Care UK Community Partnerships Ltd

Oak House

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

Oak House provides accommodation for persons who require nursing or personal care for up to 120 older people who are living with dementia, learning disabilities, mental health conditions and physical disabilities. On the day of our visit there were 110 people using the service.

The registered manager has been in post since September 2015 but was not available during our visit. 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 and associated Regulations about how the service is run.

The location was last inspected on 5 September 2014, where we found they were meeting the standards on the outcomes inspected. This is the first inspection of the location under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt staff were caring and looked after them well. Comments included, "Yes they go out of their way for you" and "They handle you in a kind way and they know you." We saw a number of good examples of how staff showed concern for people's wellbeing in a caring and meaningful way. People were supported when making decisions about end of life care.

People felt staff were skilled to provide care, treatment and support to them. Staff received appropriated induction; training and supervision. They spoke highly about the support they received from management. Care records showed staff sought consent from people before care was delivered. People's nutritional needs were met and the service ensured they were supported to maintain good health.

People said they felt safe when care was being delivered. Staff knew how to protect people from abuse and avoidable harm. People were protected from unsafe care because there were sufficient staffing levels to meet their individual needs.

People said the care they received was specific to their needs. Care plans showed how people would like to received care, support and treatment. Daily handovers for staff provided by team leaders ensured the care being given was responsive to people's needs. .

People felt the service was well-led. For example, one person commented, "The senior staff and management I think are of high quality and everything runs smoothly." Management conducted staff meetings to ensure people's welfare and safety was protected, staff understood their responsibilities and best practice was shared. The service had established effective quality assurance systems to assess monitor and improve the quality and safety of the service it provided.

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.

People said they felt safe when care was being delivered.

Staff knew how to protect people from abuse and avoidable harm.

People were protected from unsafe care because there were sufficient staffing levels to meet their individual needs.

Is the service effective?

Good

The service was effective.

People felt staff were skilled to provide care, treatment and support to them.

Staff received appropriated induction; training and supervision.

People's nutritional needs were met and the service ensured they were supported to maintain good health.

Is the service caring?

Good

The service was caring.

People felt staff were caring and looked after them well.

We saw a number of good examples of how staff showed concern for people's wellbeing in a caring and meaningful way.

People were supported when making decisions about end of life care.

Is the service responsive?

Good

The service was responsive.

People received care that was specific to their needs.

Care plans showed how people would like to received care,

support and treatment.

Daily handovers for staff provided by team leaders ensured the care being given was responsive to people's needs.

Is the service well-led?

Good

The service was well-led.

People felt the service was well-led.

Management conducted staff meetings to ensure people's welfare and safety was protected, staff understood their responsibilities and best practice was shared.

The service had established effective quality assurance systems to assess monitor and improve the quality and safety of the service it provided.

Oak House

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on 23 & 24 June 2016. The inspection team consisted of three inspectors, two experts by experience and three specialist advisors whose speciality covered dementia, nutrition and pressure ulcer care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

We received feedback about the service from a NHS practitioner for Older People with Mental Health and after our visit we received feedback from a practitioner of the local Safeguarding Adults Team.

We looked at the provider information return (PIR) which the provider sent to us. 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 also looked at all the information we have collected about the service.

As part of our inspection we spoke with eight people who used the service; four relatives; 14 staff members, the deputy manager, unit managers and the regional director. We reviewed 20 care records, 19 medicine administration records (MAR), staff records and records relating to the management of the service.

Good

Is the service safe?

Our findings

People and their relatives said they felt safe when care was being delivered. Comments from people included, "Yes I feel safe during my care", "They (staff) try to follow the caring measures as much as possible. So because of that I feel very safe", "Yeah they (staff) look after me and they are nice", "Yes, I'm insured anyway and I don't know why I feel safe but I do", "Yes, they look after me and they are nice to me and treat me nicely" and "Yes, people are around to help." Comments from relatives included, "Yes, I feel my wife is safe in here" and "Yes because there is a routine to clean him and there are always two people with him. There is no question about his safety."

People were protected from abuse because staff knew how to protect people from abuse and avoidable harm. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. For example, staff told us they had completed training on safeguarding and knew the procedure and guidance to follow in the event of any concerns they may have.

A review of the service's safeguarding policy showed staff were told what safeguarding meant; how to respond and report it and it contained all relevant agencies staff should contact. We received feedback from a practitioner from the local safeguarding adults team who stated the registered manager informed them of any safeguarding concerns and carried out investigations appropriately.

