Healthcare Homes Group Limited

Oaklands House Residential Home

Inspection report

Oaklands House
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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 1 November 2016. Oaklands House is a residential care home that provides accommodation and personal care for a maximum of 29 people. There were 29 people living in the service at the time of our inspection.

Our inspection of 27 July 2015 found that there were not sufficient staff. At this inspection we found that improvements had been made and there were sufficient staff to meet people's assessed needs.

On the day of our inspection the manager had not registered with the Care Quality Commission but we are aware that they have applied to register and are going through the registration process. 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.

Medicines were stored, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records. However, we noted on the day of our inspection that one person was not getting their medicine as prescribed. This was immediately addressed by the manager.

People's individual assessments and care plans were person-centred, reviewed monthly or when their needs changed. However, one care plan we looked at contained errors and contradictions. The service was developing records of people's life history but this was not detailed. Clear information about the service, the facilities, and how to complain was provided to people and visitors.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There was a robust system of monitoring checks and audits to identify any improvements that needed to be made. The results of these audits were monitored by the provider. The management team acted on the results of these checks to improve the quality of the service and care.

There was a development plan in place which addressed areas for improvement identified by the manager and area manager. This identified timescales and the person responsible for driving the improvement.

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.

There were sufficient staff to meet people's needs. Recruitment checks were carried out to ensure people were suitable to work in the service.

There were systems in place to minimise risks to people and to keep them safe.

Procedures were in place, and staff were trained to protect people from the risk of abuse.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the knowledge and skills necessary to provide the required care and support.

People's freedom and rights were respected by staff who acted within the requirements of the law.

People's health and wellbeing were monitored and they were supported to access healthcare services where necessary.

Is the service caring?

Good

The service was caring.

People had developed positive, caring relationships with staff.

People and their relatives were encouraged to express their views and felt these were acted upon.

Staff involved people in the decisions of daily living.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Information in care plans was not always accurate and was not

sufficiently detailed to enable staff to know the person.

People were supported to engage in activities and avoid social isolation.

People were encouraged and supported to maintain relationships that were important to them.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted an open and positive culture.

The provider and the management team sought feedback from people, their representatives and staff about the overall quality of the service.

Emphasis was placed by the management team on continuous improvement of the service. A comprehensive development plan was in place.

Oaklands House Residential Home

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 the 1 November 2016 and was unannounced. The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of caring for an older person.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered information which had been shared with us by the local authority and healthcare professionals. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the service.

During the inspection we spoke with eight people living in the service, three members of care staff, the cook, the manager and the provider's area manager. We carried out casual observations in the service. We reviewed the records kept by the service, including staff training records and procedures, audits, three staff files and information regarding the upkeep of the premises. We also looked at four care plans and risk assessments along with other relevant documentation to support our findings.

Good

Is the service safe?

Our findings

Our inspection of 27 July 2015 had found the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were not sufficient staff to meet people's needs in a timely manner. This inspection found that there were sufficient staff deployed in the service to meet people's needs. Staff felt that the staffing levels were sufficient to meet the needs of the people they supported. People told us they felt there were sufficient staff and that they did not have to wait long for call bells to be answered.

The registered manager told us that the number of staff on duty was assessed by using a dependency tool which related the number of staff required in the service to the needs of individuals. They told us that since the last inspection more staff had been employed. This included two supper cooks which had allowed care staff to concentrate on providing care and support.

On the day of the inspection, we observed Oaklands House to be calm with a relaxing atmosphere. Staffing levels were sufficient to allow people to be assisted when they needed it and people received care in a timely manner. We saw staff giving people the time they needed throughout the day, for example when accompanying people to the toilet, and helping people to move to the dining area at meal times. Staff were relaxed and unrushed and allowed people to move at their own pace.

Policies and procedures were in place to support the safe administration and management of medicines. Medicine records showed that each person had an individualised medicine administration sheet (MAR), which included a photograph of the person with a list of their known allergies. Records confirmed medicines were received, disposed of, and administered correctly. People confirmed that they received their medicines on time. People's medicines were securely stored and care staff had received appropriate training in the administration of medicines. Medicine audits were completed regularly. These looked for any omissions on the MAR charts or any errors in the administration of medicines. Where omissions or errors had occurred, systems were in place to take appropriate actions, such as further training for care staff. However, whilst observing medicines being administered we saw that one person had not received their eye drops as prescribed. The member of care staff administering medicines told us that this was because the person was having their lunch. We addressed this with the registered manager and they have confirmed that the person now receives their eye drops before they go to lunch.

