Oak Tree Care Services Limited

Oak Tree Care Services

Inspection report

62-64 Bounces Road
Edmonton
London
N9 8JS

Tel: 02088845050
Website: www.ot-cs.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an inspection of Oak Tree Care Service on 26 April 2016. This was an announced inspection where we gave the provider 48 hours' notice because we needed to ensure someone would be available to speak with us.

Oak Tree Care Service supports people at supported living services. At the time of our inspection there were four people who received personal care from the service. At our last inspection the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which was related to staffing. We found appraisals and an induction programme had not been undertaken for two staff members. We also found a person was not receiving one to one care as planned in their care arrangements and comprehensive audits were not being carried out.

The service did not have a registered manager. The provider told us a manager had been recruited and was due to start their employment. Once in post the manager would submit their application to register with the Care Quality Commission (CQC). 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.

Some risk assessments were not updated to reflect people's current needs and did not take into consideration people's health needs. When a risk was identified, assessments did not provide clear guidance to staff on the actions they needed to take to mitigate risks in protecting people, such as weight loss.

Medicines were administered on time and were stored safely. A person was allergic to a particular medicine and this was not recorded on the medicines record. We fed this back to the provider and the person's allergy was recorded. The provider told us that the GP and dispensing pharmacist were aware of the person's allergy.

People's capacity was being assessed. However, the assessments did not specify what area's people had or lacked capacity using the Mental Capacity Act 2005 principles. Due to risks to their safety, two people living at the supported living service we visited were not allowed to go outside without staff or a relative accompanying them. Appropriate Deprivation of Liberty safeguards had not been applied for.

Quality assurance and quality monitoring systems had been implemented to allow the service to demonstrate effectively the safety and quality of the service.

People had choices during mealtimes and staff assisted with meals in accordance to people's preferences.

People were protected from abuse and avoidable harm. Staff knew how to report alleged abuse and were

able to describe the different types of abuse. Staff knew how to 'whistleblow'. Whistleblowing is when someone who works for an employer raises a concern about a potential risk of harm to people who use the service.

People were supported by suitably qualified and experienced staff. Recruitment and selection procedures were in place and being followed. Checks had been undertaken to ensure staff were suitable for the role. Staff members were suitably trained to carry out their duties and knew their responsibilities to keep people safe and meet people's needs.

People were supported to plan their support and received a service that was based on their personal needs and wishes. People were involved in the planning of their care and the care plan was then signed by people to ensure they were happy with the care and support listed on the care plan.

There was a formal complaints procedure with response times. People were aware of how to make complaints and staff knew how to respond to complaints in accordance with the service's complaint policy.

People and relatives told us that staff communicated well with them. People's ability and preference on communication was recorded on their care plan.

People were supported to maintain good health and appropriate referrals to other healthcare professionals were made.

People were encouraged to be independent and their privacy and dignity was maintained.

Staff and resident meetings were held regularly.

We identified breaches of regulations relating to consent and risk management. You can see what action we have asked the provider to take at the back of the full version of this 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

Some aspects of the service were not safe.

Some risk assessments were not updated to reflect people's current circumstances and health needs.

One person's allergy was not recorded on the medicines administration chart. This allergy was recorded promptly when identified. Medicines were stored safely and administered on time.

People were protected by staff who understood how to identify abuse and whom to report this to.

Recruitment procedures were in place to ensure staff members were fit to undertake their roles and there were sufficient numbers of staff available to meet people's needs.

Is the service effective?

Requires Improvement

Some parts of the service were not effective.

People's rights were not being consistently upheld in line with the Mental Capacity Act 2005 (MCA).

Supervisions were being carried out with staff.

People were given healthy meal options, were supported with meals and were offered choice.

Staff members had the skills and knowledge to meet people's needs.

Staff supported people with accessing healthcare provisions.

Is the service caring?

Good

The service was caring.

There were positive relationships between staff and people using the service. Staff treated people with respect and dignity.

People had privacy and staff encouraged independence.

Staff had a good knowledge and understanding of people's background and preferences.

Is the service responsive?

Good

The service was responsive.

Care plans included people's care and support needs and staff followed these plans.

People participated in activities.

There was a complaint system in place. People knew how to make a complaint and staff were able to tell us how they would respond to complaints.

Is the service well-led?

Good

The service was well-led.

Audits were carried out to make continuous improvements to the service, if required.

Quality monitoring systems were in place for people to provide feedback.

Staff and residents meetings were being held regularly.

