Linkage Community Trust Limited(The)

Oak Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 8 June 2016 and was announced. 24 hours notice of the inspection was given because people who live at the service are often out of the service taking part in recreational activities. We needed to be sure that they would be in so as we could speak with them.

Oak Lodge is registered to provide accommodation and personal care for up nine people. There were nine people with a learning disability living at the service on the day of our inspection.

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

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. The management and staff understood their responsibility and made appropriate referrals for assessment. One person at the time of our inspection had their freedom lawfully restricted.

People felt safe and were cared for by kind, caring and compassionate staff. People were kept safe because staff undertook appropriate risk assessments for all aspects of their care inside and outside of the service. Care plans were developed to support people's individual needs. Staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People received their prescribed medicine safely from staff that were competent to do so. The registered provider ensured that there were always sufficient numbers of staff on duty to keep people safe.

People were given a nutritious and balanced diet and hot and cold drinks and snacks were available between meals. People had their healthcare needs identified and were able to access healthcare professionals such as their GP. Staff knew how to access specialist professional help when needed.

People were at the centre of the caring process and staff acknowledged them as unique individuals. People told us that staff were kind and caring and we saw examples of good care practice. People were always treated with dignity and respect. People were cared for by staff that were supported to undertake training to improve their knowledge and skills to perform their roles and responsibilities.

People lived busy and active lives and were encouraged to take part in hobbies and interests of their choice. Some people were supported in education, others in work placements, sporting activities and all enjoyed being part of a strong social network. Relatives commented that their loved ones were well looked after and their wellbeing had improved since moving into the service.

People were supported to make decisions about their care and treatment and maintain their independence. People had access to information about how to make a complaint in an easy read format.

The registered provider had robust systems in place to monitor the quality of the service and make improvements. Staff had access to professional development, supervision and feedback on their performance. People, their relatives and staff found the registered manager approachable.

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 is safe.

People had their risk of harm assessed.

Staff were aware of safeguarding issues and knew how to raise concerns.

People were enabled to take their own medicines safely.

Is the service effective?

Good

The service is effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities.

People were involved in planning a nutritious diet and healthy lifestyle.

Is the service caring?

Good

The service is caring.

Staff formed a strong bond with people and people felt that they mattered.

People were involved in making decisions and planning their care and their preferences were acted upon.

People were treated with dignity and staff respected their choices, needs and preferences.

Is the service responsive?

Good

The service is responsive.

People were at the heart of the service. They were enabled to

take part in a range of innovative activities of their choosing that met their social needs and enhanced their wellbeing.

People were supported to undertake meaningful occupation in the service and local community that strengthened their independence and self-esteem.

A complaints policy and procedure was in place in an easy to read and pictorial format that was accessible to people.

Is the service well-led?

Good

The service is well-led.

People were enabled to be involved in developing the service.

The provider had completed regular quality checks to help ensure that people received safe and appropriate care.

Staff had access to policies and procedures relevant to their role.

Oak Lodge

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 took place on 8 June 2016 and was announced. The inspection team was made up of one inspector.

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 what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about. In addition, we contacted health and social care professionals for their feedback on the service.

During our inspection we spoke with the registered manager, two members of care staff and four people who lived at the service. We also observed staff interacting with people in communal areas, providing care and support. Following our inspection we spoke with the relatives of three people who lived at the service.

We looked at a range of records related to the running of and the quality of the service. These included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for five people and medicine administration records for nine people.

Good

Is the service safe?

Our findings

People told us that they felt safe living in the service. We found that safety measures were put in place to support people to access the local community independently and safely. For example, people were given advice on "stranger danger" to raise awareness of the risk of harm and abuse from strangers and had a mobile phone to contact staff if they needed assistance. We observed one person share with the registered manager that they wanted to walk into the local town centre on their own. Discussion took place about where they were going and when they would return. The registered manger then set the alarm on the person's mobile phone for one hour so as they returned in time for their evening meal.

We found that people who lived at the service had a key to their bedroom door and most people had a key to the front door and had been assessed as able to enter and exit the home safely. One person told us, "I have my key and I always check I have it before I go out." People who did not have a front door key were supported by staff to exit and enter the service safely.