This was further supported by a NHS practitioner for Older People with Mental Health who commented, "Patient's safety and dignity are paramount and I observed that staff are confident in raising any safeguarding issues. If they are unsure, they would contact their manager and subsequently the care co-ordinator. The family are normally informed about any issues. Staff are aware of how to approach the Local Authority or the safeguarding team for any pertinent matters." This meant people could be assured staff would take the relevant action to ensure their safety.

There were safe recruitment processes in place. Staff files included application forms which captured their full employment histories; records of interviews and appropriate references obtained. Staff records showed disclosure and barring service (DBS) checks were undertaken. These ensured staff employed were suitable to provide care and support to people who used the service.

People were protected from unsafe care because there were sufficient staffing levels to meet their individual needs and keep them safe. We spoke with staff who confirmed there were sufficient members of staff to meet people's needs. Unit managers were clear about the ways they measured dependency levels and adjusted staffing accordingly. We observed care workers were unhurried in their support for people throughout the day and there were sufficient people on duty to support people with their physical, emotional and psychological needs. This was supported by our review of staff rosters which confirmed there were sufficient staff on duty throughout the units.

People were protected and their freedom supported and respected because the service had suitable risk assessments in place. Risk assessments related to various areas such as pressure ulcers, falls, choking, burns

and scalds (from hot drinks for example), moving and handling as well as evacuation from the home in an emergency. This was supported in all care records reviewed.

We noted staff had identified potential and likely risks as well as the severity of the risk, and detailed mitigating interventions to reduce the risk down to an acceptable level. People's needs and preferences were taken into consideration as much as was possible. Families were also given the opportunity to contribute to the risk assessment process to ensure their relatives were able to continue to do activities that they wanted to.

People received their medicines safely and in accordance with best practice. The service followed current relevant professional guidance about the management and review of medicines. For example, where people were identified as having difficulty taking their medicines for reasons such as the inability to swallow tablets due to their condition. Covert medicine was used to ensure people received their medicines safely. Covert medicine is the administration of medical treatment in disguised form. This usually involved disguising medicine by administering it in food and drink. As a result the person is unknowingly taking medicines.

People who were assessed as lacking capacity were only administered medicine covertly if a management plan was agreed and after a best interest meeting. The service had these plans in place that ensured people received their medicines in accordance with best practice guidelines. The service did not use medicines to control people's behaviour. Where behaviour on occasion had become challenging staff used alternative therapies to address this for example, distraction therapy.

Our observations of medicines rounds showed these were undertaken by trained nurses. Nurses wore red tabards to request that they were not disturbed during a medicines round, however we saw staff did approach them and ask questions. Staff undertaking the administration of medicines told us that they had received induction training and competency sign-off in the administration of medicines before they were permitted to undertake the task. Our review of records that related to nurses' medicine competencies confirmed this. Staff were required to complete e-learning modules for the management of medicines. These courses were provided by an external pharmacy and the provider. There was also face to face training provided by the pharmacy contractor for new nurses and senior care workers and covered all aspects of the ordering, storage, administration and destruction of medicines required for people. This meant people received their medicines from staff who were competent to administer them safely.

Good

Is the service effective?

Our findings

People said staff were experienced and skilled to provide care and support to them. Comments included, "Yes, all the time" and "Staff are skilled", "On a scale of 1-6, I would say an 7-8", "Yes, I don't know why but I do", "Some are very good in particular (said staff member's name)", "Yes, everything they do and how they do it." This was supported by relatives whose comments included, "Yes I think so, more than how I can care for X (family member)", "Yes they are skilled and experienced" and "Yes certainly so."

People received care and support from staff who were appropriately inducted, trained and supervised. New staff were supported to complete an induction programme before working on their own. For example, one staff member commented, "I had a good induction of two weeks followed by shadowing a senior member of staff". We noted the induction programme for new staff was comprehensive and ensured staff were aware of all their statutory and mandatory duties. Staff's competencies in all areas were clearly recorded and signed and dated when completed. This meant people received care staff who received appropriate induction.

People's needs were met by staff who had access to the training they needed. Staff said they had received training which included safeguarding, fire safety and moving and handling.They told us they had received the training they needed when they started working at the service and were supported to attend on-going training to refresh their knowledge. The regional director explained that all staff completed dementia awareness training by e-learning and there was 100% compliance. A review of the staff training matrix confirmed this. The provider also delivered a two day programme called "Fulfilling Lives" to develop staff in person centred dementia care. We noted 40% of staff had completed this. In addition to this staff were able and encouraged to complete a Level 3 distance learning course in person centred dementia care, some of the staff spoken with confirmed they had completed this.

