The Regard Partnership Limited

Oak Lodge

Inspection report

Oak Lodge
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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 Lodge provides accommodation for up to six younger adults with physical and learning disabilities. There were six people living at the home at the time of our inspection. People's needs were varied and included requiring support associated with cerebral palsy, autism and epilepsy. People had complex communication needs and required staff who knew them well to meet their needs.

There was a registered manager in post. 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.

This comprehensive unannounced inspection took place on 17 and 18 March 2016.

There were enough staff who had been appropriately recruited, to meet the needs of people. Staff had a good understanding of the risks associated with supporting people. They knew what actions to take to mitigate these risks and provide a safe environment for people to live. They understood what they needed to do to protect people from the risk of abuse. Appropriate checks had taken place before staff were employed to ensure they were able to work safely with people at the home.

The registered manager and staff had training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They had assessed that some restrictions were required to keep people safe for example, the use of bed rails and lap straps on wheelchairs. Where this was the case referrals had been made to the local authority for authorisations.

Staff had a good understanding of people as individuals, their needs and interests. Each person had the opportunity to go out every day. A 'You said, we did' board was used to demonstrate that when people made choices about activities arrangements were then made for these to happen.

We observed safe and effective teamwork among the staff when supporting people with their mobility and healthcare needs and staff continually gave reassurance to people and respected their dignity at all times.

People had access to healthcare professionals when they needed it. This included GP's, dentists, speech and language therapists and occupational therapists. Communication passports were used to ensure that all staff could work effectively with people and helped them to identify the subtle ways that people indicated their choices and made their needs known.

People were asked for their permission before staff assisted them with care or support. Staff had the skills and knowledge necessary to provide people with safe and effective care. Staff received regular support from management which made them feel supported and valued.

The registered manager was approachable and supportive and took an active role in the day to day running of the service. Staff were able to discuss concerns with them at any time and know they would be addressed appropriately. Staff and people spoke positively about the way the service was managed and the open style of management.

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's medicines were stored, administered and disposed of safely.

There were risk assessments in place and staff had a good understanding of the risks associated with the people they supported.

Staff understood the procedures in place to safeguard people from abuse.

There were enough staff who had been safely recruited to meet people's needs.

Is the service effective?

Good

The service was effective.

There was a training and supervision programme in place to ensure staff maintained current knowledge and skills.

The manager and staff had a good understanding of mental Capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were given choice about what they wanted to eat and drink and received food that they enjoyed.

People were supported to have access to healthcare services and maintain good health.

Is the service caring?

Good

The service was caring.

Staff knew people well, treated them with kindness and warmth.

Staff treated people with respect and they ensured that people's dignity was maintained at all times.

Attention was given to ensuring that people's bedrooms as far as possible reflected their choices and tastes.

Is the service responsive?

Good

The service was responsive.

People received support that was responsive to their needs because staff knew them well.

People were supported to maintain contact with their family and friends.

Communication passports were used effectively to ensure that all staff could identify how people made their needs known.

Is the service well-led?

Good

The service was well-led.

A wide range of audits were carried out to monitor the running of the home and to ensure that it was well run.

The manager was seen as approachable and supportive and took an active role in the day to day running of the service.

The regular newsletter ensured that people and their relatives were kept up to date with changes at the home.

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.

This inspection took place on 17 and 18 March 2016 and was unannounced. The inspection was carried out by two inspectors.

During the inspection we reviewed the records of the home. This included staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises. We also looked at three people's support plans and risk assessments along with other relevant documentation to support our findings.

During the inspection, we spoke with the registered manager, a senior support worker and a support worker. Following the inspection we received feedback from three healthcare professionals.

We met with people who lived at Oak Lodge. We observed the support which was delivered in communal areas to get a view of care and support provided across all areas. People used various methods of communicating with staff and we spent time sitting and observing people in areas throughout the home and were able to see the interactions between people and staff. This helped us understand the experience of people living at Oak Lodge.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the home, including previous inspection reports. We considered the information which had been shared with us by the local authority and other people and looked at notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law.