Staff were supported by management.

Oak Tree Care Services

Detailed findings

Background to this inspection

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

The inspection was carried out on 26 April 2016 and was announced. The inspection was undertaken by a single inspector.

Before the inspection we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting people's safety and wellbeing.

During the inspection we visited the providers head office and one of the supported living service that provided personal care to two people. We looked at two care plans, which consisted of people receiving personal care. We reviewed seven staff files and looked at documents linked to the day to day running of the service including a range of policies and procedures. We also looked at other documents held at the service such as quality assurance audits, risk assessments and staff meeting minutes. We spoke with one person using the service, the provider, deputy manager and two staff members.

After the inspection we spoke with two relatives and one staff member.

Requires Improvement

Is the service safe?

Our findings

People and relatives we spoke with told us they were safe at the service and had no concerns. One person told us, "Yes" when we asked them if they felt safe when receiving personal care from staff. A relative told us, "They have got my daughters safety under control." Despite these positive comments we found that some aspects of the service were not safe.

Risk assessments were undertaken with people to identify any risks around physical health, medicines, moving and handling and safeguarding. However, we found an instance when a risk was identified but the assessment did not provide clear guidance to staff on the actions they needed to take to mitigate such risks to ensure the safety of the person. For example, on the risk assessment the risk identified the person's health conditions and included that this had been referred to the learning disabilities team but had not included any information on ways to mitigate those risks leading to serious health complications. We found one person had a particular practise that could lead to serious health complications. The assessment did not include ways staff could mitigate this risk such as encouragement and reminding the person of the side effects of this practise. We found assessments had not been carried out specific to people's needs. For people who had weight issues, there was a lack of detailed guidance on what staff should do if people lost weight drastically and the action they needed to take.

The above issues related to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The deputy manager told us that staff supported people with their medicines. This was confirmed by people and relatives we spoke with. The staff we spoke with confirmed that they were confident with managing medicines. Staff had been trained in the safe management of medicines and confirmed training had been provided. We looked at the Medicines Administration Chart (MAR) for two people at the supported living service we visited. Medicines and recording sheets showed people were given the required medicine regularly and reasons were recorded for people that had not taken their medicines. We found allergies had been recorded for both people as not known however, we found evidence that showed one person was allergic to a particular medicine. It is important to record allergies to ensure both existing and new staff are aware of known allergies when administering medicines to minimise the risk of a severe allergic reaction that may impact on people's health. We fed this back to the deputy manager and provider and the persons allergy was recorded promptly. The provider told us after the inspection the GP and dispensing pharmacist were aware of this allergy therefore the risk of the person receiving this particular medicine was low.

We also found one medicine did not have a date of when it was opened and another medicine had a date of opening recorded incorrectly as that medicine had not been opened. Without the correct dates of opening and expiry the medicines may not be usable after a period of time. The service undertook audits in medicines; however, the audits had not identified the issues we found with medicines.

Systems were in place to manage people's finances. Each transaction was logged and recorded on people's individual finance sheet with receipts. An overall balance was listed after each transaction. During staff

handovers we observed that staff counted people's money to ensure this matched with the overall balance on the finance sheet. We checked two finance sheets in detail and found the records and balance was accurate.

Staff and the deputy manager were aware of their responsibilities in relation to safeguarding people. Staff had undertaken training in understanding and preventing abuse and up to date training certificates were in staff files. Staff were able to explain what abuse was and who to report abuse to. They also understood how to whistle blow and knew they could report to outside organisations such as the Care Quality Commission (CQC) and the local authority.

People and relatives told us that there was enough staff to provide personal care. A person told us, "Yes' when we asked if there was sufficient staff to provide personal care. A relative told us, "There is enough staff" and another relative commented, "There is always someone [staff] there 24/7." The provider told us that they had introduced a system, which was a phone in policy for staff to alert them if they were going to be late or not able to come into work. This enabled alternative arrangements to be quickly made to ensure that the required support could be provided. The staffing rota confirmed that staff were available to deliver personal care and if the staff was off from duty then there was appropriate cover. Both supported living services employed two care workers during the day and evening with the support of the provider and deputy manager. One staff member was employed during nights. The provider told us that on occasions such as staff sickness or holidays they had access to bank staff or agency staff. The provider told us they used the same agency staff to ensure people were supported by the same staff. We spoke to an agency staff who confirmed she had been working at the service for 10 months. This meant that people did not go without the care and support they needed. A staff member told us, "We have enough staff."