People were supported by staff who were supervised by their line managers. Staff told us supervisions were carried out regularly and this enabled them to discuss any training needs or concerns they had. A review of staff records confirmed this and showed unit managers reviewed staff's training and development needs. We noted the service selected a policy to review in detail with staff. This was displayed on staff notice boards throughout the service. Staff supervisions recorded staff's understanding of the policy to ensure staff followed the correct practices and procedures. Annual appraisals were undertaken and covered staff's past performance throughout the year and set personal and business objectives for the coming year.

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 be 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 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.
People's rights were protected because staff understood the issues of consent, mental capacity and DoLS. Where people received their medicines covertly this was recorded in the DoLS authorisation. There was clear evidence of best interest's decision making with the GP, people and their legal representatives, nurse and pharmacist having been involved in the decision making process. DoLS applications were submitted appropriately and any conditions complied with. Staff sought people's consent and involved them in decisions. Care records showed staff sought consent for care and treatment from people as well as legal representatives confirming consent. The practitioner for Older People with Mental Health commented, "Staff are familiar with applying the MCA 2005. If they are not sure and there is a need for a formal mental capacity assessment/review leading into best interest decision, staff will normally ask support from their managers." This meant staff acted in accordance with the MCA.

People's nutritional needs were met. This was supported by relatives who gave various comments such as, "I watch what X eats and what food is given to X. X is vegetarian and they (staff) cater very well to their needs" and "Good, nutritional and they(staff) ensure they take care because X is diabetic." People said they were involved in decisions about their nutrition and hydration. Comments included, "I have a sea food allergy and they (staff) take this into consideration", "There are pictures on the menus and I choose what meal I want", "I get a menu and staff ask me what food I would like."

Meals were adapted to meet people's cultural and religious needs. The chef explained to us they provided a variety of cultural foods 'We cook Asian food, Caribbean food and English food. I try and make it interesting as when elderly people become frailer, their nutritional requirements increase and their appetites decrease. Food is important'. We noted the chef had a very good understanding of people's dietary needs; food allergies and any other health conditions such as diabetes. This ensured people's nutritional needs would be met.

We noted the service had been given the highest rating for food and hygiene by the local authority. This meant the service's standards for food and hygiene was very good.

An observation of the lunch time period showed people were offered a choice of meals. Staff were seen showing people pictures of the meals on offer and then later arriving with two hot meals for people to get a better look and smell of the foods on offer before they finally made their choice.

Staff attended 'mealtimes experience training'. The purpose of this training to was give staff greater insight into how people living with dementia felt during mealtimes. Staff were blind folded and senior staff supported them with their meals to show how a lack of dignity and respect can make a person being supported with their meals feel. Staff gave overwhelming positive about feedback about the training. Staff said they had gained confidence in how to assist people with their meals and how to give them choices, whilst others said they gained a better understanding of how to present food and interact with people.

There was a system in place called resident of the day, which ensured that care plans and documentation were up-to-date and reflected currents needs and preferences. This process involved team leaders, keyworkers and housekeepers and ensured people's preferences were identified. Risk assessments and care plans would be updated when changes were identified.

People were supported to maintain good health and had access to healthcare services. People had access to a full range of healthcare support; this was provided by the NHS or other professionals. Some GP

surgeries that looked after people at the service provided proactive weekly reviews of residents health needs, this was in addition to responsive reviews of medical complaints. However, accessing GPs was variable according to the practice people were registered with. Care records showed staff liaised with other professionals such as speech and language therapist, community mental health nurses, tissue viability nurse specialists, podiatrists and dieticians. Nail care was provided for people by family members or by a visiting chiropodist.

This was further supported by a NHS practitioner for Older People with Mental Health who commented, "Communication is good general , if we leave messages they are communicated properly. For instance each floor has a unit manager which is quite helpful as professionals can contact them directly. The unit managers will normally call us if they need the patients to be reviewed, especially if there is a deterioration in mental health and warrants a medical review. The staffs will normally act upon professionals advice such as liaising with the GP for a physical health check or medication issues. They keep the family informed too."

Good

Is the service caring?

Our findings

People said that staff were caring and looked after them well. We heard various comments such as, "Yes they are concerned about my wellbeing. Staff and nurses always asked me about how I feel", "Yes they go out of their way for you", "They handle you in a kind way and they know you." This was supported by relatives comments included, "Yes I feel so", "Yes definitely, due to the good and professional care delivered by the provider" and "Yes they do, they are very attentive and do extra thing for patients, even if it is not requested."