Good

Is the service safe?

Our findings

Although most people could not tell us if they felt safe, those who could communicate verbally said they did and we observed that when people needed support there was always a staff presence to provide reassurance and guidance where appropriate. For example, when people were supported moving around Oak Lodge, staff explained clearly what they were doing and when they were doing it.

People were protected against the risks of harm and abuse. Staff had an understanding of different types of abuse and told us what actions they would take if they believed people were at risk. They told us that when an incident occurred they reported it to the manager who was responsible for referring the matter to the local safeguarding authority. When an incident or accident occurred staff completed a form which described the incident and how it had been resolved. Records relating to incidents had been documented well and where appropriate, matters had been reported to the local authority for further advice and support. However, within one person's support plan there was reference to an incident that had occurred. We asked to see the incident report relating to this incident but it could not be found. Immediately following the inspection the incident report was sent to us and the home confirmed that the matter had been referred to the local safeguarding team.

Staff told us that there were sufficient staff to meet people's individual needs. There were four staff on duty throughout the day and a waking night staff member. In addition, at night there was a sleep in staff member who was shared across both homes on the same site. This person assisted where needed for a set number of hours and was then called on only if necessary during the night hours. We were told that alongside the normal staff arrangements, the rotas also included set hours that each person was funded to receive for one to one support throughout the day. Details of the staff support provided were recorded in a personal daily outcome folder for each person. There were clear on call arrangements for evening and weekends and staff knew who to call in an emergency.

Regular health and safety checks ensured people's safety was maintained. Checks included infection control and cleaning checks, gas and electrical servicing, hoists and specialist bath servicing and portable appliance testing. All staff had received fire safety training and people had personal emergency evacuation plans. They contained information to ensure staff and emergency services were aware of people's individual needs and the assistance required in the event of an emergency evacuation. There were regular fire safety checks in place including fire drills and staff were clear about what they should do in the event of a fire. A detailed fire risk assessment had been carried out in 2015 and records showed that all actions identified had been addressed. A maintenance book was kept that included details of any faults identified and records of when they were addressed. It was noted that the manager did periodic checks to make sure that there were no tasks left outstanding.

Medicines were stored, administered, recorded and disposed of safely. People's medicines were stored in locked cupboards in their own rooms. Support plans included detailed advice about how people chose to take their medicines. Some people, who had difficulty swallowing, took their medicines with yogurt and where this was the case, their GP had signed that they were happy for this to happen. Where people were

prescribed skin creams, body charts were used to highlight the specific areas to be treated and advice was given about how much cream to apply. Some people had been prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain or were agitated. Copies of PRN protocols were stored within individual medicine's cupboards. Before giving PRN medicines, staff would discuss the need with the registered manager to ensure this was the most appropriate treatment for the person at the time. Some people who experienced pain were not able to express this verbally, and there was information in their support plans about how they may express they were in pain. If people refused medicines this was recorded and advice sought from the person's GP or on-call doctor.

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a range of documentation including photo identification, written references and evidence that a Disclosure and Barring System (police) check had been carried out to ensure people were safe to work in the care sector.

Good

Is the service effective?

Our findings

Staff knew people well, they had the knowledge and skills to look after them. Those who could tell us verbally said that the food was good. One person told us that they liked, "Cheese and pouring tea from a pot." During our inspection we observed that they had cheese and had tea from a teapot. Mealtimes were not rushed and as far as possible people were encouraged to make choices and decisions.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training on MCA and DoLS and were able to describe its principles and some of the areas that may constitute a deprivation of liberty. Referrals had been made for standard authorisations for those people who required the use of lap belts or bed rails to keep them safe. The registered manager was awaiting further contact regarding the outcome and had been in touch with the Local Authority DoLS team to seek an update. It was noted that two people wore protective equipment to keep them safe but that this had not been included in the DoLS referrals. The manager agreed that this should be added to the referral applications.

