Oatleigh Care Ltd

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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

Oatleigh Care Ltd is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 43 people across three separate units over three floors, each of which have separate adapted facilities including dining rooms and sitting areas. There were 38 people using the service when we visited.

This unannounced inspection took place on 24 October 2017. At the last inspection on 8 September 2015, the service was rated Good. At this inspection we found the service remained Good.

The service had a registered manager who had worked at the service for several years. 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.

People's medicines were administered, handled and managed safely. Risks to people were assessed and plans put in place to mitigate risks. Staff were trained on safeguarding adults from abuse. They were knowledgeable on the procedures to protect people from abuse. There were sufficient staff available to meet people's needs safely.

The environment was safe and well maintained as health and safety checks were in place. The service was clean and free from odour. Staff followed infection control guidance. Staff reported incidents and accidents and the registered manager reviewed them and used them to improve the service.

People received food and drinks to meet their nutritional needs and dietary requirements. Staff were trained, supported and supervised to provide effective care to the people and to carry out their duties effectively. People were supported to access various healthcare services to meet their needs.

People consented to the care and support they received. The service complied with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained and understood their responsibilities.

Staff were kind and compassionate to people. We observed that staff treated people with respect and promoted their dignity. Staff knew how to communicate with people in the way they understood. Staff also understood people's emotional needs. Staff provided people with the comfort and reassurance they needed in times of agitation and distress.

People at the final stages of their lives were supported in line with their wishes and they were cared for in a dignified way.

People's individual needs were assessed, planned and delivered in a way that met their needs and preferences. People and their relatives were involved in the review of their care needs. Care plans were updated to reflect people's current needs.

People were kept occupied and encouraged to participate in activities they enjoyed. The service sought the views of people and their relatives and used these to improve the service. People and their relatives knew how to complain if they were unhappy about the service. There were regular quality checks which took place to assess and monitor the quality of service 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? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Oatleigh Care Ltd

Detailed findings

Background to this inspection

We carried out this comprehensive 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 inspection visit took place on 24 October 2017 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor and an expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a registered nurse.

Before the inspection we studied the information the provider sent to us in the Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service which included notifications of events and incidents at the service. We planned the inspection using this information.

During the inspection we spoke with the registered manager, nominated individual, four people who use the service, four relatives, six care workers, two team leaders and one activities coordinator. We looked at eight people's care records, and medicines administration record (MAR) for the 38 people using the service at the time of our visit. We reviewed six staff records and other records in connection with the management of the service including complaints, health and safety and quality assurance systems. We carried out observation of how staff provided care to people.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe using the service. One person told us, "I feel very safe here. [The staff] treat us alright. I have no concerns." Another person said, "I have no worries here about safety. The staff are always here for us when we need help." One relative said, "Yes well treated. I visit every two days. [My loved one] is well looked after. I've noticed the carers also look after people less active. They are patient with them." Another relative told us, "Very safe, there are good safety precautions…no stairs for them to negotiate. They are well treated."

People continued to be protected from the risks of abuse and neglect as the service ensured there were up to date policies and procedures in place. These included safeguarding adults from abuse, whistleblowing and anti-discrimination and harassment to protect people. Staff were also trained in safeguarding vulnerable adults from abuse and they understood the different types of abuse, signs to recognise them and how to report any concern to their manager in line with their procedure. Staff we spoke with were confident that the registered manager would take appropriate action to protect people if they reported any concern. One staff member told us, "Abuse is a bad thing. I will not let it continue. I must report. Believe me [registered manager] will take it seriously." Another member of staff said, "Any form of abuse is horrible. I would report it to the manager. I am aware of the whistleblowing policy. I can raise my voice anytime." We were aware there had not been any allegations of abuse in the last 12 months. The registered manager and provider were aware of their responsibilities to adequately protect people and responded to allegations of abuse in accordance with their local authority safeguarding procedure. They also knew to inform CQC of any incidents of abuse.