People's care was not rushed and enabled staff to spend quality time with them. For example, we saw staff sitting and chatting to people and assisting people who required support at a pace that was dictated by the person. We saw a number of good examples of how staff showed concern for people's wellbeing in a caring and meaningful way. For instance, one person did not want to participate in the activities that were taking place in the lounge area. The person got up and walked out of the room, the member of staff noted the person had left the room and they (member of staff) followed the person to see if they were fine.

Every afternoon at 3pm people attended 'Tea at 3'. This involved people who wanted to participate, staff and relatives who gathered together to socialise. We observed positive relationships had been established between staff and the people who attended. People appeared relaxed and were happily engaged in conversations with other people as well as staff.

During the breakfast period we observed breakfast for one person who was in their room. A staff member took time to re-position the person so they sat up and offered them choice before they eventually assisted them with their meal. The staff member displayed patience and kindness throughout.

People were given choices and staff actively sought people's preferences and respected their choices. For instance, staff asked people questions such as, "Would you like a food protector to cover you nice clothes?" and "Would you like juice or water?" Staff clearly knew people well and matched their choice of activity to their knowledge of the person's preferences. Staff interacted with people appropriately and turned off the television in order to create a dining ambience. We asked what the purpose of this was and one care worker responded, 'We want to make it as nice as possible. This is their home'. This meant staff promoted people to exercise choice.

Staff had established good working relationships with the people they supported and demonstrated a good understanding of their care needs. For instance, one person commented, "They (Staff) know me well." Staff told us about people's family histories; their preferences; their communication needs and hobbies and interests. A review of people's care records confirmed what staff had said.

People said staff respected their privacy and their dignity was protected. Comments included, "Whenever they (staff) give me care they make sure curtains are closed and avoid any disturbances. They (staff) promote my independence by giving me exercises to rehabilitate", "Yes, they (staff) draw the curtains when giving support" and "Staff are very respectful."

People's communication needs were met because staff were aware of people's individual communication skills, abilities and preferences. We noted alternative communication books were available in Polish. This enabled staff to communicate effectively with people where English was not their first language. The deputy manager told us they were in the process of developing German and Italian communication books. Care records noted whether people were able to communicate verbally or not and their preferred method of communication. This meant information was given to people in way they could understand.

Where people had made advanced decisions these were respected. People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary people and staff were supported by palliative care specialists. Care plans we viewed had do not attempt resuscitation (DNAR) forms in place when people had made this decision. Staff confirmed people had been involved in the decision process and where people were transferred to hospital the DNAR form was sent with the person. This ensured that any wishes the person had made were upheld in the event of being transferred to another service.

The staff were proud of the way they supported people at end of life. On one of the units we noted some exceptional end of life care plans. The unit manager had engaged a person fully in planning their life goals and end of life wishes. This was very detailed and covered all aspects of the person's wishes from preferred place of care when at the end of life stage to who the person wanted contacted at the time of their death. We noted this was not reflected fully in other units and offered the service an opportunity for shared development. This was fed back to management at the end of our visit.

Good

Is the service responsive?

Our findings

People and their relatives said they received care that was specific to their needs. Comments included, "I receive care specified in my care plan so it's specific to my needs", "Provision for vegetarian shows that X (family member) is treated as an individual" and "Yes certainly so, they (staff) have to, they do things that help X (family member) with their mobility and communication problem.

People had their needs assessed before they moved into the home. Information had been sought from the person, their relatives and other professionals involved in their care.

People and their relatives were involved in developing their care and support plans. Care plans were personalised and detailed daily routines specific to each person. Staff were able to explain people's routine and preferences. For example, we saw that one person was still in bed in the early afternoon before lunch time. We asked staff if this was the person's wish, they (staff) confirmed this to be the case. However, we were unable to confirm this in the person's daily notes as the computer system that stored people's daily information was down at this point.

Care plans clearly explained how people would like to receive their care and treatment. One person had been admitted with grade three pressure sores. The person had a separate wound folder that clearly identified how staff treated the wound and a progress report of the on-going care was in place. In addition photographs had been taken to ensure staff had a clear picture of the on-going progress. This meant that any deterioration could easily be identified and actions taken such as engaging support from the tissue viability nurse (TVN). In addition people with fragile skin and who had been assessed as at risk of skin damage had appropriate pressure reliving mattresses in place. The mattresses were checked on a regular basis to ensure the setting for the person's weight was correct.

Staff were sensitive to the needs and vulnerabilities of people who required to be transferred to hospital. For example, we reviewed the care records of one person who had been seen by a GP at the request of nursing staff and subsequently was admitted to hospital. Staff ensured that documents were transferred with the resident, such as do not attempt resuscitation form, MARs chart, body maps and 'this is me' document. A member of staff went to the hospital with the person to help them with their meal after they had been admitted to hospital.

