EMH Care and Support Limited

Oak Court

Inspection report

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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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection was carried out on 17 July 2017, and was an announced inspection.

Oak Court is registered to provide personal care for people. It is an 'extra care housing' service for people aged over 55 who require at least three-and-a-half hours of care and support per week. Oak Court is a purpose built complex of 50 self-contained apartments. It includes a cinema, recreation rooms, a restaurant and a sensory landscaped garden. Oak Court is in a residential area close to the centre of Blaby, a village in south Leicestershire. At this inspection, there were 37 people living in the service.

This was the first inspection of the service since it opened in September 2015.

People were safe at Oak Court. They were protected against the risk of abuse. People felt safe in the service. Staff recognised the signs of abuse or neglect and what to look out for.

Staff followed appropriate guidance to minimise identified risks to people's health, safety and welfare. There were enough staff to keep people safe during the day. At night only one staff member was on duty, but there were seven people who required the support of two staff with their mobility. Those people did not have the required level of support available to them at night. People moved into the service with the expectation that their care needs would be met at day and night, however, due to financial constraints the provider can only provide care they are commissioned to.

The provider had appropriate arrangements in place to check the suitability and fitness of new staff.

Medicines were managed safely and people who required support with their medicines received them as prescribed.

Staff were supported through training and supervision which equipped them to carry out their roles.

The provider and staff understood their responsibilities under the Mental Capacity Act 2005. Staff sought people's consent before providing care and support.

People were supported to eat and drink enough to meet their needs. They also received the support they needed to stay healthy and to access healthcare services.

Staff were caring and treated people with dignity and respect. They ensured people's privacy was maintained particularly when being supported with their personal care needs during commissioned hours. However, some people described feeling undignified outside commissioned hours having been left unable to reach toilet facilities.

People received information about what they could expect of the service. They told us their expectations

were met until April 2017 when changes were made to how staff were deployed. The residents association and people challenged whether the service was delivering what it had promised.

Each person had an up to date, personalised support plan, which set out how their care and support needs should be met by staff. These were updated daily and reviewed regularly. People did not feel their needs were met outside commissioned hours. The provider had sought to explain why care and support could only be provided during commissioned hours and outside those hours if urgent.

A residents activities committee organised activities. There were not enough staff to ensure that people who required support with mobility and who wanted to participate in activities were able to attend these. Those people experienced social isolation at those times.

The provider ensured the complaints procedure was made available to people to enable them to make a complaint if they needed to. Regular checks and reviews of the service continued to be made to ensure people experienced good quality safe care and support.

The registered manager provided good leadership but they were constrained by being able to provide support only during hours commissioned by the local authority. This meant that people did not have access to the 24 hour care they believed they were entitled to and what had been promised when they moved in.

The provider had effective arrangements for monitoring the quality of the service people experienced. This included obtaining people's views of their experience. People and staff were encouraged to provide feedback about how the service could be improved. This was used to promote changes and improvements that people wanted.

We found two breaches of the regulations. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were safe from abuse and avoidable harm.

Risks associated with people's care and support were assessed and appropriate care provided.

Staff were safely recruited, but there were not always enough staff to meet people's needs.

Arrangements for supporting people with their medicines were in place safe and they received their medicines as prescribed.

Is the service effective?

Good

The service was effective

Staff received appropriate training and support to meet people's needs.

Staff sought and received people's consent before supporting them.

People were supported with their nutritional needs and to access health services when they needed them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were treated with dignity and respect when they received care and support during commissioned hours. However, some people felt undignified, especially during the night.

People received information about what to expect in terms of their care and support. Not all people felt the service met those expectations.

People's privacy was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

During commissioned hours people received care and support that met their needs. People's needs were not consistently met at night.

A wide range of everyday activities were available to people. However, not all people who wanted to participate in activities were supported to access them.

Some people were not able to live as independently as they wanted because they could not easily use the facilities in their apartments.

People's needs care plans were tailored to meet each individual's requirements during commissioned hours. Care plans were reviewed on a regular basis.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had not analysed the risks to people who were not consistently supported by the two staff they required.

People were involved in discussions about developing the service.