Records showed the service collected references from previous employers, proof of identity, criminal record checks and information about the experience and skills of the staff. The provider told us staff members did not commence employment until pre-employment checks had been completed. This corresponded with the start date recorded on the staff files. This minimised the risk of inappropriate staff being employed by the service.

Risk assessments and checks regarding the safety and security of the premises were up to date and had been reviewed. This included a fire safety policy, fire risk assessments, quarterly evacuation drills and weekly fire tests for the supported living service we visited. Staff were able to tell us what to do in an emergency, which corresponded with the fire safety policy. We saw evidence that demonstrated appropriate gas and electrical installation safety checks were undertaken by qualified professionals. Checks were made in portable appliance testing to ensure people living at the home were safe.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us that staff members were skilled and knowledgeable. One person told us, "Yes" when we asked if staff provided good support. A relative commented, "They [staff] do a good job." A health and social professional told us, "I have one person place with this service, overall I am happy with how the placement meeting our service user's needs." Despite these positive comments we found that some aspects of the service were not effective.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

Training in the Mental Capacity Act 2005 (MCA) had been provided, however we did not find evidence that staff had been trained in DoLS. One of the staff we spoke to was not able to explain the principles of the MCA and DoLS. Another staff member explained how MCA can be used to assess capacity however, was not able to explain DoLS. The provider told us after the inspection that training will be provided in DoLS. Staff told us they always asked for consent before providing care and treatment. The person we spoke with confirmed that staff asked for consent before proceeding with care or treatment when providing personal care. For example, staff requested the consent of people if they wanted to speak to the CQC inspector, and if a person did not want to speak then this was respected.

The provider told us that the local authority assessed people's capacity to make decisions about their support. However, we did not see records that showed people's capacity being assessed using the MCA principles. Records showed that one person had capacity and the provider told us another person lacked capacity in certain areas. The records did not cover the elements of capacity, namely can the person understand, retain, and weigh the information, and make a decision on the information. We did not see any evidence of best interest meetings or decisions being made for the person that may lack capacity to make specific decisions at particular time.

We saw that the front door was kept locked and the two people that received personal care did not go out by themselves. The deputy manager told us people were not allowed to go out without a staff member or relative accompanying them due to risks to their safety. We found that DoLS application had not been made for the two people who they felt were unable to safely go out alone and therefore this meant that people may have been unlawfully deprived of their liberty.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At our last inspection the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which was related to staffing. We found appraisals and an induction programme had not been undertaken for two staff members.

During this inspection, the staff members we spoke with told us, that they received induction training when they started working at the service and records confirmed this. We looked at two staff records that commenced employment after the last inspection and found an induction had been provided. Staff confirmed that the induction training was useful which included opportunities to shadow a more experienced member of staff and look at care plans. This made sure staff had the basic knowledge needed to begin work. Records showed that staff had undertaken mandatory training before providing personal care. Training included roles and responsibility of care workers, safeguarding, epilepsy, autism, fire safety, first aid and dementia. Staff told us that they had easy access to training and had received regular training. One staff member told us, "We had training."

Staff confirmed they received regular supervision and appraisals. They told us they could talk about concerns and any training needs. Records showed that the home maintained a system of appraisals and supervision. Formal individual one-to-one supervisions were carried out regularly. Records showed that staff had received their annual appraisal in 2015.

We noted that one person had a specific health condition that required a nutritious and balanced diet. The service assisted the person with their meals. One relative told us, "They [staff] help her if she needs help with cooking." Records showed the person's preference was recorded and choices were offered to the person when making their meals. When we spoke to the person's relative, they confirmed staff encouraged healthy eating and meals were prepared in accordance to the person's preference and likes. The person's care plan outlined that the person was to be given nutritious and healthy meals. Food intake was being monitored for the person and recorded on a food intake chart. This confirmed that the person was given healthy nutritious meals. We went into the kitchen area and saw that people had their own locked cupboard to store their food and records confirmed people were able to go out to the shop for groceries. Relatives confirmed this. One relative told us, "They go grocery shopping every Monday. They help her to pick healthy foods." Another relative commented, "They [staff] encourage healthy eating and know what she likes."