People were protected from the risk of abuse because staff had received safeguarding training that helped them to understand, recognise and respond to abuse. Staff were confident of raising concerns either through the whistleblowing process, or by escalating concerns to the registered manager and provider or to outside agencies where necessary. One member of staff said, "I know where the whistleblowing folder is, and although I would not like to have to do it, it is important for us to protect the residents."

The service had systems in place to monitor risk to people. This included regular monitoring of people's weight and any pressure ulcers. These audits were monitored by the provider to ensure the service was addressing any issues appropriately.

Risks people may be subject to from the environment or as a result of their own care or treatment needs were assessed; risk reduction measures were implemented and staff were provided with guidance on how to support people safely. Risk information was kept updated and reviewed regularly to evaluate how effective risk reduction measures were or whether further amendments and changes were needed to reduce risk levels further. Staff demonstrated knowledge of potential risks to people and their role in minimising these when providing care. The premises and equipment were managed to keep people safe with regular maintenance and safety checks. We observed that an emergency bag was kept near the front door in case the service needed to be evacuated due to fire.

The service had recruitment procedures in place to ensure that staff were suitable for the role. The process included identity checks, employment history and references. Staff were subject to criminal checks made through the disclosure and barring service (DBS).These checks are to assist employers in making safe recruitment decisions by checking for any criminal history of those who wished to work at the service.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. People were happy with the care they received and told us that it met their needs.

From the staff training records and discussion with staff we found they received training and support which equipped them for their roles. All staff completed induction training when they commenced work in the service. This included an initial orientation and training in the care certificate. The care certificate is an identified set of standards that health and social care workers need to meet to provide good quality care.

There was a rolling programme of training which included safeguarding, moving and handling and mental capacity. Records showed that not all staff were up to date with training. However, we saw that the registered manager and area manager were aware of this and had taken steps ensure staff received their training within a specified time scale.

Staff told us that they received regular supervision. One member of staff said, "I have supervision it is normally a one to one chat." Staff supervision records we saw showed that staff had received supervisions but they did not demonstrate that these meetings with their line manager had been used to improve their performance as the section of the form which would show this had been left blank. However, staff told us that they did receive personal development within the service. This was demonstrated when the deputy manager told us they had worked their way up from being a member of care staff, through being a senior carer to their present position.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The registered manager was aware of the application procedures for a DoLS authorisation but told us that at present there were not authorisations in place for the service.

Staff understood the relevant requirements of the MCA and put what they learned into practice. We observed staff spoke with people and gained their consent before providing support or assistance.
People were supported to have sufficient to eat and drink and maintain a balanced diet. One person said, "The food is excellent." Another person said, "I like a glass of sherry with my meal." We saw that they had a sherry with their meal.

We observed the lunch time meal. 20 people sat down in the service dining room to eat. The tables in the

dining room were dressed with place settings, tablecloths and condiments. The food was served efficiently with silver service for the vegetables. Nobody had to wait for their meal. People told us they were offered choice as to what they would like for their meal. One person said, "We are asked for our food choice for the next day."

People's weight and nutritional intake were monitored in line with their assessed level of risk and referrals had been made to the GP and dietician as needed. Risk assessments had been carried out to assess and identify people at risk of malnutrition of dehydration and appropriate actions put in place. We spoke with the cook who was aware of people's nutritional requirements and how these were met with fortified food or a specific diet.

People were supported to maintain good health and access healthcare services. We received excellent feedback from the community matron. They told us, "The manager and staff have to be very flexible and supportive in their approach, follow instructions and closely monitor conditions and changes in these conditions. We have found the care of a high standard, the staff always ask for help, report changes and concerns appropriately and offer very resident focussed care." Care plans showed that referrals had been made to other health care professionals such as the chiropodist and optician, when necessary.

Good

Is the service caring?

Our findings

People had developed positive caring relationships with staff. We observed that when one person had their grandchild visit, the staff knew the child and offered them a drink.

We observed the service had a friendly and welcoming atmosphere. Staff spoken with were enthusiastic about their job and understood their role in providing people with compassionate care and support. We observed staff taking action when people required support. For example, when one person expressed that they were cold, a member of staff went and fetched a cardigan from the person's room.

People were supported to express their views and be actively involved in making decisions about their care and support. An example of this was when people made their meal choice. The service had changed the day that people chose their meal from the day before the meal, to the day of the meal. This was changed back as people using the service were not happy about it. One person said, "We are asked for our food choice for the next day at lunch time, they tried to change it but we didn't like that, so we all asked for it to be changed back." We observed people completing their choice of food for the next day during the lunch meal.

We observed that people were encouraged to express their views as part of daily conversations and through resident's and relatives meetings. Minutes of meetings demonstrated that people had been involved in deciding where the service was going on outings. One person told us, "I like the trips in the mini bus but we have a rota because we can't get all of us who want to go on board." People also told us that the autumn menu had been selected at a recent meeting.

