

St Anne's Community Services

St Anne's Community Services - Oxfeld Court

Inspection report

Oxfeld Court
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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Outstanding ☆
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection took place on 17 and 18 December 2018 and was unannounced. Oxfield Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Oxfield Court provides accommodation and support to people with a learning disability.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion and were embedded within this service which worked to ensure people could live as ordinary a life as any citizen.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staffing levels were based on the needs of people at the home and were under constant review. Staff told us they had the time to support people and numbers of staff were increased when people had outings and appointments to ensure there were always sufficient numbers of staff available to support people. Staff had been trained and were confident to recognise safeguarding issues which meant people were protected from harm.

Risks were assessed and well managed to ensure people's freedoms were not overly restricted and risk assessments were based on positive outcomes for people.

Staff received ongoing support from the management team through a programme of regular supervisions and appraisals and they had been trained to ensure they had the knowledge and skills to care for people. Staff were required to undertake an annual programme of training and specialist training was provided when it was needed to ensure staff had the skills required to support the complex health needs of people living at the home.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice

We found decision specific capacity assessments had been carried out for people who lacked mental capacity to consent to aspects of their care delivery. These were compliant with the Mental Capacity Act 2005 (MCA). Staff understood the principles of the MCA and how to ensure people's human rights were respected when making decisions on their behalf.

We found all the staff to be caring in their approach to the people who lived there and treated people with dignity and respect. Staff knew the people they supported very well, and we observed people were very happy in the presence of staff and there was a very positive and friendly atmosphere. Relatives were confident about the love and care provided to their relation and spoke consistently about the caring staff.

The support people received from staff was tailored to their individual needs and staff had worked extremely hard to get to know people and understand what was important to them. People were given opportunities to live fulfilled and meaningful lives regardless of their complex needs.

The service had excelled in supporting people at the end of their lives and worked closely with the local hospice. They had taken an active role in developing a tool to help support people with a learning disability at the end of their life. They had shared their learning with other organisations and presented at various conferences and groups. This truly demonstrated their passion for improving this aspect of care delivery for people with a learning disability.

People were supported to be fully involved in how their support was provided. Information was provided in an easy read format to ensure people with different abilities were provided with information in a format they could understand. Clear, easy read plans were designed to help people manage health conditions that needed monitoring. Health and social care professionals were involved with people's support when needed and their advice was included in the care provided. There was clear evidence of person-centred care and records contained information detailing people's life histories, preferences and choices to enable staff to support them. People were involved in activities based upon their established routines and preferences.

Systems and processes for ensuring the quality of the service included nationally recognised evidence-based standards to ensure they provided a quality service to people living there. The service was well-led by a registered manager who aspired to develop the service continuously and who kept abreast of best practice and developments in this field.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	Good ●
Is the service effective? The service remains good.	Good ●
Is the service caring? The service remains good.	Good ●
Is the service responsive? The service was extremely responsive End of life care planning was outstanding, and staff worked hard to ensure people's preferences were reflected. Support was tailored to people's individual needs, staff knew people very well and understood what was important to them. People were given opportunities to live fulfilled and meaningful lives regardless of their complex needs.	Outstanding ☆
Is the service well-led? The service remains good.	Good ●

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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 17 and 18 December 2018 and was unannounced. One inspector carried out this inspection.

We reviewed information we had received from the provider such as statutory notifications. We also contacted Healthwatch to see if they had received any information about the provider or if they had conducted a recent 'enter and view' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority commissioning and monitoring team and reviewed all the information regarding the service. We also contacted the infection control team and the fire service.

The registered provider had 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.

We spoke with the area manager, the registered manager, one of the clinical leads, one nurse, three support staff. We spoke with two relatives during the inspection and spoke with three more relatives over the telephone following the inspection. We contacted three professionals after the inspection for their view on how people were supported.

We reviewed all the information held about the service including maintenance and management checks. We reviewed three staff files and information in relation to staff development.

Is the service safe?

Our findings

The service remains good.

