard is a framework put in place by the NHS from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. This provider was working towards meeting this requirement.

The provider had produced some easy read policies and procedures. Easy read is a way of using pictures alongside the written word to aid understanding. These were going to be introduced into residents meetings for discussion. For example, fire safety guidelines. People also had access to a computer which was used to follow personal interests. Photographs were used to display who lived in the service. One person had a written activity plan in their room, to assist them with their personal care. Staff told us they would present objects to people in order that they could make choices, for example with food. This enabled people to understand information and make choices about their life.

A staff member told us how they preserved people's dignity by covering body parts when carrying out personal care. They said they also gave people choices and encouraged independence. Staff and asked them what support they needed and what they could manage to do themselves. They told us they respected people's choices and wherever possible they would give people what they wanted. If there was a risk involved, they told us they would discuss this with the person. They would make a decision together as to

whether it was safe for the person to pursue their wish.

Good

Is the service responsive?

Our findings

Records demonstrated how people had been involved in the review of their care. Annual reviews had taken place and people's views had been recorded. Relevant others had also been included in reviewing care for example, relatives and professionals.

The service had an equality and diversity policy in place. Staff received training on equality and diversity. This enabled them to understand and respect people's preferences and needs and their protected and other characteristics under the Equality Act. For example, age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

We discussed with the registered manager and the regional manager how they supported people with protected characteristics. We had noted in the care plans one important aspect had not been discussed with people. Following the inspection we were sent an action plan of how people were going to be supported with this area of their life.

People were supported to attend church where this was their religious preference. One person told us they enjoyed attending church and saw this as a social gathering. People were encouraged to be as independent as possible. One person worked as a volunteer in a charity shop. Others attended an art and craft workshop. Activities were available for people in line with their interests.

People had a range of activities they could be involved in and staff ensured they got out of the house regularly. One morning we heard a staff member enter a person's bedroom and ask them what activity they wanted to do that day. Their response was to go bowling. Very quickly they were on the way to the bowling alley. We spoke to them on their return and they told us they had enjoyed their outing. Another person told us how they went to a social disco one evening per week. A further person had an interest in TV show their room was full of related memorabilia. They spent time going through their magazines and from their facial expression and body language appeared to be enjoying themselves.

The provider had a complaints policy and procedure in place. We were told there had been no complaints in the last year. Compliments had been received from an assistant social worker thanking the registered manager for making them feel welcome and for sending relevant paperwork. Another from a relative thanking the staff for their care of their family member.

People who lived in the service had the opportunity to feedback to the registered manager about complaints, issues and ideas for improvement. This could be done at any time, but a residents meeting gave them a collective opportunity to share their feelings. Records of a recent residents meeting documented a discussion and request for more puddings to be made available, and this had been actioned. There was also a complaint about having to do the weekly shopping at the supermarket. The general consensus was that people did not enjoy having to do this. Instead the food shopping was now completed on line and delivered to the service. This demonstrated people felt comfortable raising concerns and the staff listened and took appropriate action.

People's end of life care had not been fully explored with them. The registered manager told us this was a large piece of work the provider was rolling out across all its service in the near future. People did however have funeral plans in place which included their afterlife wishes, for example, whether they wished to be buried or cremated. This ensured people's wishes were documented for staff to follow when the person was deceased.

Good

Is the service well-led?

Our findings

The service had a registered manager in place. This was a requirement of the service's registration. The registered manager had been in position since May 2017. Their focus was very much about people and their needs, and how best the service could meet those needs. They had strong support from the deputy manager, who shared this aim. We observed both the deputy manager and the registered manager interact with people in a person centred and respectful way. They proved to be good role models for their staff team. When we spoke to people about the registered manager and the deputy manager, people's responses were positive.

Staff confirmed there was an open and honest culture within the service. When errors occurred these were used as learning opportunities. Staff felt supported by the senior staff in the service. Comments included, "I love it here, I love the managers. They give me good feedback, they forget I am agency staff. They give me good guidance on how to support the guys and show me how to do things the way they should be done." Another staff member told us they felt supported in their role and they had learnt a lot from the deputy manager. They said, "[Deputy manager] is always here to help me or other staff members. If there is something I haven't done before they are pretty good at going through it will me."

We heard interactions between the managers and the staff, these we found to be respectful and supportive. The senior staff were accessible to staff, and helpful in their responses. We saw there was a shared value in the service of supporting people to be as independent as possible and respecting them as individuals. Staff knew people well and focussed on their individual needs and wellbeing.

Staff felt the service was well managed. One explained this was because "I have training and support, the guys are happy and everything is in place." We could see how the registered manager had made changes to the running of the service to improve the quality of care for people. They had introduced new staff rotas to enable people to participate in activities. We were told these changes had impacted upon some staff who had resigned from their permanent roles as they could not meet the commitment. However, due to their desire to continue to work at the home they had returned as bank staff. The staff vacancies were being advertised. This provided more flexibility and assurances that people would receive appropriate support at the time they needed it.

The registered manager and deputy manager carried out a number of audits including health and safety and care plan audits amongst others. Where improvements were required an action plan had identified who was responsible and a deadline for any actions to be completed. This helped drive forward improvements to the service. These were subsequently checked by the regional manager to ensure a follow up had occurred and required improvements had been made.

Because the service was so small, feedback from relatives occurred on an informal basis but this could be formalised if needed. People's care reviews gave people, relatives and professionals an opportunity to feedback on how improvements could be made to the service provided. Staff had the opportunity to feedback ideas, suggestions or concerns through daily contact with the senior staff, supervision sessions,

appraisals and staff meetings. One staff member told us, "[Registered manager and Deputy manager] are very open. They do say if you have any ideas of how we can improve the care come and let us know."

Staff were clear about their roles and responsibilities. For example, only trained staff could carry out tasks such as the administration of medicines. Where there were concerns about staff conduct these were investigated. We received one whistleblowing concern, which was investigated. During our inspection we found no evidence to substantiate the claims. Throughout the inspection the registered manager and senior staff were honest and open with us. Where we pointed out documents could be improved upon they took immediate action to improve the records. Our findings throughout the inspection indicated a well-run service, where people were happy to live and their wellbeing was paramount.