Select Health Care Limited

Oak Bungalow

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 2 June 2016 and was unannounced.

Oak Bungalow is a care home offering support to a maximum of six younger people who have physical disabilities. At the time of this inspection there were six people living there. It is situated in the same grounds as another of the provider's care homes. It receives staffing and management support from this nearby, larger home.

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.

There were minor concerns about how risks within the environment were minimised promptly to ensure people's safety. However, individual risks associated with people's health were assessed with guidance about how these were to be managed to promote people's safety. People's medicines were managed safely.

Background checks were completed on staff to make sure they were not barred from work in care services. However, checks on employment histories were not as robust as they should be in contributing to safety. There were enough staff to contribute to supporting people safely and staff understood their obligations to report any concerns about risk or harm for people. Staff had access to training to enable them to support people competently. This included training that was focused on the specific needs of people using the service.

Mealtimes were a relaxed and pleasant experience for people. They had access to enough to eat and drink to meet their needs and were able to take part in meal preparation if they wished. They were able to access the kitchen to make drinks when they wished.

Staff understood people's needs and preferences and delivered support which took these into account. They had developed good relationships with people using the service and promoted their dignity and respect. People's concerns and views were listened to and acted upon.

The home benefited from a stable management team who were well qualified and understood their roles. Staff were well-motivated to delivery good quality care. There were systems to check the quality and safety of the service and consult with people living and working in the home. However, these were completed across the site and not specific to Oak Bungalow.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Attention was needed to minimising a minor risk within the environment to enhance safety.

People were supported by enough staff. Not all the required recruitment information was gathered to ensure prospective staff were suitable to work in care.

Staff understood how to recognise whether people may be at risk of harm or abuse and their obligations to report it.

Medicines were managed safely and people received them as the prescriber intended.

Is the service effective?

Good

The service was effective.

Staff received support and training so that they were competent to meet people's needs.

Staff understood the importance of supporting people to make decisions. Where people's capacity to make specific decisions was in question, staff followed ensured people's rights were protected.

People received enough to eat and drink to meet their needs and preferences.

People were supported to access advice from health professionals where this was needed.

Is the service caring?

Good

The service was caring.

People received support in a way that respected their privacy and dignity.

People could make choices about their care and how they

wanted this to be delivered.

Is the service responsive?

Good

The service was responsive.

Staff delivered care that took into account individual need and was flexible when people's needs changed.

People were confident that their concerns and complaints would be addressed.

Is the service well-led?

Good

The service was well led.

There were systems in place for checking the quality and safety of the service, taking into account people's views.

Staff were well motivated and enthusiastic about their work with people.

There was a stable and consistent management team and the registered manager understood the requirements of the role.

Oak Bungalow

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 2 June 2016 and was unannounced. It was completed by one inspector.

Before we visited the service we reviewed all the information we held about it. This included information about events happening within the service and which the provider must tell us about by law. 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 they had supplied to us.

During the visit, we spoke with the registered manager, clinical lead, care manager, a nurse and two care staff. We also spoke with two people who used the service. We reviewed care records for three people and medicines administration records for five people. We checked recruitment records for two staff and training records for all staff who worked regular shifts at Oak Bungalow. We also reviewed a sample of other records relating to the quality and safety of the service including medicine audits and surveys.

After our visit we contacted five professionals who commissioned services at Oak Bungalow and received brief comments from two of them.

Requires Improvement

Is the service safe?

Our findings

Most risks were identified assessed to ensure people's safety. However, sometimes they were not fully addressed and people were not always reassured about action being taken.

We found that one person had a piece of their carpet removed in the entrance to their room leaving the concrete floor exposed. They told us, and the manager confirmed that this was because of water damage. Where it had been cut, the edge of the remaining carpet was lifting and frayed. We were concerned that this presented a potential risk to the person who used their feet to manoeuvre their wheelchair. It also presented a trip hazard for staff. The manager told us that this was being replaced the week after our visit.

We received two complaints about the heating boiler 'knocking' sometimes while it was running and concerns that this meant it may not be safe. Records held in the manager's office at the nearby larger service showed that it was serviced in April 2016 to ensure that it operated safely. The registered manager explained that the noises were due to staff trying to turn the boiler up. They told us that the provider's estates manager was due to visit the service the week after the inspection because the boiler was not sufficiently powerful for the home's needs and needed replacing.