Staff asked people's consent before providing support. They had assessed people's abilities to make decisions on a range of matters and were clear that should complex decisions need to be made, a 'best interest' meeting would be held. Some people had difficulty swallowing medicines and permission had been sought with their GPs to administer medicines with yogurts. There were signed letters from GPs confirming that this was appropriate. This meant that care was provided in line with people's assessed needs and wishes.

Staff received ongoing training and support to meet people's needs. There was a training programme and the system in place showed that staff had been booked to attend updates on subjects such as medicines and DoLS. Staff told us they received training which included safeguarding, moving and handling, infection control and food hygiene. One staff member told us that the recent first aid training had been, "Absolutely brilliant, the best one I've ever been on." In addition, they received training specific to meeting the needs of the people living at Oak lodge. This included training on epilepsy and training on diet and nutrition. The manager and two senior staff had recently completed training on caring for people with cerebral palsy and the manager told us that this had been particularly beneficial. They were going to extend this training to all

staff as in addition to learning about cerebral palsy the training included advice and guidance on how to work effectively in a person centred way. We were told that all senior staff completed training on person centred care, risk assessment, care planning and supervision.

There was a structured induction programme in place when staff started work at the home. This included time to get to know people, to read their support plans and to shadow other staff. An in-house induction checklist was completed to ensure that staff knew the home's procedures. On completion, staff who had not previously worked in care went on to complete the care certificate. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff received regular supervision which was booked in advance; they told us they were able to have extra supervision if they required further support. Staff said, supervision was useful and they were able to ask for support whenever they needed it. One staff member told us that their supervisor was "Supportive" and that they had a "Good working relationship, she is approachable."

We were told that a menu meeting was held once a week. The menus were displayed in the dining room along with a picture of each meal. People were supported to make choices and a record was kept of which person had chosen each meal. Throughout our inspection people were given regular drinks and were offered a choice of what they wanted to drink. We observed staff asking people what they wanted to drink and if they were not clear what the response was they showed them the actual choice. People were given plenty of time to make a decision and staff knew the subtle movements people made that indicated their decision making.

People were supported to maintain good health and received on-going healthcare support. Everybody had a health action plan that identified the health professionals involved in their care for example, the GP and dentist. They contained important information about the person's health needs. Where professionals had provided support to people there were detailed guidelines on any recommendations they had made. For example, for one person there were detailed guidelines from the occupational therapist on moving and handling. People also had patient passports that would be used if they needed to go into hospital. Patient passports information such as: "Things you must know about me," "Things that are important to me" and "My likes and dislikes."

Good

Is the service caring?

Our findings

People were supported by staff who knew them well as individuals. Some of the staff had worked in the home a long time and they were able to tell us about people's needs, choices, personal histories and interests. We observed staff talking and communicating with people in a caring and professional manner and in a way people could understand. Those who could communicate with us verbally, told us they were happy living at Oak Lodge.

We observed staff working as a team to support a person with their health care needs. Staff communicated effectively with each other to ensure the person's safety. Their caring approach enabled the person to maintain their dignity and their continued reassurance reduced what could have been a distressful situation for the person.

When people had difficulty expressing their needs, staff worked hard to identify the problem. For example, one person indicated by specific sounds that they were unhappy. Staff took them to their room and put on music that they knew the person liked. However, this did not help them to settle. Staff spoke reassuringly to the person and offered alternative activities. When the person did not settle staff felt that the person might be in pain and a mild pain killer was administered. The person settled soon after.

We saw staff giving people the time they needed throughout the day, for example when they accompanied people to the toilet, changed their seated positions, assisted people with their meals and supported them to go out for activities. Staff were relaxed and unrushed and allowed people to move at their own pace.

People chose or were given a choice of where they spent their time whilst in the home. For example, some people moved around the home independently and others used different sounds to prompt staff to move them. Some people when asked were able to indicate either verbally or with gestures that they wanted a change. We noted that people who used wheelchairs were offered regular opportunities to change their position to comfy chairs, beanbags, bed or floor time. This meant that in addition to providing a change of scene for the person, staff were also ensuring that pressure areas were alternated.