We asked a relative whether their relation was safe at the home. They told us, "Yes, I do. I wouldn't want [name] anywhere else. The minute we walked in, I could tell." Another relative said, "Yes. I think it's [safe] because it is well staffed. There are plenty of staff around." Another relative told us their relative would not be there if they were not certain their relative was safe.

Systems were in place to identify and reduce the risks to people living in the home. People's care plans included detailed and informative risk assessments. These documents were individualised and provided staff with a clear description of any risks and guidance on the support people needed to manage these.

The provider had a system in place to ensure all incidents were recorded onto a computerised system. All serious incidents were investigated to find out the facts and produce themes of learning and the provider's quality and safety team supported the process. Learning was shared amongst the provider's other services in the area. We saw evidence lessons had been learnt around the management of a person's behaviour which had become challenging. Instead of accepting the behaviour as the "norm" support was sought for insight into ways the behaviours could be changed.

Keeping people safe without overly restricting their freedom to move around the bungalows had been a priority. Innovations such as wind down bins in toilet areas meant these areas no longer needed to be locked from people who might cause harm to themselves.

We looked at the staff rotas to check staffing levels were appropriate. These confirmed the staffing levels were appropriate to meet the needs of the people living at the home. The registered manager told us they had an additional "floating" member of staff who could be deployed across the bungalows depending on the need on each day. They also liaised closely with commissioners to request additional funded hours of care for people with a higher level of care needs. This ensured the service always had a safe staffing level for people at the home. Staff confirmed with us there were enough staff and staffing levels were increased if people were out on appointments. They said of the floating member of staff, "It is helpful, very." Staff told us there was not a high turnover of staff and said, "Most people have been here a long time. We don't use agency which is good as people need continuity. They do behave differently when new people come."

The provider followed safe recruitment practices which included obtaining references and ensuring Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. Some information was held centrally by the provider. At interview prospective candidates completed a written test, a financial transaction test and an IT test to ensure the service employed people with the skills required for their role.

Medicines were stored and administered safely, and medicine competency checks had been undertaken by

the registered manager and clinical lead staff to ensure staff were competent in their administration practices and followed national recognised best practice. One of the clinical leads had the responsibility for ensuring the safe management of medicines and they completed regular audits to ensure processes were safe.

One member of staff was a designated infection control lead with responsibility for auditing this area of practice. The home did not employ cleaning staff and care staff undertook domestic tasks amongst their caring duties. The home was found to be clean and with an adequate supply of personal protective equipment for staff.

Is the service effective?

Our findings

The service remains good.

All the relatives we spoke with told us how well trained they thought the staff were. One said, "They have the skills and the temperament." Others spoke about the training on how to manage dementia and how families were involved in this, so they could learn more about how this affected their loved ones.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 had the appropriate legal authority and were being met. We found the service was meeting this requirement and every person at the home had a DoLS authorisations in place.

Staff understood the principles of the Act and how to support people to make decisions in their everyday lives. The level of knowledge did vary with clinical staff having a greater understanding of the processes involved. People's care files contained a range of decision specific capacity assessments and best interest decisions.

Staff received ongoing support from the management team through a programme of induction, regular supervision and appraisals. The registered manager told us the provider had recently changed the system of appraising staff performance to quarterly competency checks. The provider utilised the Care Certificate for all staff new to care, which is the agreed set of standards that sets out the knowledge, skills and behaviours for care staff. All new staff shadowed more experienced staff during a two-week period and this included covering a night shift in each bungalow to gain a holistic view of people's care needs. Staff were expected to gain a nationally recognised qualification in care once they had successfully passed a probationary period. The provider had their own training department which organised training for staff in mandatory subjects and we were provided with evidence to show all staff training was up to date. Due to the complex health needs of people supported, additional specialist training was provided to staff. This included how to care for people with health needs such as a tracheostomy, suction, syringe drivers and specialist medication. This demonstrated the provider supported staff to gain the skills needed to support people safely.