People and staff confirmed that there were prompt repairs to the equipment people needed to move and transfer safely. Records showed that this was tested and serviced to make sure that it was safe for people to use. There were regular tests on fire detection systems to ensure they would work properly in an emergency. Staff received training so that they would know what to do in an emergency such as a fire. They told us, and records confirmed that they also had training in first aid so that they could respond to health emergencies pending the arrival of nursing staff from the nearby service or from emergency services.

Staff told us how they managed risks to people's safety, for example from falls and in relation to pressure area management. We observed that people at risk of developing pressure ulcers had equipment in place to manage this risk. Our discussions with staff showed that they were aware individual risks could fluctuate if people were unwell. They understood that people might need additional support at such times, for example with moving and transferring safely. The service employed its own physiotherapist who assessed how staff needed to support people to move safely. We saw this information and guidance contained within people's care records.

A staff member told us about the checks completed when they applied to work at the home, including providing sources for references and proof of their identity. The management team took up references and completed enhanced checks to ensure staff were not prohibited from working in care services. This confirmed what the registered manager said in the Provider Information Return (PIR) they sent to us. However, recruitment processes were not as robust as they could be. The application form asked prospective staff to provide employment details for the last ten years. It did not prompt staff to provide a full employment record as required by regulations. We have raised this before as an area for improvement, when the registered manager was overseeing another of the provider's services. They had not yet taken action to ensure all required information was obtained as part of the recruitment processes in this home.

People told us that there were enough staff to meet their needs. One person told us that staff came quickly when they used their bell to call for assistance. We observed that this happened and that staff intervened promptly when one person called out for help. Staff told us that they felt staffing levels allowed them to support people safely. They told us that they there had never been any problems with staffing the home.

There were systems in place to help protect people from the risk of abuse or harm. Staff understood the importance of reporting any concerns or suspicions that someone may be at risk of harm.

People told us that they felt safe in the service. They had no concerns about the way that staff treated them and said that they liked the staff. They told us that they could speak to staff if they had any concerns about the way they were treated.

Staff confirmed that they received safeguarding training so that they would recognise signs that may indicate concerns of potential abuse or harm. Training records confirmed this. Staff were clear in their obligation to report any concerns and what would lead them to suspect that someone may be at risk of harm or abuse. They told us that they had not needed to raise any concerns and felt that people using the service were safe in the home. The PIR for the service said that the management team raised safeguarding issues at each staff member's supervision. They also said they encouraged staff to report poor practice if they had concerns. Records we reviewed confirmed that the supervision agenda for staff always included opportunities for these discussions and encouraged staff to come forward with any issues if necessary.

Staff managed people's medicines in a way that ensured people received them as the prescriber intended. We found that medicines that staff administered were securely stored in a treatment room in the large service on the site nearby to Oak Bungalow. The registered manager explained that secure storage facilities in Oak Bungalow were limited. The facilities within the treatment room at the nearby property were safer for storage and auditing purposes. Qualified nursing staff took responsibility for administering them when they were needed. One person spent time in the main home and received their medicines during the day there. For others, nursing staff took the medicines to Oak Bungalow to give to people when required. We discussed with the manager considering review of these arrangements to ensure the transfer between the properties was as safe as possible.

We had difficulties establishing from both conflicting assessments and care plan information whether one person was administering their own medicines or whether staff did this. We eventually verified that it was the person's preference to manage their own medicine and they were able to do this safely. The manager undertook to ensure records were updated to show this clearly.

Medicine administration record (MAR) charts we reviewed contained no omissions of signatures. Nursing staff carried out regular checks to ensure that medicines were accounted for. We found only one minor anomaly in the three audits we reviewed and concluded with the home's clinical lead that staff had administered a medicine but omitted a signature.

We found that one person had their medicines administered covertly in their food. There was an appropriate and documented consultation process about the person's ability to understand and give informed consent to having their medicines. This involved clinical staff at the home, a family member and the person's doctor. We discussed with the registered manager and clinical lead that it was appropriate to consult the pharmacy. This was to make sure that the medicines prepared in this way would not be impaired.

Good

Is the service effective?

Our findings

People received support from staff who were properly trained and supported to meet their needs. People told us that staff, "…know what they're doing." They felt that staff understood their needs and were competent to meet them.

Staff told us that the training opportunities were good. They described training as a mix of DVD training with workbooks and face-to-face training. They said that training that needed renewal, for example in the use of equipment to assist people with mobility or in first aid, was updated regularly. We confirmed this from training records for the staff who worked regularly in Oak Bungalow. Records showed there were some slight slippages where training was overdue and that updates were being arranged. Staff had also completed training in the specific needs of people using the service, for example in relation to brain injury and behaviour that may challenge the service.