The provider promoted an open and transparent culture at the service but people's expectations and what the service provided differed.

The provider had procedures for monitoring the quality of the service which included seeking people's views.

Oak Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was a comprehensive inspection which took place on 17 July 2017. The inspection was announced. We gave the service 48 hours' notice because the service is an 'extra care housing' service and we needed to be sure the manager would be available and we wanted to arrange to speak with as many people as possible who used the service.

The inspection team consisted of one inspector.

Before the inspection, we asked 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 looked at notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

We contacted the local authority that funded some of the care of people using the service and Healthwatch Leicestershire, the local consumer champion for people using adult social care services, to see if they had feedback about the service. We used this information to help us to plan our inspection.

The registered manager of the service was away, but we spoke with an operations manager, the provider's head of regulated care who was visiting the service and two team leaders. We spoke with 12 people who used the service and a relative of another person who used the service.

We looked at the provider's records. These included four people's care records, which included care plans, risk assessments and 20 people's daily care records for the day of our inspection. We looked at the service's Statement of Purpose, two staff files, a sample of audits, the most recent satisfaction survey, staff rotas, and policies and procedures.

After our inspection the provider sent us a summary of a meeting a senior manager had attended on 19 July 2017 to address concerns people had about the service.

Requires Improvement

Is the service safe?

Our findings

Some people expressed reservations about how safe they felt at night time. They told us they were concerned that only one support worker was on duty from 10pm to 07.00am. People's comments included, "It is not right that there is only one carer at night because some people require two carers to support them" and "One carer can't deal with two emergencies at once."

One of the seven people who required two support workers to support them with their mobility told us, "I can't go to the toilet at night because I need two staff to support me."

People told us they felt they had been discouraged from using their call alarms at night. A person told us, "I've been told not to use the call alarm unless it is urgent." Other people told us, "The night worker will only come out to emergencies" and "At night I get scared, but I'm reluctant to use my buzzer." People told us they had not had those concerns before April 2017 (when staff rotas were changed). A person told us, "Care was just a buzzer away until April." People therefore had a perception that they should not use their call alarms at night.

The provider showed us records that showed that the night staff had responded to 'non-emergency' calls, for example when people felt anxious, couldn't fall asleep or wanted support with personal care. There had been 22 such occasions in the two months before our inspection. However, one support worker was not enough to manage calls from people who required two staff to support them. A relative told us that they had been asked to act as a 'second carer' on one occasion. This was a risk to those people and staff. Staff told us that a safer level of staffing at night would be two staff.

Staffing levels were based on the number of hours of support people were assessed as requiring by the local authority that funded their care. Those hours of support were called 'commissioned hours'. There were enough staff to support people for their commissioned hours. However, people were concerned that they did not receive support outside commissioned hours. That was because they understood that they were entitled to `24 hour' support as described in the provider's marketing literature. People told us that the main reason they chose to live at Oak Court was that care and support was available 24 hours a day. Since April 2017 the provider was relying on more agency staff than before because of a recent turnover in permanent staff. More staff were being recruited at the time of our inspection.

Apart from people's concerns about staffing levels at night time, they were concerned that they did not receive support in between commissioned hours because there were not enough staff. For example, people told us they no longer participated in communal activities because staff would not support them from their rooms to where the activities took place at Oak Court. A person told us, "Numbers are falling for activities because people cannot get down from their rooms." Another person told us, "People are isolated in their rooms because there is no one to help them."

People's concerns about staffing levels applied only to the period from April 2017. They told us that before then they had no concerns. A person told us, "At first it was really good. It was brilliant. We got everything we

needed." Another person, to the agreement of others, said "They [the provider] promised 24/7 care but it is not what we are getting now." Other people felt that they had to give notice of when they may require support outside commissioned hours which they felt unreasonable. A person explained, "How do I know when I'll need to go to the bathroom?" Another asked, "How can I predict when I need to go?" Two people told us they had been left in discomfort for several hours because they had not been supported to a bath room. A member of staff told us, "People will be left in soiled beds and clothes [because of staffing levels]."

We found there were not enough staff deployed to meet people's needs. This was a breach of Regulation 18 HSCA RA Regulations 2014 (Staffing).

