Mental Health Concern

Oakwell

Inspection report

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Date of inspection visit:
10 February 2016
12 February 2016

Date of publication:
01 April 2016

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 inspection took place on 10 and 12 February 2016 and was unannounced. This meant the staff and provider did not know we would be visiting.

Oakwell provides care and accommodation for up to 13 people who have mental health needs. On the day of our inspection there were nine people using the service.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Oakwell was last inspected by CQC on 6 November 2013 and was compliant with the regulations in force at that time.

Accidents and incidents were appropriately recorded and investigated. However, some CQC notifiable incidents had not been reported to CQC. Staff had been trained in how to manage behaviour that challenged and in safeguarding vulnerable adults. People were protected against the risks associated with the unsafe use and management of medicines.

The home was clean, spacious and suitable for the people who used the service and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place. Staff were suitably trained and training sessions were planned for any due or overdue refresher training. Staff received regular supervisions and appraisals.

The provider was working within the principles of the Mental Capacity Act.

Staff were aware of how to protect people from the risk of poor nutrition and people had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits to and from external health care specialists.

People who used the service, and family members, were complimentary about the standard of care at Oakwell. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible. People had been involved in planning their care and care records were written in a person centred way.

Activities were arranged for people who used the service based on their likes and interests and to help meet

their social needs.

People who used the service, and family members, were aware of how to make a complaint however there had been no formal complaints recorded at the service.

The service had a positive culture that was person-centred, open and inclusive. Staff felt supported by the registered manager. The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

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.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated. However, some CQC notifiable incidents had not been reported to CQC.

Staff had been trained in how to manage behaviour that challenged and in safeguarding vulnerable adults.

Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People had access to their own kitchens and were supported by staff in making healthy choices regarding their diet.

People had access to healthcare services and received ongoing healthcare support.

The provider was working within the principles of the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they moved into Oakwell and care plans were written in a person centred way.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well led.

The service had links with other local organisations.

Staff felt supported by the manager and were comfortable raising any concerns.

People who used the service, family members and staff were regularly consulted about the quality of the service.

The provider visited Oakwell regularly to check the quality of the service.

Oakwell

Detailed findings

Background to this inspection

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

This inspection took place on 10 and 12 February 2016 and was unannounced. This meant the staff and provider did not know we would be visiting. One Adult Social Care inspector took part in this inspection.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including the local authority and clinical commissioning group. No concerns were raised by any of these professionals.

Before the inspection, the provider completed 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.

During our inspection we spoke with two people who used the service and one family member. We also spoke with the registered manager, clinical lead and two care workers.

We looked at the personal care or treatment records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Is the service safe?

Our findings

We asked people and family members whether they or their relatives felt safe at Oakwell. A family member told us, "Oh, yes." A person who used the service told us, "Yes, I like the fact the doors have codes."

We looked at the recruitment records for three members of staff and saw that appropriate checks had been undertaken before staff began working at the home. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was also obtained from each member of staff and included copies of passports and driving licences. We saw copies of application forms and we checked these to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We discussed staffing levels with the registered manager and looked at staff rotas. We saw there were sufficient numbers of staff on duty to care for the people who lived at Oakwell and staffing levels also provided the flexibility for staff to accompany people who used the service on external activities. The registered manager told us they had carried out analysis on incident reports and identified peak times when incidents had occurred. Staffing levels had been adjusted so one extra care staff was on duty during these peak times.

We asked the registered manager how staff absences were covered. They told us most absences were covered by their own staff and the registered manager and clinical lead also covered absences. The provider also had bank staff available. The registered manager told us the service did not use agency staff. We asked staff whether there were enough of staff on duty. They told us, "It's one of the best places I've been for staffing levels" and "We have a great team, who are very flexible. Staff come in at short notice". People who used the service told us they had no concerns regarding staffing at Oakwell. This demonstrated there were enough staff on duty to meet the needs of the people who used the service.

The home is a modern, three storey building that is split into two individual units. Entry to the premises was via a locked front door and a side door, which had keypad access. Staff, and people who used the service, we spoke with told us that access to the home at night could only be obtained via the locked front door. This meant staff knew who was entering or leaving the home. The home was clean, spacious and suitable for the people who used the service.