We spoke with the relatives of three people who lived at the service who told us that their loved ones were safe. One relative said, "Staff know what they are doing. [person's name] is in safe hands." Another relative told us, "I wouldn't leave them there if I didn't think they were safe."
The provider had developed and trained their staff to understand and use policies and procedures to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe, how to recognise signs of abuse and followed local safeguarding protocols.

There were systems in place to support staff when the registered manager was not on duty. Staff had access to an emergency folder that contained contingency plans to be actioned in an emergency situation such as a fire or electrical failure. Staff had access to an on-call registered manager out of hours for support and guidance.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care both in and out of the service, such as road safety and safely using the kitchen. One staff member said, "[name of person] is independent. His road safety risk assessment is low, so they can go shopping on their own." Care plans were in place to enable staff to reduce the risk and maintain a person's safety.

People who lived at the service and their relatives told us that there were enough staff on duty to look after them and keep them safe. The registered manager calculated staffing levels to provide people with the level of support they needed on a daily basis, depending on the activities and events people were taking part in. For example, one person received hydrotherapy at a fitness and leisure centre and their support worker accompanied them for the full day. Another person had work experience at a garden centre and their support worker took them there and worked alongside them.

We looked at two staff files and saw that there were robust recruitment processes in place that ensured all

necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post. The staff we spoke with were experienced and had worked at the service for several years. They told us that new staff were supported through a period of induction, had a workbook and worked shadow shifts with them until they were confident to work on their own.

There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned. Most people were self-administering (SAM) their medicines and individual risk assessments had been undertaken for safe storage, administration and disposal. People had their medicines stored in a locked safe in their bedroom and stock levels were recorded each time a person took their medicines. People had given their signed consent to self-administer and had information on any identified risks or hazards. Furthermore, staff had access to a medicines policy and SAM procedures. We found that when people visited their family home that they had a separate home leave MAR chart that a family member signed to confirm that their relative had taken their prescribed medicines. One person's parent told us that this was a great achievement for their relative to take their own medicine and said, "We never thought that he would be able to take his own medication. But when he is home for leave or on holiday he takes one tablet every night at 10 o'clock."

People received their medicine from staff who had received training in medicines management and had been assessed as competent to administer them. We looked at medicine administration records (MAR) for nine people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person was on social leave. There was guidance to support staff to give people non-prescribed medicine such as cough mixture or sun cream. We saw that one person had a special plan for emergency medicine to be given when they had a seizure to ensure that it was administered safely and in a timely manner.

Good

Is the service effective?

Our findings

People and their relatives told us that staff had the knowledge and skills to carry out their roles and responsibilities. We observed staff carry out their duties in a professional and confident manner.

All staff undertook mandatory training in key areas such as safeguarding, deprivation of liberty safeguards and health and safety. In addition, staff were provided with training in areas relevant to the care needs of people who lived in the service such the care of a person living with epilepsy and autistic spectrum disorder and supporting a person in everyday activities with sensory loss.

Staff received a supervision session every two months and an annual appraisal. We looked at supervision records for two members of staff and saw that their feedback was positive and their professional development needs had been identified and required action recorded. For example, a new care plan format had recently been introduced and one member of staff had identified this as a training need that required support to be achieved. The registered manager also received regular supervision and an annual appraisal from their line manager.

We observed that people's consent to care and treatment was sought by staff. For example, we saw that people had given their signed consent to have their photograph taken for identification purposes and to receive care. A member of care staff said, "We always get consent, most people here are able to give their consent." Where a person lacked capacity to give their consent staff followed the principles of the Mental Capacity Act 2005 (MCA).

The 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 found that the provider had followed the requirements in the DoLS and one application had been submitted to the local authority and was approved. This person had a close relative appointed as their Relevant Person's Representative (RPR). An RPR is person appointed to represent the person in all matters relating to their DoLS authorisation and to speak on their behalf. Furthermore, we saw that the provider had complied with the conditions of the DoLS. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

The importance of eating a nutritious and balanced diet played a significant role in people's health education to have a healthy lifestyle. Large print and pictorial guidance on healthy eating was on display in

the kitchen. Staff and people had access to guidance on common food allergens such as nuts and gluten and how to identify them on food packaging. People who lived at the service met with staff every Sunday to discuss and plan the following week's meal preferences and shopping list.