The service maintained people's wellbeing, health and safety as they continued to ensure risks were thoroughly assessed. Comprehensive management plans were developed and implemented to minimise identified risks to people. This included risks such as wandering, going missing, skin integrity, pressure sores, choking, falls, malnutrition and hydration; behaviour and mental health. We saw one person had a missing person plan due to their inclination to leave the building which was a risk to their safety and well-being. The plan included brief description to identify the person, possible places to locate the person and people to contact. The service also developed plan to manage this person's behaviour such as engaging them in activities to keep them entertained and observing them.

People at risk of choking had care plans developed with the involvement of speech and language therapist (SALT). We observed that their care plans followed the recommendations of SALT to reduce the risk of choking. During our inspection we observed and confirmed that people were supported in line with their care plans.

People had a Personal Emergency Evacuation Plans (PEEP) with information about the risk level associated with evacuating them safely in the event of a fire. Staff also knew what to do in case of an emergency to keep people safe.

The health and safety of the environment was well maintained. Assessments of fire, legionella, security, gas safety, electrical and infection were conducted by external contractors in the areas to identify potential hazards. We checked the recommendations that had been from these assessments made and they had

been completed. Record showed that regular fire drills took place so staff knew what actions to take in event of a fire. Weekly checks of fire alarms also took place to ensure they were functioning properly. Fire extinguishers, smoke detectors and other fire management equipment were serviced and maintained annually by professional contractors to ensure they were in good working condition.

The service retained an adequate level of staffing and staff were appropriately deployed to safely meet people's needs. One relative told us, "There seem to be more when she initially came in but there always appear to be three." Another said, "Yes, there are enough staff. They look after her during the night too." A third relative told us, "I think there are enough staff. There are enough staff to help." Staff told us they were enough on each shift to support people. One staff member told us, "We are enough on each floor. If we need more, they can increase it. It depends on how many residents we have." Another staff member said, "The number of carers in morning and evening is good. We manage well. We look after people alright. Sometimes when it is busy they send more carers to help us." We checked the rota and it showed there was adequate cover during the day and night as indicated in the staffing planning tool. We saw that any requests for help were responded to quickly and staff supported people in an unrushed manner. The registered manager told us staffing levels were planned according to people's needs. Planned and unplanned staff absences were covered internally by bank staff or by staff willing to do extra shifts as overtime. This ensured people received the support they required from staff.
The provider ensured their recruitment practices were safe. Recruitment records contained at least two satisfactory references and criminal check result. Applicant's experiences, knowledge and qualifications were also checked during interview which formed part of the recruitment process. This ensured only suitable staff were allowed to work with people at the service.
People's medicines remained managed and administered in a safe way. Staff who administered medicines were trained and assessed as competent to do so. Medicine administration record (MAR) charts were correctly and legibly signed. MAR noted people's allergies so staff knew what medicines were unsafe for people to take. Medicines were locked away in the clinic room and only senior staff had access to the room. The temperature of the room was checked regularly to ensure it was within safe storage of limit. Medicines audit were carried out regularly by team leaders to ensure medicines were administered as prescribed and all medicines were accounted for.

The service was clean and free from odour. There were domestic staff available and we observed that they and the care staff follow good infection control principles. For example, we saw them use personal protective equipment appropriately. There were adequate clinical and waste disposal systems available.

The service learnt from incidents to protect people from avoidable harm. Records of accidents and incidents were maintained. The registered manager reviewed incidents records and took action to reduce recurrence. For example, one person's had a missing person plan in place following an incident of them going missing.

Good

Is the service effective?

Our findings

People continued to be cared for by staff who received training and support to be effective in their roles. One person told us, "They [staff] are very good. They care for us alright." Another person said, "The carers' know their jobs and they do it well." A relative told us, "Yes, I think the carers are trained." Another relative said, "They [management] check their [staff] competency and they get a certificate. They do the job as they should."