People had 'Galatean Risk Screening Tools (GRIST) in place. The GRIST was a generic risk assessment, reviewed annually, and included information on the risk of suicide, self-harm, harm to others, risk to dependents, self-neglect and vulnerability. For example, we saw one person was at risk of self-neglect due to making poor diet choices despite being a diabetic. We saw these risk assessments were up to date and staff had clear guidance should the person suffer from hyperglycaemia (high blood sugar) or hypoglycaemia (low blood sugar).

Hot water temperature checks had been carried out for all rooms and bathrooms. We saw some temperatures had exceeded the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014. We discussed this with the registered manager who agreed to address this with the provider. The registered manager told us the people who used the service were able to regulate water temperatures for their own personal use, for example, showers and baths. Risk assessments were in place, which demonstrated that people had the capacity to regulate the water temperature in their rooms and showers.

Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, a fire safety service had taken place in April 2015, the fire risk assessment was up to date and regular checks had been carried out on the fire alarm and fire-fighting equipment. We saw a copy of the evacuation plan and personal emergency evacuation plans were in place for each person who used the service.

We saw a copy of the provider's safeguarding policy and procedure, which had been reviewed in January 2016. This provided information on recognising and preventing abuse, roles and responsibilities and making a safeguarding referral. Records showed that staff had received training in safeguarding vulnerable adults. One member of staff was overdue their refresher training but this training was booked for March 2016.

Staff had been trained in how to manage behaviours that challenge. A staff member told us they were the 'behaviours that challenge' champion and had helped to develop the training package and cascaded it to staff.

We looked at how the provider recorded accidents and incidents. We looked at individual accident and incident records that had been recorded on the provider's electronic system and saw these had been appropriately actioned by the service. The registered manager told us each accident and incident was checked by the provider and analysis was carried out to identify any trends.

We looked at the management of medicines and saw that for all but one person, medicines were stored safely and securely in locked cabinets in people's bedrooms. The other person's medicines were stored securely in the office. It was recorded that this person had a history of non-compliance with their medicines while living independently and as a result needed support to take their medicines as prescribed. The person's care plan described that the person would initially be observed by staff in the office when taking their medicines with the aim for the person being "Empowered to do so independently." We saw the person had signed the care plan to show they agreed with it.

We looked at the ordering and administration of medicines process, which included a nominated individual contact at the local pharmacy. Medicines were ordered in four week supplies and were delivered by the pharmacy to the service. Medicines were audited as part of the four weekly cycle and additional individual audits for each person were carried out every six weeks.

Medicines care plans were in place and described the medicine and what it was for, what the aim of the plan was, for example, for the person to be responsible for administering their own medicines and be aware of the side effects. One of the people who used the service told us, "I take my own medicines. I have a dosette in my locked cabinet in my room. When it's empty, I change it on a Friday and collect a week's worth. I sign and they sign." We asked the person about self- administration of medicines. They told us, "They [Staff] ask me if I've taken my medicines. They check." This showed that appropriate arrangements were in place for the administration and storage of medicines.

Good

Is the service effective?

Our findings

People who lived at Oakwell received effective care and support from well trained and well supported staff. A family member told us, "Absolutely first class, they've been really good" and "I thank them for where [Name] is today. It's down to them". A person who used the service told us they had a "Great relationship with staff."

Staff received regular supervisions, case note reviews and appraisals. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Supervision discussions included organisational philosophy, work with individual residents, personal and professional support, training and development needs and any other issues. Case note reviews were carried out by the clinical lead and included a discussion with the keyworker and an evaluation of documentation. We also saw records that confirmed staff received an annual appraisal, which included a review of objectives and discussed conduct, communication, quality of service, leadership and management. Staff members we spoke with confirmed they received regular supervisions and an annual appraisal. They told us, "Loads" and "I usually ask for supervisions".