In addition, people could help themselves to hot and cold drinks throughout the day and bowls of fruit and snacks were available in the communal areas and we saw people helped themselves to them. We saw that there were information leaflets available on eating and drinking well. We saw that a record of all food and drink intake was kept for each person who lived at the service to ensure they maintained a healthy diet.

At lunchtime people who lived at the service were supported to prepare a light meal of their choice such as a toasted sandwiched and macaroni on toast. Support staff ensured that people who were out of the service taking part in work experience or training classes were provided with a midday meal.

People who lived at the service and their relatives told us that there was always plenty to eat and drink and that the food was good. One person laughed and said, "That's because we cook all our meals." One person's relative told us, "[name of person] is well fed. Extremely good food." Another person's relatives told us, "He eats well, he helps prepare meals. He is learning to cook."

People who lived at the service were supported to maintain good health and wellbeing. We found that they had guidance on the benefits of regular exercise to help maintain good health and were supported to do so. For example, we saw one person attended dance and drama classes, another person attended regular hydrotherapy sessions and two people attended the local gym. We saw that people had shared with staff important things that helped to maintain their emotional and psychological wellbeing. For example, one person had recorded, that they did not like loud noises as this upset them. Their relative confirmed this and said, "Sometimes he just likes to sit in his room, he likes the quiet." There was information available for support workers on action to be taken in a heatwave to keep people hydrated and protect their skin from the risks of sunburn. We noted that people were provided with a copy of this in their personal file.

We spoke with relatives of people who lived at the service and they told us that a member of staff always supported people to visit their GP and dentist and kept them up to date about their health needs. One person's relative said, "[person's name] is getting a tooth extracted soon, a wisdom tooth, and the staff have been brilliant about it." Another person's relative said, "If they are poorly the staff will ring and let me know."

People received a weekly health check to monitor their general health and wellbeing that included a record of their weight. They also had regular visits with their support worker to their GP, dentist and chiropodist. When a person had an appointment at the hospital out-patient department their support worker helped them prepare and supported them on their visit. People had a booklet called 'All About Me' that they took with them when they visited the hospital. This informed hospital staff about them as a person, their likes and dislikes and how they liked to be cared for and communicated with. In addition, they had an emergency 'grab sheet' that went with them if they needed urgent medical care with information about their general health, medicines and family contacts. Staff told us about the procedures they would go through to get medical help if a person became unwell.

We noted that people had routine health checks specific to their age and gender. We found that where a person required support with sensitive and intimate health issues, staff enabled them to access the appropriate healthcare professional and supported them through the process.

Good

Is the service caring?

Our findings

We saw that there was a good relationship between people who lived at the service and staff and observed lots of friendly banter and positive interaction. Staff supported people to make decisions about all aspects of their care, the smooth running of the service and how they spent their leisure time. We saw that staff had the skills to help people new to the service settle in and feel involved. One person told us, "When I first moved in, I was very shy. I didn't know anyone. But I got used to it and now know everyone." A member of staff told us that staff built a good relationship with people and said, "It's their home, they matter. We have to listen to them. Care the way they should be cared for. We involve them, praise them, they have a sense of humour, we bond with them and make them feel understood and thought about."

We spoke with relatives who told us that their loved ones were well cared for. One person's relative said, "We are extremely happy with it and he is extremely happy. He has told us that he never wants to leave Oak Lodge. The staff are very caring." Another person's relative said, "The care is very good. The staff are immensely caring. They know how to deal with her strengths and treat her with humour and music. We looked at homes in a one hundred mile radius and this was the best we saw. She has the scope to be individual. She has become more independent."

The service did not employ ancillary staff, such as housekeepers and cooks. People were allocated two house days each week and were supported to undertake a range of housekeeping activities, such as their personal laundry, preparing and cooking meals and cleaning duties. We observed that staff took a person's abilities into consideration and gave them the level of support they needed to undertake a task, feel involved and proud of their achievement. For example we saw that one person who was registered as partially sighted was supported to do their laundry and hang their washing on the clothes line rather than staff do this for them. Another person with limited mobility sat at the kitchen table and prepared the vegetables for the evening meal. We found that people were praised for their efforts.