Referrals were made to other health care professionals such as dieticians, psychiatrists, psychologists, GPs, and learning disability professionals. This showed people received additional health care support when appropriate.

The four bungalows were designed for people with mobility impairments with wide corridors and level access showering facilities and an adapted bath. Bedrooms had overhead tracking hoist to support safe moving and handling. Work was planned to improve accessibility further by widening some bedroom doorways to accommodate the larger mobility equipment people had been assessed to use. There was a programme of refurbishment in place. We noted some repainting was required and some areas of the drive into the properties needed repair. We were told there were plans in place in the future to address these issues, although there was no definite date arranged.

Is the service caring?

Our findings

The service remains good.

Relatives told us how caring and compassionate staff were. One said, "We are absolutely delighted with the care and love at the home." Another said, "The way they talk to [relative], the way they treat [relative] is though they don't have a disability." Another relative told us, "They are personal, hugging and kissing [relative]. The love is there." We observed this strong, visible person-centred culture at the home. Both staff and management were fully committed to ensuring people received the best possible care in a supportive and compassionate environment.

Staff recognised people with complex needs could be supported to remain as independent as possible. They told us about one person who they supported to require an environment with lower support needs. They had supported the person to manage their own health condition, with positive outcomes for the person.

People's human right to be treated with respect was clearly understood by staff, who protected their privacy and cared for them respectfully. Staff told us they protected people's privacy and dignity saying, "We pull curtains and close doors when offering personal care. We cover them when taking them out of the bathroom. We put a towel in front when hoisting them onto the commode."

We asked staff how they ensured information was held confidentially. Staff told us, "We don't discuss confidential information out of the work place with "jo public"; "All records are locked away" and "We go out of the room to discuss confidential information."

Staff understood and interpreted people's non-verbal communication, which enabled people to engage more with those around them. People showed they valued their relationships with the staff team. We observed this through people's facial expressions and body language as they responded positively to staff who were supporting them. Extensive communication plans and tools were in place that were bespoke and tailored to each person. These included a variety of tools such as pictorial reference, Makaton, and the use of IT. Some people had applications programmed onto their individual electronic devices to help make choices and express their views and communicate. This helped the person make choices regarding, for example, activities, outings, food and other areas of importance in a person's life. One relative said, "It lists all the names of all the carers," which enabled them to choose who they wanted to support them.

Staff were not rushed in their interactions with people. They spent time with people individually, observing them discreetly or supporting them to engage if they were not involved in some activity. We observed people were involved and engaged in their care and support.

Staff advocated on behalf of people they supported and professionals we spoke with confirmed this was a strength of the organisation, always ensuring the best outcomes for people supported.

Equality and diversity remained high on the provider's agenda with a designated equality lead. Staff and people using the service were protected against discrimination and we saw evidence of this in terms of the protected characteristics. For example, staff worked hard to ensure everyone was treated fairly and without discrimination or at a disadvantage when considering activities for people. Staff and people at the service had been offered support to take part in national events such as Gay Pride.

Is the service responsive?

Our findings

This domain has improved to outstanding.

The support people received from staff was tailored to their individual needs and staff had worked extremely hard to get to know people and understand what was important to them. People were given opportunities to live fulfilled and meaningful lives regardless of their complex needs. There were lots of different activities offered to people throughout the day including going out into the community and the service had the use of an adapted vehicle.

Staff went to great lengths before a person moved in to make sure they could provide them with all their health and social care needs to ensure the best outcome for the person. This was not hurried as they recognised each person had very individual support needs and they wanted to get this right. Each person had a key worker who took a key role in coordinating a person's care and promoted continuity of support between the staff team. We reviewed people's support files to check these correlated with the care we observed. We found they were person-centred and detailed.

Relatives told us how they were kept involved in their relations care. One said, "They tell us everything that is happening. Consult with us on everything. It's like an extension of the family. Not them taking over." One relative we spoke with said of the staff, "The key worker is brilliant." They explained to us how they had gone above and beyond to ensure they could spend time together over the festive period by driving their relative out of area to their home, "so I could have lunch with [name] and do some shopping with them. It was a really nice thing to do. They suggested it."