Staff told us how they consulted with people and involved them in making decisions. We observed people being asked for their opinions on various matters and being involved in day to day decisions, for example where they wished to sit.

People's privacy and dignity were respected. One person said, "You can have a private word [with the registered manager] if you need to." People could spend time alone in their bed room if they wished, or join others in the two communal rooms. We observed care staff knocking on people's bedrooms and awaiting a response before entering which appeared to be normal practice.

People were supported to be comfortable in their surroundings. We saw that people were able to personalise their bedrooms with their own belongings and possessions. This helped promote a sense of comfort and familiarity. For example, some people had photographs of themselves or others had a photograph with a family member.

Requires Improvement

Is the service responsive?

Our findings

Care plans covered a range of people's care needs such as diet, mobility, medicines, mental and physical health and social needs. They were reviewed and updated regularly. However, people's care plans did not contain any information about people's personal history, individual preferences, interests and aspirations. We asked the registered manager and area manager about this. They told us that the service was currently working on a "This is me" profile for each person. They showed us a number of these that had been completed. However, the documents they showed us were designed to be used to go with a person when they went into hospital and did not contain details which would support staff with providing individualised care.

Some care plans we looked at contained errors or contradictions. For example one person's diabetes care plan stated in one section that their sugar levels could be checked randomly, however, in another section the care plan stated, "They are now checked weekly" with the risk assessment saying that they should be checked twice weekly. This contradictory information could mean that the person did not get their blood sugar levels checked when necessary.

Care plans demonstrated that people had been involved in writing them. People we spoke with did not always recall being involved in any reviews of their care but care plans demonstrated people's involvement with a signature. During our inspection, it was clear that staff knew people well and were aware of their care and support needs.

Care plans contained details of how individual conditions were managed. For example, the care plan for one person who lived with diabetes contained an explanation of their medicines, diet and how their diabetes was managed. This meant that staff knew what support the person needed with this condition. However, as demonstrated above this information was not always accurate.

People were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid social isolation. During our inspection, we saw that people had visitors and visiting friends in the sheltered bungalows which were part of the same complex. Another person was observed going out with their family.

The service had an activities co-ordinator who told us, "The residents are asked regularly what activities they would like to do." They went on to explain that they had noticed that people preferred to join in activities in the afternoon. We observed people participating in a game of bingo in the afternoon. The bingo cards had large numbers on them so that people with poor eyesight would be able to join in the game. We also saw people decorating cakes which they later ate with their afternoon tea.

People were encouraged to remain as independent as possible and to feel valued. Two people told us that they liked to dust and clean their own rooms but received help from staff for places they could not do.

People told us that they knew how to complain but had not had any cause to complain. The service

complaints policy was clearly displayed in the service reception. Records demonstrated that the one complaint the service had received in the past year had been investigated and resolved according to the policy.

Good

Is the service well-led?

Our findings

People were complimentary about the way the home was run. One person said, "I've come back to the Ritz." Another person said, "The atmosphere is very good here." A commissioner of services told us that several people they had placed at the service on respite care, after experiencing the care provided had decided to live in the service permanently.

The manager had previously been the deputy manager at the service and was in the process of applying for their registration with the CQC. They were supported by a deputy manager and the provider's area manager. Management responsibilities were clearly defined and the provider had a senior management structure that oversaw Oaklands House and their other services.

The manager ensured they stayed up to date with developments in the industry through attending regular regional meetings with other managers and support from the area manager. The manager was working towards further qualifications in the health and social care industry.

Staff were enthusiastic about their role which was reflected in the way they provided care and support. One person told us, "My children didn't want me to move here, but it was my choice and I have enjoyed living here." Staff were positive about the support they received from the manager and appreciated their style of leadership. They described the manager as "supportive."

The manager and the provider's area manager were both relatively new to their post and were working together to improve the quality of the service. There was a comprehensive Home Development Plan in place which was addressing some of the concerns identified at this inspection. The development plan provided the names of people who were responsible for dealing with actions with a timescale for when these would be completed. It had been regularly reviewed and updated. This reassured us that the management team were aware of where the service needed to develop and had plans in place to achieve this.

The service regularly sought people's views on the quality of the service provided with residents meetings and quality surveys. People told us that if they were not happy with the quality of the care provided , they would have no qualms approaching the manager. The service improvement plan addressed the availability of minutes of meetings to people to further engage with people.

The registered manager and area manager were open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service. The service's policies and operating procedures were appropriate for the type of service and were clearly summarised, to help staff when they needed to refer to them. They were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance. Records were kept securely and confidentially.