We looked at the provider's electronic training matrix and saw all staff completed statutory training. This included fire safety, moving and handling, food hygiene, infection control, health and safety, control of substances hazardous to health (COSHH) and first aid. Staff also completed other training that was relevant to their role, for example, behaviour that challenges, medicines, safeguarding and mental capacity. Records we looked at showed that most of the training was up to date and where training was overdue, it had been identified and booked. For example, we saw staff had been booked on first aid, fire safety, health and safety and moving and handling training before the end of February. We were unable to see all the individual certificates for the training that had taken place. We discussed this with the registered manager who showed us staff training declaration forms, which staff recorded and signed for training they had completed. We discussed training with staff, who confirmed they had completed the training as recorded on the training matrix. Staff told us, "All mine is up to date" and "If it's not part of statutory training, you can always ask for it if it's relevant to the job".

Staff completed a comprehensive induction to the service. This included completing statutory training prior to undertaking an induction to the home and they spent six months on probation. The registered manager told us all new staff were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care.

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 and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw mental capacity assessments were in place and best interest decisions had been made appropriately for people, for example for administration of medicines and finances. We also saw staff had completed training in mental capacity and Deprivation of Liberty Safeguards. We discussed DoLS with the registered manager, who told us no DoLS applications had been submitted for people who lived at Oakwell as all the people were independent and free to leave the premises if they wished.

We saw copies of residents' contracts, which were signed by each person who used the service agreeing to respect the rights of other people who used the service, keeping the living area in an acceptable condition and abiding by the alcohol and smoking policies. We saw copies of 'Consent to share information about you' forms in the care records. These were completed by the person who used the service to state whether they gave consent to contact the person's next of kin or family member, what information they were comfortable sharing and with who. All of the records we saw had been signed by the person who used the service and dated.

People had access to their own kitchens and were supported by staff in making healthy choices regarding their diet. People were regularly weighed and measurements recorded. We saw some people who used the service were diabetic. One person measured their own blood glucose levels three times per day. The person's care record stated, "Has adequate diet but could be healthier" and "Staff to encourage and support me in carrying out exercise and choosing healthier options in meal planning". Another person's care record stated, "[Name] to consume a healthy diet" and "Staff to offer support and education re maintaining a healthy BM level". We saw this person's blood sugar levels were often higher than the recommended levels as recorded in the care plan. We discussed this with the registered manager, who told us the person had capacity to make decisions about their diet and although staff gave advice and supported the person to choose healthy options, the person chose what they wanted to eat. We saw this person administered their own insulin, all records were signed and dated by the person who used the service, and these were regularly evaluated and up to date. We also saw nutritional screening tools were used. Staff we spoke with were aware of people's nutritional needs and records of what people had eaten were kept.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits to and from external specialists including GPs, opticians and hospital appointments. A family member told us they were kept up to date about their relative's health and health appointments. They told us, "If there's anything, they get in touch."

Good

Is the service caring?

Our findings

People who used the service were complimentary about the standard of care at Oakwell. One person told us, "I think I've got a good relationship with all the staff here. My keyworker and co-keyworker are fantastic. My keyworker has gone out of his way to talk to me and help. They are a really good team". A family member told us, "Through them, [Name] has learned how to cook, do their laundry, go out. They've done well there."

People we saw were well presented and looked comfortable with staff. We saw staff talking to people in a polite and respectful manner and staff interacted with people at every opportunity. For example, we observed a member of staff tell a person they were going out in the car and they asked the person whether they wanted to come with them. The person said, "No, not this time" and the staff member said, "Well, you're always welcome". We saw staff knocking before entering people's rooms and closing bedroom doors behind them to ensure people's privacy. We also saw staff asking people's permission, for example, to show us their bedroom and to go into a person's bedroom to test the smoke alarm. A person who used the service told us, "Staff always knock on my door. They won't come in unless I say they can. They respect my decision."

Staff told us that all the staff acknowledged that Oakwell was the people's own house and always knocked on doors and waited for a response before entering. They also told us people were encouraged to personalise their own space and were given the option of male or female carers to assist with personal care. Staff told us, "We take the time to value the person" and "Their room is theirs. We knock and wait until they say we can come in. We chat through the door if necessary". This meant staff respected people's privacy and dignity.