Every person we spoke with told us they felt safe when they received care and support during the day time. People said they felt safe because of the caring nature of the staff. People's comments included, "I feel safe with the carers. I can talk to any of them if I'm worried about anything" and "I feel safer here than when I lived at home." It was evident that people felt safe in the company of staff.

People were protected from abuse or harm. Staff had received training about safeguarding adults which included training about how to use the provider's safeguarding reporting procedures. Staff knew how to identify and report signs of abuse or harm and the appropriate action that should be taken to safeguard people. They also knew how to contact the local authority adult safeguarding team or CQC with any concerns they had about people's safety.

Staff told us that they felt confident in telling managers or using the provider's whistleblowing procedures (telling a senior manager) if they had any concerns. The provider had information about the whistleblowing procedure that was available to staff. The provider supported the formation of a 'residents association' at Oak Court to whom people could raise concerns. People had raised concerns with the residents association which the provider listened and responded to at meetings of residents. The most recent meeting was on 19 July 2017.

People were protected from avoidable harm. Staff were trained in first aid, health and safety and fire awareness. The premises were cleaned to a high standard. People commented on that, a person said, "It's very clean." The registered manager or deputy carried out regular health and safety checks of the premises. Every person had a personal evacuation plan that informed them how to stay safe in an emergency such as a fire. The provider carried out safety checks of the premises such as fire safety checks. Maintenance and health and safety checks of the building were carried out by the provider's maintenance department.

People's care plans contained detailed information about their needs and how they should be safely supported. The plans included risk assessments associated with people's mobility, for example, risks of falling or risks associated with people's care routines such as bathing. People were supported in accordance with their risk management plans. A person told us, "I feel very safe when they support me." We saw staff supporting people to walk at a pace that was comfortable for them which protected people from a risk of falling.

People's care plans outlined what people could do on their own and activities where they required assistance, for example standing up from a seat or sitting down, getting into and out of bed, washing and dressing. This meant that people were supported to take responsible risks according to their level of dependency. It ensured they could follow their daily lifestyle with the minimum necessary restrictions. Risk assessments were reviewed and updated when necessary, for example when a person experienced a fall.

Team leaders had procedures for maintaining up to date records of incidents at Oak Court. This was so they

could identify and address any trends in factors that resulted in incidents should any occur.

The registered manager and provider followed safe recruitment procedures that enabled them to check the suitability and fitness of staff to support people. Records showed the staff who worked at Oak Court had undergone a thorough and challenging assessment of their suitability to work at the service. People who used the service had been involved in the recruitment process at the interview stage.

Suitably trained staff supported people with their medicines. People's medicines were stored safely in their apartments. There were procedures in place to reduce the risk of medications errors being made, for example team leaders checked that the right medicines were kept in a person's room. People's care records included guidance for staff about how to support people with their medicines. A team leader's description of how a person was supported matched exactly what was in the person's care records.

People were supported with their medicines in the privacy of their apartments. They told us they knew what their medicines were for. They had their medicines at the right times Staff who supported people with their medicines had annual medication competency assessments. Team leaders carry out medication audits on a monthly basis to check that the management of medicines at Oak Court was safe.

Good

Is the service effective?

Our findings

People told us that they felt they were supported by staff who understood their needs and the way they wanted to be supported. Comments from people included, "The staff are very good. They are understanding of my needs"; "I am very satisfied with the care I get from the staff, it is very good" and "The carers are really good. I cannot fault them."

People were supported by staff who had received training that prepared them to be able to provide care that met people's needs. All new unqualified staff had induction training that was based on the Care Certificate that was introduced in April 2015. The Care Certificate consists of a period of assessed practice. It is designed to ensure that all care workers have the same introductory skills, knowledge, and behaviours to provide compassionate, safe, and high quality care and support. It is a national induction tool, the standards of which providers are expected to follow, to help ensure staff work to the expected requirements within the health and social care sector. Sixteen staff were supported to complete the Care Certificate in the first 12 weeks of their employment.