Relatives told us that their family members healthcare needs were met. One relative told us, "They [staff] always take her for blood test every couple of weeks; they are really good with that." People's care plans listed details of health professionals such as GP and also included their current health condition. The staff we spoke with told us people had access to healthcare professionals particularly if they were unwell. One staff member told us, "I support people with healthcare appointments." Staff gave us examples of where they were able to identify if the person was not well such as looking at their body language, facial expression and response. Records showed that people had been referred to healthcare professionals such as the GP, district nurse and dietician. Outcomes of the visits were recorded on people's individual's records along with any letters from specialists. Records showed that people were supported to go to hospital when needed and referrals were made to other healthcare professionals when required.

Good

Is the service caring?

Our findings

People and relatives that we spoke with were happy with the staff and spoke positively about their relationship with them. They told us that staff were caring, friendly and treated people with respect. One person told us, "Yes" when we asked if staff were caring. The staff members spoke warmly of the people and told us that they had built positive relationships with people by spending time, listening and talking to people regularly. Staff told us they were not rushed and had time to interact with people and build relationships with them. A relative told us, "They [staff] are really clued on to her." We saw people were relaxed and there was general chatter and laughter between the staff and the people that lived at the supported living service we visited.

We found the care plans completed by the service contained information about the needs of people and duties required. This enabled staff to support people in a meaningful way that recognised their individuality and preferences.

The staff we spoke with demonstrated a detailed knowledge of people as individuals and knew what their personal likes and dislikes were. Staff were able to tell us the background of the people and the support they required. Staff told us that they received information on the needs of people using the service and were given time to read people's assessments, care plans and risk assessments. This helped staff to gain an understanding of the needs of people using the service and how best to support them.

Relatives told us that the staff understood how to meet their family member's needs and provided a personalised service that promoted their dignity and privacy. We observed people could freely go into their flats when they wanted to and close the door without interruptions from staff and people. Staff told us that they would knock on people's door and wait for a response before entering. Observation confirmed staff knocked on people's door before entering. Staff told us that when providing particular support or treatment, it was done in private and we did not observe treatment or specific support being provided in front of people that would had negatively impacted on a person's dignity. Relatives confirmed that their family member's privacy and dignity was respected.

Staff supported people to be independent in their day-to-day lives. Staff members told us people were encouraged to be independent, one staff member commented, "We encourage independence." Observations confirmed staff encouraged people while supporting them. We observed people were able to move around independently and go to the lounge, kitchen and hallways if they wanted to. A relative commented "They [staff] do try to promote independence as much as possible. Within boundaries they do try to get her to do what she can." A health and social professional told us, "They do encourage independence."

Staff members were trained on equality and diversity. The staff member we spoke with told us that they treated people equally. Relatives confirmed this and had no concerns about staff approach and observations confirmed that staff approach towards people were positive. Cultural and religious beliefs were discussed with people. Their preferences were recorded in care plans. The provider should note that

the equality and diversity policy primarily focused on staff and not the people the service provided personal care too and this policy should also reflect the people receiving personal care and being treated equally at all times.

Care plans listed how to communicate with people. For example, one person's care plan listed for staff to speak slowly using short sentences. There was also a communication dictionary, which listed how people indicated if they were happy, sad, tired, unwell or angry. Not all of the people were able to fully express their views verbally. Staff made use of body language, hand gestures and employed other methods of communication to support people with non-verbal communication to have a voice and maintain choice and control. Care plans provided detailed information to inform staff how a person communicated.

Good

Is the service responsive?

Our findings

We asked relatives if they found the service provided by Oak Tree Care Service to be responsive to their needs. Relatives spoken with confirmed the service was responsive and that staff were attentive to their family member's needs. One relative told us, "They [staff] do right by her, provide lunch and make sure she is dressed." A health and social professional commented, "Overall I am happy with how the placement is meeting our service user's needs."

All care plans had a personal profile outlining health conditions, current medication, nutrition, identity, religion, communication, hobbies and mobility. There was a section on 'What people like about me' and 'People in my life' providing background information about the person. This helped staff to understand people's preferences and interests and helped develop positive relationships and provide personalised care. There was a daily log that staff completed, which recorded daily activities and support provided for each person. These daily logs provided staff with information so that they could respond to people positively and in accordance with their needs.

Care plans were reviewed regularly. Staff understood the importance of recording changes in people's needs. We found that timely and appropriate referrals were made to health professionals, which ensured that changes to people's needs were addressed.

Relatives we spoke with expressed confidence that any changes in people's care were responded to promptly and communicated to them. One relative told us, "They always call me if anything goes wrong" and another relative told us, "If I ever have a query with anything, I always had responses and it is dealt with." People's care plans included the support and care required. Staff told us that they felt there was enough information within people's care plans for them to understand what support people needed. They were able to tell us in detail about the needs of the individuals they were supporting.