Each person's care record included a recovery focussed assessment (RFA). The RFA included important information about the person, such as preferred name, date of birth and details of the person's next of kin. The RFA was broken down into different areas, which included information on what the person liked to do, relationships, hopes for the future, independence, choice and control, and stability and consistency. We saw that the RFA had been written in consultation with the person and included evidence of personal choice and preferences. For example, we saw one person liked to spend time in the home with other residents and occasionally met a family member for lunch or to go shopping.

The RFA provided information on how people maintained their independence, sometimes with support from staff. For example, "Staff to support and encourage [Name] to carry out activities of daily living." Activities of daily living included laundry, grocery shopping, cooking, buying their own clothes and managing their own finances. One person told us, "I do all my own washing, cooking and cleaning. I'm always cleaning." Another person told us, "I've learned how to do my own cooking since I came here." This demonstrated that staff supported people to be independent and people were encouraged to care for themselves where possible.

People who used the service told us they felt involved in their care and how the service was run. One person told us, "I have a one to one with staff every day. We discuss anything that's bothering me or if I've had any

problems. It makes me think the staff care about me. If I don't have a one to one, the staff ask me. I usually have them at night time but they are flexible though."

Information on advocacy services was provided to people who used the service. Advocacy services help vulnerable people access information and services and be involved in decisions about their lives. A guide to advocacy was available in one of the lounges and the registered manager told us one person at the service had an advocate.

We discussed end of life plans with the registered manager who told us an end of life plan had been in place for a person who used to live at the service. The registered manager felt however that it was a difficult subject to address with the current client group. The registered manager told us they and other members of staff had palliative care experience and end of life plans would be discussed with people if it was necessary.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated.

Care plans were in place and included medication, mental health, physical health and hygiene, activities and finances and budgeting. Each care plan described the focus of the plan, aim of the plan and actions to be taken. For example, one person had a care plan in place due to fluctuation of mood. The aim of the plan was to assist the person in meaningful activities, encourage the person to become more self-aware of when their mental health relapsed, encourage them to develop a social network outside Oakwell and to continue to promote their independence. The care plan provided a guide for staff for low and elevated moods. We saw the care plan was regularly evaluated and included updates on activities carried out, mood level and diet. All the care plans we saw had been signed by the person who used the service and their key worker. People who used the service told us they were involved in planning their care and felt "Fully involved."

The recovery focussed assessments described how staff should respond to changes in people's moods. For example, when one person experienced low moods, they spent long periods asleep and neglected their activities of daily living. Guidance for staff included, "At these times [Name] requires the optimum level of support, encouragement, reassurance and assistance" however the occurrences of low moods had decreased due to "[Name] trusting staff and being able to recognise that regular medication helps to reduce the anxiety."

Each person who used the service had a 'relapse plan' in their care records. This provided important information on what factors contributed to a person's good mental health, factors that could contribute to a relapse or poor mental health, signs and symptoms of a relapse and action to be taken in the event of a relapse. For example, going out with a family member, having their own money and going on holidays was important to one person's good mental health. The relapse plan provided information to staff on how to recognise the signs and symptoms of a relapse in the person's good mental health and what action to take. Another example being, one person would become low in mood, stop carrying out their activities of daily living and stop taking their medicines. Staff were instructed to engage with the person, offer one to one sessions and support the person to take their medicines.

People were able to make choices about their health, accommodation and activities. For example, we saw one person was given advice with regards to smoking but declined to stop smoking at that time. This was documented in their care records. Another person told us, "I love my room. I've been able to decorate it myself. [The registered manager] let me choose my own paint. Nowhere I've ever lived before allowed me to decorate or personalise my own room."

We saw activities were arranged for people based on their likes and interests. Some people attended the "Club house", which was a local community day centre that provided support from people who themselves had mental health problems. Activities at the centre included a café, computer suite, knitting and crochet, drama, video and photography, arts and crafts, and cooking. We saw one person was a keen gardener and accessed a social inclusion gardening network (SIGN) at allotments in County Durham. Other person

centred activities included a well woman's group, swimming, visits to an animal rescue centre and shopping trips. One person told us, "I'm always doing something." People had activities care plans in place. One person's care plan stated, "[Name] has identified that their days lack structure and often feels bored but is unsure of how to occupy their time in a meaningful way." The action plan described that staff were to agree an activities plan with the person on a Sunday to help them "Become an active member of the wider community, promote good health and social inclusion." We saw each activity was documented in the person's care plan, for example, "Visited mother's", "Went to library with staff" and "Went to gym".