We saw where a person had communication difficulties that processes were in place to enable them to communicate to the best of their ability. For example, one person had a hand held computer that they used to communicate and a range of picture cards that they used to tell a story. Another person who was registered partially sighted had their care files and other documents printed in large print on yellow paper as this made it easier for them to read. In addition, people had a personal communication passport with information on how they wanted staff to speak with them. We read in one person's passport that, "staff not to use long words, only offer two choices and to give the person time to respond."

We saw that one person who responded well to visual prompts had shared their personal goals with their key worker. To enable them to remain focussed on their goals they had a large person centred care plan on their bedroom wall that identified their goals and how to achieve them. They told us, "I am going to cook for myself today." We saw that one of their goals was to cook meals with support.

People were provided with information on how to access an advocate to support them through complex decision making, such as moving into the service. Advocacy services are independent of the service and

local authority and can support people to make and communicate their wishes. We saw that one person had been offered an advocate but had declined and asked for their parent to represent them instead.

People were supported to maintain contact with family and friends and could receive visitors at any time. They told us that friends from other services often visited them for a chat or a social event. Furthermore, people had access to computers and mobile phones and were enabled to contact their relatives and friends through social media.

We saw that people's right to their privacy and personal space was respected. For example, we noted that staff always knocked on a person's bedroom door before entering. We saw that some people had the key to their bedroom door. This provided a sense of security and ownership and ensured that other people could not enter a person's bedroom without their permission.

Good

Is the service responsive?

Our findings

People had care plans tailored to meet their individual needs and they were actively involved in writing and reviewing their care plans. When we asked people if they were familiar with their care plans they all said yes. One person said, "Oh yes. We have care plans, daily notes, a key worker and a complaints book. We also choose our own key worker." Another person said, "I sign everything, to say that it is all done."

We saw that care plans were written in an easy read and pictorial format. The use of pictures enabled people to relate better to their identified care needs. People who lived at the service had a monthly care plan review with their key worker and new goals were set. Relatives told us that they and their loved one were involved in reviews of their care with their key worker. One relative said, "We always attend the reviews with him." Another relative said, "We go to every review. We are really involved, we like to be involved."

People were supported to maintain relationships with others who mattered to them. One person told us that they had a girlfriend who lived in a neighbouring service and they were special to them. One person's relative told us that their loved one would soon be going on holiday and were looking forward to it because their friend who lived in another service would be going also.

We found that people had a good quality of life and told us that they always looked forward to the next big event. One person spoke excitedly about the holiday that they were going on as they would be travelling by coach.

Four people invited us to look at their bedroom. We found that they had chosen their own decoration and soft furnishings. People were supported to personalise their bedroom with items from home such as pieces of furniture, photographs and keepsakes. We found that people's sporting and academic achievements were recognised. For example, we saw people had displayed sporting trophies, newspaper stories and certificates of achievement. One person who played football for the local amateur football team proudly showed us their recently awarded "players player of the year" trophy.

On the day of our inspection, most people were out all day taking part in hobbies and interests of their choice. For example, one person was attending a speech and drama class and another was undertaking a life skills programme. In addition, others were supported to take part in meaningful employment and develop new skills. We noted that one person was on work experience in a garden centre and another was assistant gardener in a care home for older people. One person spoke with us about their cleaning job in another service owned by the provider and said, "It makes me feel good."

In addition to individual hobbies and pastimes, people who lived in the service took part in group events. For example, everyone enjoyed a trip to a holiday park the previous weekend. People told us that they had a great day out and one person said, "We went swimming, and watched shows and went on the rides." Another person told us how they celebrated a friend's birthday. They said, "We went to the zoo. We all went. Then we went to [name of a person] house and had tea."
We saw that staff exchanged information about a person's care needs and wellbeing at shift handover to

maintain continuity of care. Comments shared included, to arrange a trip to see the poppies of remembrance at Lincoln Castle and to assist two people who were going on holiday to pack their suitcases.