One staff member told us how they had completed 'shadowing shifts' during their induction, working alongside more experienced colleagues. They said that they felt that this helped them understand how to meet people's needs and to gain confidence in their role. Records for two new staff showed they were completing the Care Certificate, which is recognised as representing best practice in induction.

Staff told us that they had opportunities to achieve qualifications in care if they wanted to pursue this. Training records showed that regular staff either already had qualifications in care, or were working towards them, if they were not undergoing induction and not qualified nurses. This confirmed what the registered manager told us in their Provider Information Return. Staff said they felt well supported by their line manager and received supervision regularly. They also said that they could raise any matters of concern at any time if they felt they needed to.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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 were aware of the importance of ensuring people understood the decisions they needed to make about their health and welfare and sought people's consent. People told us that staff asked for their permission before assisting them with care tasks. They said that they were able to make decisions for

themselves. We heard staff asking people whether they needed assistance. Staff spoken with recognised that people's capacity to make informed decisions about their care could fluctuate with their health. They said that sometimes people might need more explanation to assist them or more time to make their decision.

Where a person's capacity to make a specific decision was in doubt, we found that staff followed a clear process reflecting the principles of the MCA. Staff had assessed with other parties, that they were not able to understand essential information about their health. Records showed the process staff had followed to assess whether the person understood the importance of accepting treatment and to agree what represented their best interests. The management team was able to tell us how the capacity of another person, to make a significant lifestyle decision was under review, involving the person and others who knew them well.

The manager understood when to make an application to deprive someone of their liberty in order to ensure their safety. At the time of our visit, no one who received care in Oak Bungalow had needed this to happen.

People had enough to eat and drink to meet their needs and promote their welfare. People told us that they liked the food, could use the microwave and make drinks when they wanted to. They said they were able to make choices about what they would like to eat. Staff supported one person to prepare their own meals and they chose to eat their main meal at lunchtime. During the meal, we heard conversation and laughter between the person and a staff member, helping to create a relaxed and informal experience for the person concerned.

People's risk of not eating or drinking enough was assessed within their plans of care if it was appropriate. We noted that one person's assessment was partially completed but this was because the person did not want to be weighed when they arrived at the home. They had agreed to this monitoring intermittently since then.

Staff supported people to maintain their health and access advice about this when they needed it. One person told us that staff had, "…a really good understanding…" of their underlying health condition and how this affected them.

People, staff and records confirmed that support with people's health was available from nurses based in the nearby service. There was also a team of therapists on site providing physiotherapy, occupational therapy and psychology support. We noted that, where appropriate, staff supported people to see their GP, dentist or other healthcare professionals.

Good

Is the service caring?

Our findings

People told us they could choose where they spent their time and preferred to be in their rooms, the kitchen area, the garden or out in the community. They acknowledged that the home was short of storage space and told us that they did not use the lounge much. They agreed that it was not as homely as it could be.

We saw that equipment was stored in the lounge, for example, an armchair, commode and old printers piled in a corner, compromising its appeal to people living in the home. There were no pictures on the walls but two were propped on the hearth. In the other corner of the room, there had been some effort to screen an area used for storing folding chairs and a gazebo. People did not feel this limited their choice because they did not want to use their lounge. However, it did not present a homely appearance should the clientele or people's wishes change.

People told us they were able to decide how they wanted their rooms arranged. Two people showed us their rooms and we saw that these reflected people's interests and preferences. One person had arranged for the garden outside their room to be landscaped so they could enjoy using it or looking at it through their patio doors.

People told us that they were able to make choices and be involved in decisions about their care. One person told us that they could make decisions about what they wanted to do and what support they needed. We could see that they had signed some of their records to show their agreement when staff discussed these with them. Another person told us how they did not like to join in reviews about their care plan and paperwork. They described this as making them not feel as if they were, "…a person…" but said it was their choice whether they participated or not.

People were able to make positive and caring relationships with staff. People had some say in who supported them when they felt they had a particular rapport with staff. For example, one person told us, "I have asked for particular carers and, if they are around, [care manager] will sort it." They told us that the service respected their wish to receive support with personal care from staff of the same gender. They went on to say that they felt staff were good at, "…letting people be themselves." Another person told us that they liked the staff and, "They're all good."

Staff promoted and respected people's privacy, dignity and independence. A person living in the home told us how staff supported them to be independent as much as possible, taking into account their fluctuating health each day. Staff were able to describe how another person's independence had been encouraged over time so that they had gained confidence and skills in the community.