We observed two staff supporting one person from their wheelchair to a beanbag in the lounge area. Staff gave clear instructions to each other and reassured the person throughout the process. Within about ten minutes the person had slipped into an uncomfortable position but staff noticed this immediately and readjusted their position.

Support plans included advice for staff to ensure that they gave people private time. Attention was given to ensuring that people's dignity was respected. We saw that when one person's top was soiled after a drink, staff immediately took them to their bedroom to change. Before staff took people out they always ensured that people were taken to their room for a quick freshen up before going out.

People's bedrooms were individually decorated and furnished with people's own memorabilia, pictures and collections. For example, one person liked to collect clocks and another, guitars.

People had an allocated key worker. A key worker is a person who co-ordinates all aspects of a person's care and has responsibilities for working with them to develop a relationship to help and support them in their day to day lives. Monthly Key workers meetings were being introduced to plan activities with people and to give them opportunities to discuss any individual issues.

One person had a fish tank in their room and kept a folder with a picture of each fish and the food they required each day. They prompted staff to provide them with assistance, when needed, to feed the fish and to attend to cleaning of the tank. They were very proud of the fish tank and loved the opportunity to talk about the fish.

Good

Is the service responsive?

Our findings

People received support that met their needs and was personalised to their individual choices and preferences. The home supported people to maintain relationships with their relatives and friends. One person was regularly taken to see their relative even though the length of the visit was very short. Staff told us, "Even if the visit is only five minutes it's important to them." Links were also set up to ensure that a person who had family members abroad were able to communicate with them by social media.

Some people regularly went to a monthly disco and attended a regular club. Aromatherapy sessions were also arranged six weekly. A 'You said, we did' board was displayed in the lounge area. This included photos of activities that had either happened or plans for forthcoming activities. One staff member told us that they had recently taken one person to the cinema and this had been a very positive experience. They said the person, "Thoroughly enjoyed the trip and was talking about it for days after." They said that they hoped the activity could be introduced on a regular basis. Activities had been planned for two people to go to London and for others to go on another outing. People were supported to use local amenities on a daily basis.

We were told that the personal daily outcomes (PDO) folders were used to record goals that had been set for individuals and to ensure they were met. It was not clear what goals had been set for each individual. However, the PDOs were used to record what activities people had been involved in. The information recorded did not provide sufficient information to demonstrate that staff were working in a person centred way or to assist in evaluating a person's daily activities. For example, comments included out for a walk, socialising in the lounge, out for a drink, sensory. However, the provider information return (PIR) completed in advance of this inspection highlighted that the PDO was a new document and that it would be monitored regularly to ensure that staff were supported with any shortfalls in recording. It was noted that the document had been reviewed at regular intervals and was still under development. We therefore assessed that this had limited impact on the quality of people's daily activities.

There was a complaint's policy in place and an easy read version was also on display. A speaking out form was available to record any concerns people might raise. People were regularly asked if they were happy or if there was anything they would like to do differently. The last complaint recorded was in 2012.

Staff were able to tell us some of the signs people who could not communicate verbally would use to indicate that they were unhappy and we saw that staff responded to people when they indicated signs of unhappiness. For example, one person was distressed and staff gave them a pain killer.

At the start of the inspection the manager told us that care plans were being rewritten to make them more person centred. There was a range of documentation held for each person related to their care needs. This included information about their medical needs, support needs, ability to consent and information about their daily personal objectives. They contained detailed information and guidance about people's routines, and the support they required to meet their individual needs. Where someone had epilepsy there was another folder with guidelines detailing how to support people during and after a seizure.

Each person also had a communication passport which provided information about how each person made their needs and wishes known. Staff told us that the communication passports were under review. Where people had limited verbal communication there was advice about how people might present when they were tired, bored, thirsty, sad or angry. One person's plan stated that they often shouted when they were upset/angry. We observed this behaviour but noted that almost immediately the person was sitting with their feet up which was recorded as how the person presented when they were relaxed. We discussed this with a staff member who had been delegated the task of communication champion. We looked at one of the passports that had been reviewed and updated and saw that this included more detailed advice for staff. The staff member told us that, "As a result of advice from the SALT team staff are much better at recognising people's body movements and facial expressions and this has helped them to become aware of the choices people are making."