Staff had a structured induction programme lasting between six and eight weeks. During that period they learned about the people they would be supporting. They read people's care plans, shadowed experienced staff before being observed supporting people. They supported people without direct supervision only after a team leader assessed them as ready and competent to do so. A person told us, "The staff are very good. They understand my needs and another said, "The staff make sure I have everything I need". Several people described staff as "very hard working."

Staff we spoke with were able to describe the needs of people in detail. Staff were supported to understand people's needs because they were given 'day cards' which set out in detail how people should be supported. Support staff made records of how they supported people. People told us they read the records. A person told us, "I read the notes the carers make. The notes are accurate." This meant that people could be confident of receiving care and support from staff who understood their needs.

Staff were supported through supervision meetings with their line manager where they discussed their performance and people's needs. They had personal development plans to support further training and carer development. The registered manager and team leaders ensured that staff received refresher training when it was due. Staff told us that they felt adequately supported through training and supervision. Staff at Oak Court had been nominated for regional carers awards.

People were less complimentary about agency staff. Comments included, "The agency carers are not as good. I have to explain what they should be doing." Two people described how agency staff lacked the attention to detail that permanent staff showed. Both told us that agency staff did not know how to prepare simple breakfasts. A person told us that they believed agency staff did not read the 'day cards' that included details of how to support people. We shared this with the operations manager who told us that agency staff were required to read the cards and that measures would be introduced to ensure they did this in future.

Staff communicated effectively with each other and people they supported. They shared appropriate and relevant information about people at 'handovers' when staff starting a shift were informed about people's needs for the remainder of the day. Staff were given information sheets including information about the support people required. We found that written and verbal communication of information was informative and ensured that staff had the information they needed to support people with their needs. When staff supported people they made themselves clearly understood by adopting communication styles that suited people and met their preferences. We saw that happen when staff supported people to go to communal areas such as the restaurant and activities rooms.

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

We checked whether the service was working within the principles of the MCA and we found that there were no people who lacked mental capacity to make specific decisions. All people were presumed to have mental capacity to make their own decisions which is an important principle of the MCA.

Staff sought and obtained people's consent before they provided care and support. A person told us, "They always explain what they are going to do before they do it." People told us that when they changed their minds about their care and support, for example whether to have a shower or whether to eat, staff respected their decision. This showed that staff provided care and support in line with people's wishes and did nothing without their consent.

People chose whether to have meals either in the Oak Court restaurant or in their apartments. They had a choice of main meals, but could ask for alternatives if they wanted. A person told us, "The food is really good. We have a choice of two cooked meals but can ask for something else like fresh sandwiches, soup or salad." Another told us, "I enjoyed my lunch today. It was very nice." People either made their own breakfasts, were supported to make breakfast, or they had a choice of breakfast from the restaurant. Healthy eating was encouraged through the choice of meals which included healthy options. People's preferences were catered for because the chef had a record of people's likes and dislikes.

People were supported to maintain good health. A person told us, "Whenever I've felt unwell a team leader did a welfare check." Another person said, "The staff always call for a doctor if I am unwell." Staff supported people to arrange or attend appointments they had with health professionals. They arranged for GP's, district nurses, chiropodists, physiotherapists and others to visit people when required. People's care plans included a section about their health needs and how those should be met, for example with prescribed medication and appointments with the appropriate health professionals. Staff maintained records about people's healthcare appointments, the outcomes and any actions that were recommended to support people effectively.

Requires Improvement

Is the service caring?

Our findings

People we spoke with were unanimous in saying that staff were kind and caring. Comments included, "The staff are wonderful"; "The staff are very caring and helpful"; "The staff are very nice to me" and "They are such lovely people." We observed positive interactions between people and staff. People looked at ease and comfortable in the presence of staff.

People said they were treated with dignity during scheduled and day time visits. However, some people told us they experienced a lack of dignity sometimes during the day, but mostly during the night. A person said, "Waiting for over 15 minutes during the day is not dignified." People told us about their own experience or what others told them about theirs. A person told us, "I've been left for six hours and I know of a person who was left in a soiled bed at night." Another person told us they couldn't go to their bathroom at night without two staff to support them. Another person who required the support of two staff told us, "I've been left lying in a soiled bed at night." A person told us they had been told that if staff were not available they would have to rely on the incontinence pads they wore. Staff told us that people had been left in those situations for up to 30 minutes during the night and "all night".