The service had excelled in supporting people at the end of their lives and worked closely with the local hospice. Staff said, "We involve families at an early stage. No decisions are made without involving families." For one a person who had died, we saw staff had written the order of service and read the eulogy at the service. They really ensured people were treated with dignity and respect at this time. Staff told us the support to families did not end when the person had died but staff continued to support relatives to come to terms with their loss. This included passing on the story books about the person's life to families, who in turn agreed for staff to use these to assist their development in this area of practice.

Staff supported people with very complex health needs, life-limiting illnesses and people with a learning disability who had developed other health problems such as dementia or cancer. The team had worked hard to improve people's end of life experiences preventing unnecessary hospital admissions and ensuring people were able to remain at the home for the rest of their lives. One relative told us the home's end of life care was one of the important factors in choosing the home, and they openly discussed this aspect of care before choosing this as the home for their relation. Another relative said, "They talked to me. I've had a booklet to fill in about [relatives] wishes. That was one of the things about the placement." Staff talked about one person who was not discharged before they reached the end of their life and said, "We took their home to them in hospital. Their music, their things, familiar staff. Staff feel confident dealing with end of life care." They told us they had planned a meeting with the hospital to learn from this experience to ensure

lessons are learnt across all organisations.

We contacted professionals for their view on this aspect of the service and we received very positive feedback. One colleague said, "I have found them to be inclusive and multi-professional (including the learning disability matron, families and GP on most occasions), definitely client centred, and they have acted as real advocates for their clients. Whenever I have reviewed clients there I have found them to appear well cared for, well supported and with detailed care plans already in place.

Staff at the home had obtained funding from the Clinical Commissioning Group to set up an end of life tool called 'Doing it my Way'. This has been recognised at a number of awards including being a regional finalist in 'The Great British Care Awards' and were highly commended at the Royal College of Nursing awards. NHS England have referred to the 'POLE' (Probabilities of Life Expectancy) document which is part of 'Doing it my Way'. The tool is freely available for anyone to use <http://www.st-annes.org.uk/wp-content/uploads/2012/12/End-of-Life-Care-document-October-2016-Final.pdf> and forms part of mandatory training for all the registered provider's staff. The clinical lead has presented the tool at various conferences and groups and directed other organisation to the website to share their learning. Staff at the service have shared their work with the British Institute of Learning Disabilities (BILD) and were invited to join a steering group looking at 'Supporting people with learning disabilities as they grow older or have/are developing Dementia. This group aims to raise the profile of the issues and developing and sharing resources to try to enable people with learning disabilities to live as well as they can for as long as they can which reflects the principles of "Doing it my way". BILD asked to incorporate the end of life guide into their apprenticeship programme materials'

This demonstrated the service's passion for improving this aspect of care delivery to the wider audience. The lead staff member said, "One of our main beliefs is that we share 'Doing it my way' with other service providers, to influence and enhance the care they provide to their clients throughout the person's life and at the end of their life."

A person's spiritual and religious needs once identified, were incorporated into their Advance Care Plan. Other factors which made a person's life complete was incorporated into their Advance Care Plan to make this personal such as something they particularly enjoyed, their favourite sport, music, or pastime.

The clinical lead nurses had undergone additional training to support staff to become "dementia friends" and gain an insight into supporting a person with dementia. As part of the training they accessed the "dementia bus" to give staff an insight into living with dementia. This Virtual Dementia Tour supports staff understanding of dementia through simulation by walking in the shoes of a person living with dementia. Relatives told us how staff had the knowledge and skills to be able to provide responsive care as their dementia developed and their relation developed new needs. They said, "[Relative] wouldn't want for anything. They are becoming less and less able. They have everything set up. They are good at thinking ahead."