We saw a copy of the provider's complaints policy and procedure. This provided information of the procedure to be followed when making a complaint, for example, who to make the complaint to, timescales and other contact details if the complainant was not happy with the outcome. We saw there had been no formal complaints recorded at the service since April 2015. People who used the service, and family members we spoke with, were aware of how to make a complaint but did not have any complaints about the service. A person who used the service told us, "I know that if I had a complaint, I would go to [registered manager] or [clinical lead]. [The registered manager] is very fair and honest. A family member told us, "None whatsoever. I haven't had a complaint about Oakwell at all." This showed the provider had an effective complaints policy and procedure in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

Staff we spoke with felt supported by the manager and told us they were comfortable raising any concerns. The also told us there had been lots of changes but it had been "Positive". Staff told us, "I love it. It's very rewarding" and "There's an open door policy. I can go to them [management] any time with a problem. Everything is taken seriously and dealt with. They involve us and I feel valued".

We saw the results of the staff survey that took place in 2015. The survey included questions on job satisfaction, communication and change, future, 'demands on you', 'how much say you have', working relationships and an action plan for any identified issues. We found that as a result of the survey, for example, an employee forum had been agreed by the provider's board and recently implemented.

Staff meetings were held regularly and the most recent meeting had taken place on 9 February 2016. The minutes for the meeting showed discussions had taken place on statutory training, where staff were asked to check their own training records and book on to appropriate courses as necessary, the smoking shelter, referrals and key worker allocation, away days, appraisals, house rules, medicines, recruitment and any other business.

The service had links with the community. These included the Ivy Centre, a safe space for people to connect, learn and develop skills, the 'Club house' and a social inclusion gardening centre. Mental health advice and information services were also made available from other support services in the local area.

During the inspection, we found there had been Care Quality Commission (CQC) notifiable incidents at Oakwell that had not been reported to CQC. The registered manager contacted the provider's head office and analysis identified there were 12 incidents since April 2015 where the registered manager had correctly completed the incident record however when it was submitted to head office, these notifications had not been submitted to CQC. The registered manager agreed to arrange to have these notifications retrospectively submitted to CQC.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. We saw the provider carried out quarterly visits to the home, which included an audit of care records. These audits checked whether the documentation complied with NMC (National Medical Council) guidelines for record keeping, whether each person's support package demonstrated that all domains were assessed and recovery focused, whether each person's care records demonstrated appropriate support planning and whether care records were regularly reviewed. Each audit included an action plan for the registered manager to action prior to the next visit. The registered manager told us these visits were going to be announced in advance in the future so they could invite and involve key workers and families in the discussions.

We saw other audits completed at the service included medicines, infection control and health and safety. A copy of the latest infection control audit, carried out on 11 February 2016 included checks of the general environment, hand hygiene, bathrooms, bedrooms, kitchens, linen, waste disposal and medical equipment. The audit included an action plan for any issues that had been identified.

We saw records of residents' meetings, which were held regularly, the most recent meeting had taken place on 3 February 2016. Subjects discussed at this meeting included food in communal areas, cigarettes, new staff, security, informing staff who was going in or out, yearly holiday, new rooms and healthy eating. People were asked for suggestions for the yearly holiday and a communal healthy eating event was to take place once per month with a theme. A person who used the service told us, "We have a residents' meeting every month or couple of months."

We saw the results of the service users' satisfaction survey that took place in 2015. This included questions on compassion and hopefulness, openness and friendliness, experience and expertise, hard work, creativity and innovation and going the extra mile. There had been eight responses from people who lived at Oakwell and most of the answers and comments were positive about the quality of the service provided. Comments included, "I feel that I have got my dignity back", "Hopeful of the future", "Increased confidence levels" and "Thankful of help received".

This showed that the provider gathered information about the quality of their service from a variety of sources.