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they had received an induction and had completed mandatory training when they began working at the home. A member of staff said, "I had the Care Certificate Induction with 15 modules. It covered everything I need to know about the job." Another staff member told us, "I have done many trainings and I am still learning. I completed the Care Certificate induction when I started." Records confirmed that staff had completed the Care Certificate induction which is the benchmark that has been set for the induction for health and social care staff. Records also showed that all staff had completed training in core areas of care delivery including moving and handling, safeguarding, health and safety, dementia care, dignity and privacy, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). There was a training planner in place which monitored to ensure that staff training was kept up to date.

Staff told us and record confirmed that they were supported through regular supervision and an appraisal of their performance. One staff member said, "I have supervision often…I feel supported and we work as a team." Another staff member told us, "I receive one to one supervisions every three months. If I want they [the management] can do more. The managers are supportive to us. I can speak to them about anything even personal issues." Notes of supervision meetings covered performance related issues, standard of work, care provided to people and training required. Annual appraisals of staff performance also took place and staff were given formal feedback about their performance and goals were set so they knew their strengths and weaknesses; and areas of development.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA. The provider ensured all staff had been trained in the MCA. Staff understood their responsibilities to ensure people consented to their care and support before they were given. Staff knew to involve people's relatives and other professionals in decision making if the person was unable to give their consent of if there were doubts about the person's capacity to make informed decisions. Record showed that staff had assessed people's ability to consent to

various aspects of their care. Care records noted the support people required to help them in making decisions. For example, providing information in a clear format and discuss issues when people were alert. Where people lacked capacity to make decisions, we saw that their relatives had been involved in helping to make decisions in their best interests. Where people lacked capacity to make decisions, best interest meeting were carried out with professionals to ensure decisions were made to people's advantage.

.. Staff understood their responsibilities in ensuring they followed the requirements of the DoLS. The registered manager continued to submit DoLS authorisation applications to the local authority as required to ensure they did not deprive people of their liberty unlawfully. We saw that DoLS in place were valid and their conditions complied with.

People's nutrition and hydration needs continued to be met by the service. People told us they liked the food provided to them. One person said, "The food taste nice. I enjoy it." Another person told us, "Lunch was lovely. I enjoyed it. The food here is always very good." A relative told us, "The food seems to come up fresh. She mainly eats it all." People's nutritional and dietary requirements were recorded on their care plans. Support people need to eat and drink was also included to guide staff. One relative confirmed that people received the support they required. They said, "They get a special diet because they can't swallow. The staff feed them." Another relative told us, "I see the staff during meal times helping people to eat."

During our observation at lunchtime, we saw that staff offered choices of food and drink to people. People were given the support they required as recorded in their care plans. For example, staff supported people to cut their food into small pieces where this was part of their care. We saw staff supporting people unable to eat independently themselves. People received food that met their health or religious requirements. One person had food prepared in accordance with their faith. Food was served to people in a presentable way. People ate in their own pace and in relaxed atmosphere. People were offered and encouraged to have drinks and snacks at regular intervals throughout the day.

The service remained effective in assisting people to access healthcare services they needed. One relative told us how the service liaises with community district nurses to visit regularly to dress their loved one's wound. Record showed that people had regular visits from a range of health professionals, for example, G.P's, psychiatrists, physiotherapists, diabetic nurses, dentists and chiropodists. One person told us how staff had made a referral to the audiologist to sort out their hearing aids. Another person told us they had been booked to see the optician about their glasses. A third person commented, "They [staff] are very good in arranging appointments to attend to us quickly." We saw that staff followed doctors' recommendations and prescriptions with regards to changes in people's medicines and treatment plans.

Good

Is the service caring?

Our findings

Staff consistently treated people in a caring manner. People told us staff were kind and understanding towards them. One person said, "The staff are nice to all of us. They are patient and listen." Another person told us, "People [staff] here have been absolutely wonderful to me. I am no longer poorly." One relative told us how staff cared for their loved one who displayed behaviour that challenged staff. They said, "[Staff] are very understanding and patient." Another relative told us, "I see the [staff] when I visit and they are lovely and polite."