We spoke with the registered manager to find out how they were using technology to support people at the service and to have a positive impact on their lives. One person had an electronic system to enable them to make their wishes known. Technology solutions included epilepsy alarms, pagers, movement sensors and they also had sensory equipment in the bathroom. We were told relatives donated the money for this. The system changed the colour of the water and reflections projected around the room from a calm ambient theme to a shark theme on another disc, which went down well with some people at the home.

The provider was meeting the Accessible Information Standard which requires them to ask, record, flag and

share information about people's communication needs. Staff had developed an easy read guide to support the person to record their end of life wishes in an advanced care plan. This had been designed to prompt thoughts such as: 'What would I like to do with my belongings when I die?' and 'Would I prefer to be buried or cremated? Developed with the individual in mind, it's an easy-to-read guide that outlines all a person's wishes regarding what happens when they die. Staff at the service had also devised picture books for people to take to appointments which would inform people about the person, their history, likes and dislikes and how to interpret their behaviours. People had been extremely positive about the books and we saw an email from one relative highly praising the benefits of this during a recent review of their relative's needs. Staff were aware of people's individual communication methods and could explain these to us in detail. All information at the service was provided to people in easy read formats to ensure accessibility. We saw easy read complaints procedures and easy read information guide for service users and their relatives, which was detailed and informative.

People and their relatives were actively encouraged to express their views about the service and were given clear information about how to make a complaint. There was a complaints policy with an easy read version which was available in each bungalow. Meetings with key workers were also used to give people the opportunity to express themselves in other ways if they were unable to complain verbally. The registered manager told us there had been no complaints at the service. We asked staff if any concerns had been raised with them and what they would do. One member of staff said, "None. If they did, we would listen to them and report it to the nurse in charge. Inform them of what has been said." We were confident all complaints would be listened to and acted upon and this was confirmed by relatives who told us they had no complaints.

Is the service well-led?

Our findings

The service remains good.

The service was well-led by a registered manager who had oversight of how the home was run. Without exception staff and relatives said they felt well-supported. They were very positive about the registered manager. Staff all told us the registered manager was approachable, accessible and visible within the service. One relative said of the registered manager, "She is excellent. We are delighted with [relative's] care."

Staff spoke consistently about the service being a good place to work. One said, "This is the best place I've worked, and I've worked in care a long time." Another said, "It is a good place to work. We get a lot of compliments from family. We all work as a team. We all help each other."

The registered manager and the two clinical leads worked across all bungalows to ensure they knew how each bungalow was working, each having a responsibility for leading in an area of care. This involved supporting staff to develop their skills in this area. This had been recognised by relatives who commented on the skills of individual staff.

Systems were in place which continuously assessed and monitored the quality of the service. The provider had a Quality and Safety Team and we were shown information how these positively supported managers to safeguarding people from harm. Learning materials from incidents were of high quality and had been developed to reflect on current knowledge but also provide them with information to improve their practice. The provider tested knowledge of staff in areas of risk such as choking and falls, to ensure any training needs were identified. Staff at Oxfield Court had scored highly demonstrating their knowledge in this area, and this was reflective of the people they supported who have high risk of harm in this area. Feedback was provided to staff to ensure they received praise in areas they excelled in.

The regional manager undertook regular quality assurance checks with overview from the provider. They told us they visited the service once a month and framed their audits around the CQC key lines of enquiry and used the good and outstanding care guide as a baseline. The regional manager had both a visible presence at the service and regular contact with the registered manager and told us they had daily telephone contact. From our discussions with the regional manager it was clear they knew the people supported at the home and the staff which showed they had an overview of how the service was running and where improvements were to be made to ensure they were continuously improving.

Meetings were also held at the service for both staff and people living at the service. The provider held a dignity meeting which people at each service could attend to represent the home. This ensured people's voice was used to drive up improvements and to ensure support was personalised.

The registered manager was clearly able to demonstrate how the organisation was continually striving to improve their service by partnership working at a local level with commissioners, and health professionals and at a national level through good practice events and forums. Representatives from the home provided

training to some local and national organisations to help promote and educate about end of life care for those people who live with a learning disability.