Daily handovers for staff provided by team leaders ensured the care being given was responsive to people's needs.

People were actively engaged in a wide variety of social activities. We observed people being supported in a variety of large group, small group and one-to-one activities within all three floors throughout the day, there were high levels of wellbeing observed. One person commented, "The activities are really good and I like them. So when they don't happen I miss them because they relax my mind." Care records showed people were encouraged to maintain their hobbies and interests. This showed people's social needs were being met.

The practitioner for Older People with Mental Health commented, "Perhaps, I would like to see more outdoor activities for more functional patients, using the space around the care home more effectively and a little bit of creativity such as small groups for gardening or visiting the farms etc."

People and their relatives said they were aware of how to make a complaint. Comments included, "No never complained about anything, but if I have an issues, I will raise it up or my family will do that with the authority", "Not yet, no cause for that presently", "I have not had any reason to find fault even though X (family member) has been here for eighteen months" and "No, for example, the fan was not working this morning and it was immediately dealt with." A review of the complaint log showed complaints received was responded to appropriately and in line with the service's complaints policy.

Good

Is the service well-led?

Our findings

People and their relatives spoke positively about the service. Comments included, "They (management and staff) are perfectly adequate in what they do", "We are very satisfied. Staff acts in a professional manner", "I don't know much about the management and leadership, I am more in contact with the carers and nurses, who are doing a brilliant job", "The senior staff and management I think are of high quality and everything runs smoothly. For example, breakfast and support to get ready in the mornings", "I've not met the managers but its good here" and "If the captain of the ship is capable the ship sails well."

Staff members positively acknowledged the benefits of working with the deputy manager and had confidence in their skills, knowledge and support. Staff told us that they felt well supported by management and the deputy manager had worked to bring the individual unit managers together into a more functional team that were able to help each other and share best practice. We heard comments such as, "I am very happy here it's a team, we help each other" and "The manager (registered) is excellent I can ask them anything."

We noted staff team meetings, heads of department meetings and clinical meetings regularly took place in order to ensure people's welfare and safety was protected, staff understood their responsibilities and best practice was shared.

The registered manager had recognised the challenges of the service and had worked effectively in ensuring the service had improved since the last inspection. One member of staff told us "We have had three managers, the current manager has made improvements and you can 'feel' the difference, however, this has taken some time for this to happen". Another member of staff told us "The manager is supportive, they respect what you are saying and they have 'picked this place up'. This meant staff had confidence the registered manager would listen to their concerns and it be received openly and dealt with appropriately.

Oak House newsletters communicated events and changes that occurred in the service to people, those who represented them and staff.

During our inspection we observed that the units we visited were organised and well run by staff who displayed appropriate values and behaviours towards people. For example, where people required additional assistance this was observed being completed by staff who provided support promptly and efficiently that was tailored to people's individual needs.

The service had quality assurance systems to assess monitor and improve the quality and safety of the service it provided. Audits were undertaken that covered areas such as medicine, care plans, infection control, tissue viability, nutrition and fire safety. Spot check audits were carried out on the food by management and the chef. This was to get direct feedback from people about the quality of the food.

Policy of the week was displayed in all staff offices. This helped staff to focus in more detail on a policy in order to understand their responsibilities and ensure correct practice was undertaken when they provided

care, treatment and support to people. The policy that was currently focused on was the MCA and best practice.

People were able to provide feedback to the service and the service ensured this was responded to appropriately. This was supported by a review of the 'Your Care Rating 2015 residents' survey results'. For example, 100% of people felt they could have visitors when they wanted; the home was safe and secure place to live and felt they had enough of their own things around them (photos, ornaments, etc.). Whilst 55% of people thought the laundry service was good; 39% of people felt the food served at mealtimes was of good quality.

In response to the feedback given the service had taken action. A review of minutes of staff team meeting dated 9 & 18 May 2016 showed management instructed staff to ensure people's laundry were handled correctly and introduced a new system of allocated tasks to ensure staff were accountable when carrying out this task. To ensure people's meal time experience was good staff had to undertake 'meal time experience' training; the chef worked closely with management to ensure feedback received from people were appropriately responded to.

When asked whether the service was well-led the practitioner for Older People with Mental Health commented, "I personally think the presence of Unit Managers at operational level has helped to improve things a lot. Staff can seek support and guidance and hence reduce the risk of making mistakes. The staff level is adequate and visible on the floors which is reassuring in itself."