We observed that staff spoke with people in a respectful manner and knocked on doors before entering people's rooms to offer assistance. Staff knew about one person's wish not to be disturbed at certain times and the person told us this was respected. A person commented to us that they had raised concerns about staff completing people's daily care records using the kitchen. They said that they felt this was an intrusion in people's home and that staff should not use this area to do their paperwork. They told us how staff had

changed the arrangements and respected their wishes.

People were able to receive visitors when they wished and supported to stay in touch with their family. One person told us how they were looking forward to a birthday celebration with their family in the near future.

Good

Is the service responsive?

Our findings

People received support that was centred on their individual needs. People told us that they were involved in reviews of their care if they wanted to be and felt that staff supported them in the way they wanted. One person commented to us that they could not remember what was in their plan of care or whether staff had spoken to them about it. However, they knew that sometimes they could not remember things well and were happy with the support they received.

Another person told us that their needs had changed a lot since they had started to need care. They said that staff understood this, adapted well and supported them flexibly. Staff spoken with commented that every day was different in the support that they needed to offer.

We noted that some records showed people had identified goals they wished to achieve, for example, to increase their health and independence. People's progress was not always clear in records but our discussions and observations showed that these people were making progress.

People's care plans and assessments of risks or needs were reviewed regularly. There was basic information about people's needs within the home but full details were held in the nearby service. However, staff said they had enough information about the support each person needed. They gave us clear information about each person's needs, how these had changed over time, and what support they needed. They described each person as individual and knew about people's histories, interests and preferences. Records of the support that staff offered showed this matched people's assessed care needs.

People told us about their hobbies and interests. Staff described to us how people liked to spend their time and what they enjoyed doing. This corresponded with what people told us. Most people were able to initiate activities for themselves and people told us that they had things to do which they enjoyed. They told us that they could go to the nearby service for larger group activities if they wanted to and one person did this on a daily basis.

People told us that they could complain and raise complaints if they needed to. Those spoken with told us that they usually raised any issues with the care manager overseeing the site. They were confident that the staff member would listen and sort out their concerns. They told us they could also speak to the registered manager if they needed to. They told us that they had no complaints and were happy with the service they received. During our visit, the registered manager spoke with someone about a potential concern so that they could deal with this at an early stage if it was a problem.

Good

Is the service well-led?

Our findings

People living and working in the home were empowered to express their views about it. We found that there were surveys for people to complete and to express their views. People were less clear that they were formally consulted as part of monitoring visits completed on behalf of the registered provider. However, one person described that they were normally out during the day and so they may have missed the opportunity to present their views. Another person told us how staff knew they would not want to be disturbed if they were resting when these visits took place.

People said that they were able to make suggestions for improvements to staff or a member of the management team if they needed to. The only frustration they expressed to us was that it sometimes took a while to respond to repairs if these did not directly affect people's safety. They told us that they understood that sometimes it took a while to get expenditure approved by the provider's head office.

We found that the provider's consultation process asked for people's views across the services on the site. Checks on quality and safety were also completed across these services. This included monitoring of health and safety, sample audits of care plans and care records, and management of people's medicines. We discussed with the registered manager that this made it more difficult to identify whether they needed to make separate and specific improvements at Oak Bungalow. The registered manager confirmed after our visit that they were taking action to ensure some separation of processes. This would contribute to ensuring there was a programme of continual improvement specifically for Oak Bungalow as a care home in its own right, separately registered with the Care Quality Commission (CQC).

Staff were well motivated to carry out their duties. They were positive about morale and communication within Oak Bungalow. One staff member said that they felt the team worked very well and got on well together. They told us that the provider had asked for their views in a questionnaire in the past. They also told us that they felt able to raise suggestions and ideas with the management team. Another staff member told us that morale was good and that there was a nice atmosphere in the home.

The service had a stable and consistent management team, based at the nearby larger home. In addition, there were clinical staff and a team of therapists to provide additional advice and support for staff in relation to care for people using the service. The registered manager provided us with information about other groups and networks they were part of, to ensure they were aware of best practice and developments within the care industry. The management team had an understanding of one another's roles and the care manager took an active role in overseeing staff deployment and supervision at Oak Bungalow. Staff and people using the service said they felt that this made the management team accessible and visible to them.

The registered manager understood the notifications that they had to make to the CQC about events happening within the service. They had completed the form we sent to ask for information about the service in a prompt manner and understood the requirements upon them to comply with information requests.