Peoples dignity was not being maintained due to the change in service provision. This is was a breach of Regulation 10 HSCA RA Regulations 2014 (Dignity and respect)

People were understanding of staff. Their comments included, "They [staff] want to do their best but they haven't the time"; "They try their hardest." We found that there were not enough staff to ensure that people consistently experienced care that was dignified.

People felt that they were not getting the service they believed they were paying for. People told us that they were not getting the 24 hour care and support that was promised in the provider's brochure about the service. This referred to `24 hour on-site care and support tailored to your needs.' The provider's statement of purpose, which was part of their application to register with CQC, states `staff are available 24 hours a day for support and care.' People had 'service user guides' in their apartments which referred to people being provided with as much support as they needed. The information people received about the service and how it would support them was not, according to what people told us, what they experienced. People said that they felt they were expected to plan and anticipate when they would require support rather than receive support when they need it.

The provider's position was that people received support during 'commissioned hours' which were the times of scheduled visits to their apartments and when they needed 'urgent' support in between commissioned hours. However, peoples' perception was that they had to "pay to go to the toilet" or "had to plan when they would require urgent help".

People told us that their earlier experience of the service had been much better. Comments from people included, "I came here because I thought I'd be looked after, but it changed from April 2017"; "They used to do my care then sit and chat and ask how I was, now they do the care and leave"; "The care isn't what the

brochure says anymore" and "Six months ago it was completely different, now they are not providing what they did before." People were not experiencing the same level of care and support they had become accustomed to.

People's interpretation of the provider's information about the service differed from the provider's. The provider had sought to explain to people that they would receive care and support during commissioned hours and in between if they had urgent needs. However, people were not satisfied with the explanations and they continued to rely on what they believed the provider's brochures promised. They continued to press for clarity of information and a meeting was led at Oak Court on 19 July 2017 that was attended by senior managers from the provider. The provider was going to send a letter to all of the people using the service to explain the extent of care and support people could expect.

Staff respected people's privacy. They did not go to people's apartments rooms outside of commissioned hours unless requested. People who were independently mobile had free movement around the service and could choose where to sit and spend their recreational time. We saw those people were able to spend time the way they wanted. Some people chose to spend time in the communal lounge; others in their apartments. However, people who required the support of staff to leave their room were not always supported outside commissioned hours and their choice about where they went was therefore restricted.

People lived independent lives in their apartments. Their contact with staff was limited to scheduled times when staff came to their apartments to support them with personal care, and when they used call alarms to request a visit. People told us that staff showed them respect and supported them with dignity at those times. People told us staff were discreet when they provided personal care and that they felt comfortable at those times. In a recent satisfaction survey the provider carried out, people said that staff maintained their dignity during care routines.

The service respected people's diversity. The registered manager arranged for a translation service to help communicate with a person whose first language was not English. The person was supported to have foods that were a feature of their culture. People's faith and spiritual needs were respected. The service arranged for local faith representatives to visit people at Oak Court. Culturally diverse events such as Chinese New Year and religious and non-religious festivals were celebrated. The majority of people living at Oak Court shared the same cultural and ethnic background, but the provider had policies and procedures to ensure people's rights and protection from discrimination.

The provider promoted dignity and respect through policies and staff training. We saw and heard staff speak respectfully with people. A person told us, "The staff speak so politely to me." Staff referred to people by their preferred names. When staff supported people to walk or use wheelchairs they did so whilst engaging in conversation with people that they evidently enjoyed.

Requires Improvement

Is the service responsive?

Our findings

People told us that they were very pleased with the care and support they experienced before 1 April 2017 when changes were made to staff deployment. Comments included, "The care is really good when we get it, but we don't always get it when we need it"; "I was attracted to come here because of the care and support. I wish it would return to how it was" and "It was brilliant to begin with but not now."

Among the conditions of eligibility to use the service where that people were aged over 55 and required at least three and a half hours of care and support per week. The assessments of the hours of care required were made by the local authority. The hours of care a person was assessed as requiring were called 'commissioned hours'.