People's care plans were personalised and person centred to people's needs and preferences. Staff told us they had time to provide person centred care. One relative told us, "I think it is a good care plan." The provider told us that they always provided staff time to provide person centred care and also to build good relationships with the people they supported. Staff confirmed this. One staff member commented, "We are not rushed." We found that people had input into the care plans and choice in the care and support they received. Care plans were signed by people to ensure they agreed with the information in their care plan. A relative told us when asked if they were involved in care planning, "I have meetings with the [director] about her care needs."

There was a staff handover and communication record, which recorded key information about people's daily routines such as behaviours and the support they required. The deputy manager and staff we spoke with told us that the information was used to communicate between shifts on the care people received during each shift. Observations confirmed that these records were used during staff handovers.

Care plans recorded people's hobbies and interests. There was an activities timetable for each person at the

supported living service we visited that showed when they would be going out to participate in activities. Records, staff and relatives confirmed people participated in activities. One relative told us, "The other service had a birthday party, she went there and danced and enjoyed herself" and another relative told us, "Recently she joined a dance class." We saw photos and videos that showed a person going to birthday parties and joining in with the celebration. We saw an occupational therapy report which listed that a person should participate in particular activities and we saw evidence that the person had participated in these activities. A health and social care professional told us, "They assist her to attend a local college three to four days a week."

There were procedures in place to handle complaints. The policy provided people who used the service and their representatives with clear information about how to raise any concerns and how they would be managed. People and relatives knew how to make complaints and staff were able to tell us how they would respond to complaints. The provider had told us no complaints had been received since the last inspection. A relative told us, "My sister has never made a complaint." We requested to be shown where the complaints book was kept and if this was accessible for people and relatives to use. The provider was unable to show us the complaints book. We were assured by the provider that the complaints book would be kept at the supported living service making it accessible for people and relatives.

Good

Is the service well-led?

Our findings

We asked relatives if they found the service provided by Oak Tree Care Service to be well led. Relative spoken with confirmed they were happy with the way the service was managed. One relative told us, "The management are brilliant."

The provider told us spot checks were carried out, which included observing staff when they were caring for people to check that they was providing a good quality service. The results of these observations were communicated to staff with a view to improve practice. Spot checks were recorded briefly on the provider's handbook detailing the findings. We did not see information on what percentage of spot checks had been done and what was still outstanding. Keeping detailed records of spot checks was important to keep track of the number of checks undertaken and help identify areas of improvements or best practise that could be used in staff supervision and appraisals. We fed this back to the provider who assured us that comprehensive records of spot checks would be kept and used as a learning tool within staff supervision.

The service had a quality monitoring system which included meeting with people and relatives. The provider told us that the service used to use questionnaires, however, this was not always effective as people and relatives did not consent to take part. The provider told us that they now meet with the people and relatives to speak about the service on a regular basis. Relatives confirmed this. One relative told us, "He [provider] contacts me for one to one meetings to review her care needs." Records showed that these discussions took place with families and people.

Health and safety records kept in the service showed that regular checks were undertaken, for example on potential hazards in people's flats, fire safety and finance. The audits listed issues and where action was required to be taken to make continuous improvements to the service.

Staff members were positive about the management. One staff member told us, "They [management] are approachable and very supportive" and another staff commented, "She [deputy manager] is supportive" and "He [director] is good." Staff told us that they were supported in their role, the service was well-led and there was an open culture where they could raise concerns and felt this would be addressed promptly. Staff were committed to providing a good quality service and were aware of the aims of the service. They could speak with management when they needed to and felt that their comments were listened to. The interactions between staff and management, we observed were professional and respectful.

Staff meetings minutes showed staff discussed training needs, care plans, staffing and about the people living at the service to ensure issues or concerns were addressed as a team and relevant action was taken if required. We saw people were involved in the residents meetings and were able to raise any issues or improvements to the service directly to management at those meetings. Topics included food, activities and staffing. We noted that one person commented at a recent meeting that she liked the service and food.

The services statement of purpose was to provide high quality care, supporting people to make informed choices, promote independence and ensure people were valued. Staff told us that the vision and values of

the service were communicated in staff meetings and supervisions to ensure values were upheld and people received high quality care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person as the registered person was not always acting in accordance with the Mental Capacity Act 2005. (Regulation 11(1)(3))

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users (Regulation 12(2)(b))