We observed staff interacting with people. Staff spoke to people in a polite and gentle way. There was a sharing of laughter and jokes. We also observed staff engaged with people who were less able to interact verbally. Staff took a position where could maintain eye contact with people. They communicated with them in the way they could understand using low and soft tone of voice, gestures and gentle and appropriate touch. People were comfortable and relaxed in staff presence.

Staff understood what people liked and disliked; things they appreciated and how to calm them down when distressed. We observed staff support a person who was agitated and restless. They maintained a calm approach and gave the person time and space to express themselves. Staff enabled the person to relax. They engaged them in conversation that interested them and held their hands to reassure them. Staff also knew what made people agitated and confused. Staff ensured they avoided what made people agitated. For example, staff ensured people sat during mealtimes in the positions they preferred and with people they were familiar with.

Staff consistently and continuously respected people's privacy, dignity and self-worth because the service had trained staff in dignity in care. A relative told us "They give her a shower in the morning. They don't demean her." Another said, "She's always neatly dressed and presentable." We saw staff ask for permission before going into people's rooms. We saw staff adjust people's clothes gently and respectfully. Staff gave us examples of how they promoted people's dignity and privacy. One staff member said, "When you help people with washing. Do not expose them unnecessarily." People's beliefs, cultural values and religion were maintained and promoted. An assessment of people's needs and requirements in relation to their religion, culture, disability, relationship, gender and sexuality was completed when they joined the service. Care plans noted what people needed d to meet these. People had the opportunity to choose which gender of staff provided personal care to them. Religious services were regularly held and people were supported to attend if they wished. The service was wheelchair accessible so people with physical disabilities were not restricted. People's cultural and religious foods were catered for. For example, people had halal food as they required. Halal is the type of food standard permissible in Islamic religion. The activities provided in the service also covered a range of religious and cultural celebrations. For example, at the time of our visit the Divali festival had just been celebrated.

Staff encouraged people to maintain contact with their friends and family. Relatives and friends of people were able to visit as they wished. We saw relatives having private time with their loved ones in their rooms or

in communal areas without interruptions.

The service supported people as they wished as they approached the end of their life. Care records detailed their Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) status. This had been put in place in consultation with people, their relatives and GP. There was an end of life care plan in place for people at this stage and it covered if people wanted to spend their final days. Staff understood these plans. The service continued to liaise with the local palliative care team as required to ensure people received care to meet their needs.

Good

Is the service responsive?

Our findings

The service continued to deliver care and support to people that met their individual needs. The service carried out initial assessment of people's needs to establish they were able to meet them fully. People and their relatives told us they were involved in planning their care. One relative said, "I tell them what [My loved one] likes and they will act on it." Another relative told us, "Yes, I am involved. They discuss [my loved one's] needs with me and I make suggestions." Care records also showed people and their relatives had input in the review of their care needs, where this was appropriate and their views taken into account.

Care plans provided details of how people's need would be met. It covered their physical health, mental health, social needs and activities of daily living. One person's care plan stated how staff were to support them to manage their level of anxiety, confusion and sleep disturbance at night. It stated "Staff to spend time with [person name] chatting with them to settle them. Offer them a book to read as they like reading. Provide reassurance." Staff understood what support people needed and they supported them in the way that met their needs.

Staff knew people's preferred routine, patterns and behaviours. We saw a staff member offer a cup of tea to a person and then gave them a magazine. The staff member told us that was the person's routine at that time. We spoke to the person and they confirmed this to us. Staff knew when people liked to go to bed and when they woke up in the morning. Daily logs showed staff delivered care to meet people's needs and preferences.

People's needs were regularly reviewed and updated to reflect any changes. We saw care plans were updated following hospital admissions to note changes to their health conditions and support. One person's care plan was updated to highlight their frequent falls and the support they required with this. People's personal details and profiles were also updated as required to reflect their current circumstance. For example, if contact details changed.

People were supported continue to maintain their independence. Staff told us they encouraged them to do as much as possible for themselves. People were provided with mobility aids so they could walk with minimal support. Equipment such as grab rails was installed in the bathrooms and toilets to assist people to transfer independently.