One person who lived at the service was the elected representative for the "client parliament group." It was there responsibility to speak on behalf of their peers with the directors and the chief executive of the provider organisation to implement changes to the services. The person told us, "I don't like the seating arrangements in the new mini bus. Some face backwards. We have asked for this to be changed." The minutes of the parliament meetings are recorded and we were told this was to ensure that issues were addressed as requested.

People were regularly asked for feedback on the service they received and we saw the results of a recent survey that they had responded to. The questions were laid out in an easy read pictorial format with smiley faces to answer yes and sad faces to answer no. People had all agreed that staff were friendly and kind. People and their relatives were provided information on how to make a complaint in word and picture format. Staff told us that if a person complained to them they would escalate the concern to the registered manager or the on-call manager if out of hours. However, they told us that they had no reason to complain and could talk with staff or the registered manager at any time. One person's relative said, "If anything wasn't right I would bring it up at the review, but we've never had any concerns."

Good

Is the service well-led?

Our findings

People who lived at the service were invited to regular monthly house meetings and could input to the agenda. We read the minutes of the last meeting held on 19 May 2016. The main topic of discussion was the forthcoming European Referendum. People had received their polling cards and wanted support to make their decision. Therefore, people were provided with information cards to support a yes or no vote. We saw that people had signed their agreement with the recorded minutes. At lunchtime we observed two people discuss with the registered manager their thoughts on the referendum.

Staff told us that they found the registered manager approachable and supportive. One staff member said, "[Registered manager] is very approachable. Really understands and listens to staff. Always get back to us. When she wants something done she asks nicely. She has a good rapport with staff." Another staff member said, "[Registered manager] does listen to us and positive change happens." The staff member also said, "We have staff meetings about once a month. We all have a voice and feel listened to by [registered manager]. We discuss trips and events for the residents."

We found that the registered manager was visible, knew their staff and the people in their care and all were at ease with each other. The people and their relatives that we spoke with knew who the registered manager was by name and in person. People who lived at the service were at ease with the registered manager and we saw that they frequently popped into their office for a chat or ask for advice.

Relatives had recently been asked to complete a survey with their feedback on the quality of the service. We saw that the overall results for the organisation were positive. However, on the day of our inspection the registered manager had not yet received the individual results for the service. We asked relatives about the survey and one relative said, "We do get the survey form, but I don't need to fill it in as I address things as I see them."

Staff told us that they were a good team and that they were proud to work in the service. One staff member said, "It's a good place, a happy place. We have a good team and staff pull together." Relative praised the registered manager and their staff and one relative said, "It's faultless. Mood is brilliant, great atmosphere. There are no tensions. I can't fault it. We know [registered manager]. Very nice and we can phone at any time."

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding, dignity and mental capacity. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager.

The registered manager told us what events were notifiable to CQC as part of the provider's registration requirements, for example when there is an untoward accident or incident. We found that a recent safeguarding concern had been investigated by the registered manager and appropriate actions had been taken. The registered manager told us of an incident where one person who lived at the service had raised

concerns about another person who would not get out of bed and leave their bedroom when the fire alarm sounded and they had been concerned for their safety and welfare and that of others. This led to individual reviews of the evacuation process and personal emergency evacuation plans being introduced. People who lived in the service have since been trained in safe evacuation procedures.

There was a programme of regular audits that covered key areas such as health and safety, medicines and infection control. In addition, the provider had a quality assurance process that involved all registered managers undertaking audit and monitoring of another registered manager's service every two or three months. Following their audit an action plan with realistic timescales was developed and a follow up visit was undertaken to monitor progress. In addition, registered managers undertook a self-assessment using CQC key lines of enquiry and rating system, to monitor their progress against their regulation requirements.

Staff were aware of the whistleblowing process and told us how they would share their concerns. We also found that staff were supported to learn lessons from and mistakes or near misses and this was achieved through information sharing at team meetings, shift handovers and by email. The registered manager told us, "I always send staff important messages by email. Staff are expected to read their emails at least once a week. That way I can to ensure that they are aware."