People's needs were assessed by the local authority to ensure they met the eligibility criteria to live at Oak Court. The provider informed people about how they could be supported through individual agreements which people consented to before they began to use the service. However, we found that the assessments did not include support during the night time, which the provider did not question when accepting people into the service.

People's care plans care plans were detailed. They included assessments of people's need and how they should be supported. The care plans were supplemented by 'day cards' which set out in detail how a person needed to be supported that day. Staff therefore had information about what was important to people and how to support them. People told us they saw staff read their care plans during care visits to their apartments. They told us the care and support they received at scheduled visits was good. A person told us, "The carers have been magnificent with their care" and another person said, "My care has been really good at the times carers have been."

People received the care they needed during commissioned hours. They told us they had, until April 2017, received care when they needed it. A person told us that their earlier experience of the service was "Like a dream come true" and another said, "The care used to be constant but it's not anymore." Staff told us they had less time to support people outside of commissioned times. People who required the support of two staff did not have that level of support at night time. A person had been told by the registered manager that the service could no longer provide the level of care the person needed. This meant they did not consistently receive care and support that met their needs; and for a small number of people this had affected their dignity. However, the provider was constrained by the commissioned hours stipulated by the local authority.

One reason people enjoyed living at Oak Court was because of the facilities that were available which fostered a community spirit and friendships to develop. We saw people use these facilities either alone or with other people. For example, we saw people use a library, a restaurant and an arts and crafts room. People organised their own activities through a residents' activities committee. These included keep fit, games and entertainments such as pantomimes, musicals and dramatics. People told us that the activities promoted social inclusion. However, people also told us that some people were no longer able to join in

activities they liked because there were not enough staff to support people from their rooms to attend. A person who was on the residents' activities committee told us, "Fewer people are coming to activities and they are experiencing isolation as a result." Another person told us, "We have lost most of the support that covered daytime and evening activities, leading to social isolation for many of the tenants who now have no one to bring them down."

People told us they liked their apartments. A person said, "I love the place." People who were mobile and did not rely on walking frames or wheelchairs told us the quality and facilities of their apartments supported their independence. A person told us, "I've more freedom here than I have ever had." People told us that they had expected to be able to use fixture and fittings in their apartments with ease and comfort. A person invited us into their apartment to show how difficult it was for them to use the oven and to safely reach into kitchen floor and wall units because of their limited mobility. They told us, "The apartments and kitchen appliances are lovely but they are not accessible for me." Another person told us, "The kitchen facilities are awkward. I can't reach into the lower cupboards." We saw another apartment that was occupied by a person who relied on a wheel chair which had no adaptions. As a result, door frames and adjacent wall areas were scuffed or damaged because the doors were not wide enough to allow easy passage. Another person told us, "The cupboards are too high for me to be able to open them and the way the cooker door opens isn't right for a person in a wheelchair." A person told us, "We want kitchens we can use so that we can be more independent." Another person told us they found the controls in their shower difficult to use. People referred their concerns to the residents association who shared them with the provider. The provider was not the landlord of Oak Court and not directly responsible for the maintenance of the premises. They were supporting people with how they could raise concerns about the facilities in their apartments with the landlord.

The provider had systems in place to receive people's feedback about the service. A 'residents association' was active at the service and its chairperson met regularly with the registered manager, sometimes as often as three times a week, to feedback peoples' views. People's views were listened to and meetings were arranged for senior managers to explain the situation at Oak Court and why the service was not what people understood or expected it to be.

The provider had appropriate arrangements for dealing with people's complaints or concerns. People had access to a complaints procedure. Complaints were dealt with promptly and actions were taken to address people's concerns. Most individual complaints had been about fixtures and fittings in people's apartments. These had been mostly addressed though a person told us, "It's difficult to get answers about who is responsible for repairs. I reported a problem with the floor covering in the wet room in January." People's concerns about the extent of care they received were addressed through dialogue with the residents association and meetings. People remained unhappy with the responses they received, but their dissatisfaction was with the provider not the service.