People enjoyed a range of activities in the service to engage and occupy them. The service had an activities coordinator who organised activities. We saw there were individual and group activities available. We saw staff supporting people through Namaste a sensory programme; provided on one-to-one basis. It provided people with a sense of security and comfort. People enjoyed and showed signs they were relaxed.

On the day of our visit an exercise group took place in the morning and singing and dancing after lunch time. People and visiting relatives participated. They told us they enjoyed it. One relative said, "I come here to dance with [my loved one]. We have fun doing so."

We saw posters and pictures of various activities people had taken part in. They included musical performance, poetry, singalongs, celebrations of festivals, feasts and events such as St Patrick day, Christmas, barbecue parties, birthday celebrations and various occasions at the home. This showed people were supported to relax and enjoy social activities together.

People and their relatives knew how to complain if they were unhappy with the service. One relative told us, "I would initially speak to the team leader in charge. If I feel they don't resolve it I will speak to the registered manager. They don't hide themselves away. I have not raised a complaint yet. I am happy. When I ask for things they do it raise away. Another relative said, "I will go to the office. I would write to CQC if I need to. I have no complaints for now.
There was a complaints procedure which sets out three stages and provided details of how to escalate concerns to external organisations. We saw that the provider resolved concerns promptly before they escalated. For example, a relative had asked that they wanted their loved one's clothes labelled so they were easy to identify and not mixed-up with other people's clothes. This was acted on it. The relative told us they were pleased with how staff responded promptly. Complaints had been managed in line with the provider's complaints policy.

Good

Is the service well-led?

Our findings

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. They knew their responsibilities to send notifications to us of significant incidents that occurred in the service. Our record showed that they had complied with this requirement.

There was clear and visible leadership in the service. The registered manager was experienced in managing a care service of this kind. They had the support of two other registered managers who managed the other two services located within the same building. Staff told us that they received the direction, support and guidance they needed to deliver their roles effectively. One staff member told us, "All the managers listen and support us well. I can speak to anyone and they sort out my problem." Another staff member said, "There is always someone to speak to. The team leaders are here. I can speak to [registered manager] or [another registered manager." Staff also told us that the registered manager visited each unit daily and they were able to discuss any issues they may have with them.

The service continued to promote an open and transparent culture. Feedbacks were sought from people and their relatives about the service provided through meetings and satisfaction surveys. 86% of people and their relatives rated the service excellent and 13% as good. There were no actions to follow up from the most recent survey. Minutes of residents meetings showed people were asked and gave their feedback about activities, food and care and support they received. People were happy with the service they received. There were also no actions to follow up from the minute of residents meetings reviewed. Regular staff meetings were held to discuss various issues about the service delivered to people. Staff roles, their responsibilities and the standard of care expected were made clear during the meetings.

The provider and registered manager maintained effective systems through which they assessed and monitored the quality of the service delivered. The registered manager carried out daily checks around the service to identify any issues or concerns relating to people, the staff and aspects of health and safety. They said it also gave them a chance to observe how people were supported and to obtain any feedback from them. The registered manager undertook monthly audits to review people's care plans, DNAR and end of life wishes, medicine management, DoLS conditions, falls management, pressure sores, continence care, and nutrition and pain management. Monthly checks were also carried out to assess systems for managing incidents and accidents, infection control, first aid and, health and safety. We reviewed the most recent audits completed and there were no concerns to follow up.

The provider conducted an annual evaluation of the whole service including catering, activities, staffing, health and safety, environment, documentation and key aspects of care delivery. The registered manager told us it helped them improve the quality of service on an on-going basis.

The service worked in partnership with other organisations to improve the service and meet the needs of

people. They had recently taking part in dementia research conducted by a charity organisation. The research was aimed at helping identify early signs of dementia so as to aid early diagnosis and treatment. The provider had also worked with an organisation to develop and train staff on the Namaste programme. We also saw that they had partnerships with the local schools and charity and church groups who visited regularly to deliver activities to people.