Good

Is the service well-led?

Our findings

From our discussions with staff, the manager and our observations, we found the culture at the home was open, relaxed and inclusive. Care was person centred and staff enabled people to make choices and decisions. Staff said the manager was available and they could talk to them at any time.

A service user survey was carried out in September 2015. The process was not person centred in that there was only one format used to gain people's views and people living at Oak Lodge had varied abilities to express their views. However, within the format used there was space to record if the person had required support to complete the form. Some people could give yes/no answers to questions but when this was not possible the staff member completed the form on their behalf. This meant that it was the staff member's views recorded not the persons. However, throughout our inspection we observed several instances where people made their needs known and staff responded to them. For example, when people wanted a drink or when they were uncomfortable and wanted to move to a different position. This meant that people's voices were heard so the lack of a person centred survey had little impact for people. However, the registered manager was clear that this was an area she would develop further.

The provider had systems in place to monitor the management and quality of the home, for example external management carried out a six monthly quality audit and this had been done in October 2015. In addition, external management carried out a six monthly health and safety audit and the last audit had been carried out in January 2016. In both cases the home was assessed under set criteria to ensure they met the provider's standards. There were no shortfalls found.

Alongside the above audits, one of the provider's locality managers also visited the home on a monthly basis. One month they provided supervision to the manager and the following month they carried out a service review of the care provided. During their visit they looked at a range of areas including, care plans, medicines, staff recruitment, supervisions and appraisals. We looked at a medicines audit carried out as part of this process and saw that a few minor actions had been identified and actions had been taken to address them.

There were a series of quality assurance checks completed each shift and these were recorded on the daily shift form. This included environmental, infection control, medicine and food hygiene checks. If checks had not been completed for any reason, this was also recorded to ensure staff on the following shift were aware and could address the matter. For example, the shift plan ensured that staff were clear about what was expected of them on each given shift and meant that people could be confident that their needs would be met.

The views of relatives and professionals were also sought through annual satisfaction surveys. Although some people had very limited contact from relatives, the results of the last surveys carried out in August 2015 were very positive. Where an issue was highlighted the manager responded to the relative detailing the action that would be raised to address the matter. Results of the professional survey were wholly positive.

The home had good working relationships with visiting professionals. One visiting professional told us that the home, "Utilised the health team well" and said staff were, "Particularly good at trying to empower people to maintain their independence." Another professional told us that the registered manager and staff team, "Are welcoming, and long term staff know their residents well and appear to have good relationships with them." They went on to say that advice they have provided, "Has been received well with staff engaging in discussion, keeping me up to date and following guidelines."

Staff told us that their views were heard through the supervision process and through regular staff meetings. Meetings were held monthly and staff said they were updated about new ideas and changes that were taking place. Detailed minutes were kept of the outcome and demonstrated that a range of matters had been discussed and that action plans had been agreed.

The home ensured that people and their relatives were kept up to date with what was going on in the home. A monthly newsletter was compiled and sent to people and their relatives. The newsletter included photos of activities that had occurred during the previous month. For example, the February edition showed photos of a Valentine's celebrations when people from other homes within the organisation joined together with Oak Lodge for a party. There were also photos of new staff, birthday photos for one person and a staff member's birthday, and information about the monthly house meetings.

We discussed 'duty of candour' (a requirement that all registered providers are open and transparent about care and treatment provided when incidents occur) with the registered manager who was able to tell us how this would be followed and the actions that would be taken if necessary to ensure it was met. There was a policy on 'duty of candour.'

The provider completed a PIR (provider information return) in advance of the inspection. This included areas where the home was planning to make improvements. For example, it stated that the home would be continuing to use the SALT team to help them develop people's communication passports. During out inspection we saw that this had happened.