People's compliments about the service far outweighed the number of complaints. We saw 18 compliments about the quality of the staff. These described staff as being kind, passionate about their role and attentive to people's health needs.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with were unanimous about how well the service was run until April 2017. Comments included, "It was brilliant to begin with"; "It started out as a Rolls-Royce service but now we've got a scrappy banger" and "I'd like it to be the way it was in the beginning."

There were people who required the support of two staff with personal care routines but that level of support was not available during the night. The provider had not analysed the risks associated with those people not consistently receiving the level of support they required. The provider had made changes in April 2017 to how rotas and shift patterns were managed. This meant that the periods of support available to people were limited to the commissioned hours and emergencies. The provider was in consultation with the local authority about extending the commissioned hours.

People praised the registered manager and staff. They told us the registered manager and management team at Oak Court were supportive and understanding of their needs. They told us the registered manager regularly met with them individually or in groups to explain the challenges the service faced. People told us that the changes they wanted to see, which were to restore the service to what it had been before April 2017, was something they felt was outside of the registered manager's control.

The service had a registered manager who was away at the time of our inspection. 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. Whilst the registered manager was away the service was run by the operations manager. The operations manager visited the service monthly or as and when necessary to support the registered manager and to carry out monitoring checks.

The registered manager attended regular meetings with other organisations providing similar services to learn about and share best practice. They were supported by senior managers from the provider's head office to run the service from when it opened in September 2015. They continued to be supported as the number of people using the service increased.

People knew who the registered manager and members of the management team at Oak Court were. We saw people go into the team leaders' office to discuss things with them. The registered manager was away at the time of our inspection but people knew who was covering for them and we saw people speak with them in a relaxed and comfortable manner. This demonstrated that people felt confident and comfortable to approach members of the management team.

The care and support people received was based on the local authority's assessment of their needs. The assessments calculated the number of hours of care and support people required, which were the commissioned hours during which the provider met people's needs. The delivery of care was therefore in partnership with the local authority. A senior manager explained this to people at meetings including one

that took place on 19 July 2017, two days after our inspection. They said they were discussing people's concerns with the local authority with a view to resolving them.

Feedback we received about the meeting of 19 July 2017 was that people remained dissatisfied with the answers to their questions and concerns despite the provider's efforts support people to understand the model of care. Feedback we received about the meeting of 19 July 2017 was that people remained dissatisfied with the answers to their questions and concerns. The provider had not been able to support people to understand the model of care.

The provider had systems for monitoring the quality of the service people experienced. This included seeking and listening to people's feedback which had recently been critical. This showed that the provider understood the principles of good quality assurance and used these principles to critically review the service. People's feedback was through reviews of their care plans, the residents association and everyday dialogue that the registered manager and staff encouraged. The service carried out a survey of people's views. People's responses were positive though the survey was carried before April 2017.

The registered manager and team leaders completed monthly audits of all aspects of the service, such as the support people received with their medication, care records, health and safety checks of the premises and learning and development for staff. The use of call alarms was also monitored to assess how often people requested support outside commissioned hours.

An operations manager made visits to carry out their own checks and to verify the registered manager's and team leader's checks to ensure that the service ran smoothly. The provider used their monitoring activity to review the service and how staffing resources were called upon. The activity identified areas where the service was performing well, for example support during commissioned hours, and where there were issues, for example outside commissioned hours. The provider had a 'compliance team' that checked whether the service was meeting the conditions of its registration and the fundamental standards of care that we inspect.

The registered manager and members of the management team were aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the service. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

The service worked in partnership with the local authority and district council to make Oak Court a social hub in the local community. People from the local community were able to mix with people who lived at Oak Court and use the same facilities. This promoted community integration. The service had attained a silver 'Investors in People' award which showed that it valued staff and supported them to meet its aims to deliver quality care and support to people who lived at Oak Court.

The service had a comprehensive range of policies and procedures necessary for the running of the service to ensure that staff were provided with appropriate guidance. Staff we spoke told us they had access to these policies and procedures.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were left in undignified situations because there were not enough staff to support them in between commissioned visits and at night. Regulation10 (1) Service users must be treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployed to ensure that people who required the support of two staff with their mobility received that support at all times. Regulation 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed.