Bupa Care Homes Limited

Oakhill House Care Home

Inspection report

Eady Close
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20 June 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Oakhill House Care Home on 19 and 20 June 2017. This was an unannounced inspection. Oakhill House Care Home is situated in the town of Horsham. The service provides nursing care and support for up to 49 older people, most of whom are living with dementia. On the days of the inspection, there were 42 people using the service. There are four communal lounges, two dining rooms and well maintained gardens.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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. On the days of the inspection, the registered manager was away and the service was being overseen by a regional management team.

At the last inspection undertaken on the 23 February 2016 we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to the management of people's medicines. This was because medicines were not stored correctly, not everybody had access to their medicines and the recording of topical creams was inconsistent. A recommendation was also made in relation to people's dining experience. The provider sent us an action plan stating they would have addressed all of these concerns by July 2016. At this inspection we found the provider had made improvements to people's dining experience and to the management of medicines.

Systems were in place for the ordering, storage and disposal of people's medicines. Each person had a medicine profile and people and their relatives confirmed they received their medicines when required. However, the administration of topical creams was inconsistent. Medication Administration Records (MAR charts) failed to consistently reflect if people were administered their topical cream as prescribed. The provider's quality assurance framework had identified this shortfall, yet no action had been taken. Nursing staff were regularly disrupted when administering medicines which posed a risk. Nursing staff also confirmed they felt this was an area of concern. We have identified this as an area of practice that needs improvement and have made a recommendation for improvement.

Arrangements were in place for the provision of meaningful activities and stimulation. However, these arrangements were not yet consistently embedded into practice. Steps were being taken to reduce the risk of social isolation, but these required strengthening. We have identified this as an area of practice that needs improvement.

Appropriate recruitment checks took place before staff started work. Staffing levels were based on the individual needs of people and sufficient staffing levels were being maintained with regular use of agency staff. Staff felt staffing levels could be tough at times but agreed that despite these struggles, people received good care. The provider was actively taking steps to minimise the use of agency staff.

Oakhill House Care Home had been subject to a period of instability. Staff told us that morale had been low but confirmed things were starting to improve. The provider's regional management team were supporting the service. A quality assurance system was in place and clear actions had been identified on how to drive improvement. However, these positive improvements were not yet embedded or sustained.

People told us they felt safe living at Oakhill House Care Home. One person told us, "I feel safe because everyone is very nice to me and they know my name. I have a bad memory but they all recognize me and nobody is quarrelling." Staff worked in accordance with people's wishes and people were treated with respect and dignity. It was apparent that staff knew people's needs and preferences well. Positive relationships had developed amongst people living at the service as well as with staff.

Staff were kind and sensitive to people when they were providing support and people had their privacy and dignity considered. Individual risks to people were assessed and reviewed. Whilst encouraging people to maintain independence when possible, people's choices and wishes were supported. Management and staff had a good understanding of mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff demonstrated a clear understanding of how to recognise and report abuse.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. Where people were at risk of dehydration or malnutrition, staff worked in partnership with healthcare professionals. Staff were knowledgeable about people's behaviours which might challenge and areas of care which might pose a risk to people. Staff recognised the importance that soft toys can bring to people living with dementia and interacted with people through their soft toys.

All required maintenance and servicing of equipment had taken place. Fire evacuation plans and personal evacuation procedure information was available in event of an emergency evacuation. People's confidentiality was maintained by staff and records were kept securely with only those with authorisation having access to them. People's right to make a complaint or comment was welcomed and acknowledged and action had been taken in response to people's concerns.

During our inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

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

Oakhill House Care Home was not consistently safe.

Systems were in place for the administration and disposal of medicines. However, nursing staff were continually disrupted when administering medicines, which posed a risk of people using the service.

Staffing levels were sustained with regular input from agency staff. Staff had a good understanding about how to recognise and report safeguarding concerns.

Appropriate checks where undertaken to ensure suitable staff were employed to work at the service. The environment and equipment was well maintained to ensure safety.

Is the service effective?

Good

Oakhill House Care Home was effective.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to health care services to maintain their health and well-being.

Staff felt supported and had regular supervision and appraisals. People were actively involved in day to day choices and decisions. Management and staff had a good understanding of mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to eat and drink. Meal choices were provided and people spoke highly about the meals provided.

Is the service caring?

Good

Oakhill House Care Home was caring.

People were supported in a stable and caring environment. The staff promoted an atmosphere which was kind and friendly and staff had developed positive relationships with people.

Staff were dedicated to supporting people to alleviate any

anxiety or agitation they might be experiencing. People's confidential information was stored securely.

Staff knew people very well and displayed kindness, patience and compassion when providing care.

Is the service responsive?

Requires Improvement

Oakhill House Care Home was not consistently responsive.

The provision of meaningful activities required strengthening. Further work was required to ensure that the risk of social isolation was minimised.

People's needs had been assessed and care plans were in place. People felt able to raise any concerns and acknowledged that these concerns would be listened too.

Is the service well-led?

Requires Improvement

Oakhill House Care Home was not consistently well-led.

The service was supported by a regional management team who were dedicated to driving and embedding improvement. Actions had been identified to drive improvement; however, these improvements were not yet embedded or sustained.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the service.

Oakhill House Care 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.

The inspection took place on the 19 and 20 June 2017 and was unannounced. The inspection team consisted of two inspectors 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. The service was last inspected in February 2016 where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns with the management of people's medicines. The serviced received an overall rating of 'Requires Improvement'. After our inspection in February 2016, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breach.

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. Prior to the inspection we looked at the previous inspection report and information that had been shared with us. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with seven people, five visiting relatives, the activity coordinator, three registered nurses, a member of the housekeeping team, seven care staff, the regional director, the lifestyle manager, quality manager and regional support manager. Some people had complex ways of communicating and most people had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about peoples' care and how the service was managed. These included the care records for seven people, medicine administration record (MAR) sheets, seven staff training and support and employment records and records relating to the management of the service.

We observed care and support in the communal lounges and dining room during the day. We also spent time observing the lunchtime experience people had and the administration of medicines.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Oakhill House Care Home. One person told us, "I feel safe because everyone is very nice to me and they know my name. I have a bad memory but they all recognise me and nobody is quarrelling." Relatives also confirmed they felt confident living their loved ones in the care of Oakhill House Care Home. One visiting relative told us, "I think it is safe when they have lots of staff on duty. The nurses are very good and tell me immediately if she falls." However, despite these positive comments, we found areas of care which were not consistently safe.

At our last inspection in February 2016, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the management of medicines was not safe. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by July 2016. At this inspection, we found some improvements had been made to the management of medicines; however there remained concerns about some aspects of administration of medicines.

Measures to improve the system for ordering people's diabetic medicines had improved. Robust mechanisms were now in place to ensure that people always had access to prescribed medicines to maintain their blood sugar levels. Medicines were now stored at correct temperatures and appropriate arrangements were in place to dispose of unwanted medicines. Some people continued to have their medicines covertly. This is when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. Covert administration is only likely to be necessary or appropriate where a person actively refuses their medicine but is judged not to have the capacity (as determined by the Mental Capacity Act 2005) to understand the consequences of their refusal and the medicine is deemed essential to the person's health and wellbeing. At the last inspection in February 2016, where people were receiving their medicines covertly, there was no record of any meeting or documented guidance on how the medicine should be covertly administered in a safe way to avoid altering the structure of the medicines. Improvements had been made and clear guidance was now in place. Documentation confirmed that each person had a medicine administration record (MAR) chart which contained information on their medicines as well as any known allergies. Any handwritten MAR charts were now countersigned by two staff members as advised by the Nursing and Midwifery Council (NMC) Standards for Medicines Management. Clear guidelines were in place for the administration of 'as required' medicines (PRN) outlining the reasons a person needed their medicine and how often it was to be given in 24 hours. Systems were in place to assess people's pain levels and ensure appropriate pain relief was provided to people when required. People and their relatives confirmed they had no concerns with the administration of medicines. One relative told us, "There is never a problem with her medication. It is regular and always on time."

Despite these improvements we found one aspect of medicine management which posed a risk. During the inspection, we spent time with the registered nurses whilst they administered medicines. We observed on numerous occasions that nurses were disturbed and disrupted when administering medicines by care staff. This meant they often had to finish supporting the person, close and lock the medicines trolley whilst they

attended to something else, then returned to administering medicines. This therefore had an impact on the time people received their medicines. Registered nursing staff also raised concerns over this practice. One registered nurse told us, "I don't feel safe when administering medicines; I am worried I could lose my pin if something happened because I was distracted." Another registered nurse told us, "Care staff constantly interrupting, they feel they have to report immediately, which means I am distracted." We brought these concerns to the attention of the management team who confirmed they were aware of them. A member of the management team told us, "We have ordered the do not disturb red tabards which will hopefully have an impact. Although there is a do not disturb sign on the medicines trolley, care staff continue to disturb the nurses and this is a culture we need to address." We have identified this as an area of practice that needs improvement.

We recommend that the provider seeks guidance from a national source about protected time when administering medicines.

Systems were in place to determine staffing levels based on people's individual care needs. The regional director told us, "If at a situation we feel staff are under pressure, we get additional staff. If a person's needs have increased, we will utilise the funding calculator to determine how many hours of care per day that individual needs and then go back to the funding authority to advise that additional intervention is required." One person had recently been discharged back to Oakhill House Care Home following a period of time in hospital. Staff identified that their care needs had increased and consequently they required one to one care for a period of time. The provider assessed the person's needs and using that assessment, the local authority funded the additional one to one care. Staffing levels consisted of two registered nurses throughout the day and 11 staff members. At night, staffing levels consisted of two registered nurses and five staff members. A member of the management team told us, "Every week we complete the staffing to meet resident care needs reviews and that explores if staffing levels for the week are sufficient or if we need to increase staffing levels." Staffing rota's confirmed that the service was mostly maintaining these staffing levels but with regular input from agency staff. For example, the night rota for the week commencing 9 June 2017 reflected that every night there was either an agency nurse or agency care worker on shift.

Due to the local challenges of recruiting, the provider was committed to recruiting to vacant posts to minimise the use of agency staff. The regional director told us, "We are thinking of ways to incentive ways to recruit people. For example, we are piloting a peripatetic carer role. This entails a carer being based here and at other local care home and they are asked to work at either care homes. We pay for their travel and the pay rate is slightly higher." The management team acknowledge that recruitment was a key struggle for Oakhill House Care Home. One member of the management team told us, "We are using agency, but we use the same agency to ensure continuity of staff. We have a bank of agency nurses that come here regularly along with agency care staff."

Staff felt staffing levels were a struggle at times. One staff member told us, "We are doing our best. Yesterday we had a few issues as we were three care staff short. We managed to get one agency worker. Some agency staff are really good, whereas others are not. If we get an agency staff member that hasn't been here before, that can be challenging as we have to explain and tutor them which has an impact on us." Another staff member told us, "Staffing levels can be up and down. When down, it is tough. We don't get time to interact with people; we have to purely focus on meeting people's needs." The use of agency staff had been noticed by people and their relatives. One relative told us, "I think there is a shortage of permanent nurses and carers. The permanent ones are excellent, you could not fault them, but they have too many agency staff." From our observations, we could see that staff were busy and working extremely hard. People's care needs were met and people's safety was not compromised. This was an area of practice that was being addressed by the regional director and management team.

The risk of people receiving unsafe care and treatment had been assessed and actions implemented to mitigate any such risks. The provider had consulted nationally recognised guidance such as the Health and Safety Executive (HSE) and the National Institute for Health and Care Excellence (NICE). There were individual risk assessments in place which supported people to stay safe, whilst encouraging them to be independent. Some people were supported to undertake positive risks. We observed some people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. Steps had been taken to minimise the risk of people suffering harm if they did fall. For example, one person was identified at very high risk of falling. To mitigate the risk of harm, staff told us that a low profile bed and crash mat had been given to them. Staff told us of some of the steps they took to mitigate the risk of falling. One staff member explained, "Some people like to walk around the service despite being at risk of falling. We ensure they have appropriate footwear on, the hallways are clear and we check on them regularly." People's risk of falling had been assessed, however, where people had been assessed at high risk of falls, a subsequent care plan was not always in place advising on the steps required to minimise the risk of falling. We brought this to the attention of the management team. They were responsive to our concerns and agreed to take action. Where people required the assistance of two staff members to move and transfer along with a mobility aid (hoist), risk assessments considered the equipment required, handling constraints and other factors which may prevent a safe transfer.

Management of pressure damage is an integral element of providing safe care to people living in nursing homes. Pressure damage is often preventable and requires on-going monitoring and nursing care input. We looked at the management of pressure damage throughout the home. Risk assessments were in place which calculated people's risk of skin break down (Waterlow score). Where people were assessed at high risk, actions were implemented to reduce these risks. These included the implementation of air flow mattresses and regular re-positioning. Re-positioning charts were in place, which reflected the frequency of the re-positioning. For example, one person required support to re-position every four hours. However, their re-positioning chart contained some gaps. On the 14 June 2017, one person was supported to change their position at 12.15pm and then not until 19.00pm. Their care plan advised they should receive support every four hours. We found this was a consistent theme across the service. We discussed these concerns with the management team who identified that there were gaps due to people being supported to sit in the lounge. The management team confirmed that recording could be improved to reflect when people were supported to access the lounge and then supported to go to back to bed. They agreed they would address this concern.

For people requiring the support of an air flow mattress (inflatable mattress which could protect people from the risk of pressure damage), it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown. People's care plans identified the required setting of the air flow mattress and staff visually checked the setting daily, however, this was not recorded. The management team agreed this was a shortfall and addressed this concern during the inspection. Where people had sustained any wounds such as skin tears, documentation reflected that people's dressings were changed in line with the frequency recorded in their wound care management plan. A member of the nursing staff team told us, "The management of skin integrity here is very good. Nobody has a grade three or four pressure ulcer which is really promising."

People were cared for by staff that the provider had deemed safe to work with them. Before staff started work identity and security checks had been completed, and their employment history gained. In addition to this their suitability to work in the health and social care sector was checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with adults at risk. Documentation confirmed that registered nurses all had current registration with the Nursing and Midwifery Council (NMC).

Regular maintenance and environmental checks had been completed. Fire evacuation and emergency procedures were displayed around the service. Staff and people had access to clear information to follow in the event of an emergency. Including Personal Emergency Evacuation Procedures (PEEPS). PEEPS included individual information about people and things which need to be considered in the event of an emergency evacuation. Including mobility, health, and the number of staff required to assist them. There was regular training for both day and night staff and evacuation equipment was located in the building in the event an emergency evacuation was required. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. In the event of the building needing to be evacuated, a place of safety had been nominated.

Staff had the knowledge and confidence to identify safeguarding concerns and were aware of their responsibilities in reporting any concerns. Records confirmed that staff had received training in safeguarding. Staff were able to tell us what may constitute abuse, signs which may alert them to concerns and reporting procedures. One staff member told us, "If I had any concerns or saw something I wasn't happy with, I would inform the management team." Where safeguarding concerns had been raised, the management team worked in partnership with the local safeguarding team to ensure the safety of the person. For example, concerns had been raised that there was a delay in a person being administered their pain patch. The provider completed an internal investigation and identified clear actions to prevent any future incidences occurring again.

Good

Is the service effective?

Our findings

Oakhill House Care Home was providing effective care which met people's needs. People and their relatives told us they felt that staff were trained and skilful. One relative told us, "The carers are fantastic." Another visiting relative told us, "The staff work very hard."

At the last inspection we identified areas of improvement in relation to the dining experience. People living on the second floor of the home had a poor dining experience. They did not receive appropriate support to enable them to have a positive experience that was conducive to maintaining good nutrition and hydration. Recommendations were made and at this inspection, we found improvements had been made.

Guidance produced by Alzheimer's society advised that 'eating and having a good meal is part of our everyday life and important to everybody, not least to people living with dementia. It also suggests making the environment as stimulating to the senses as possible to encourage people living with dementia to eat and drink. Improvements had been made since the last inspection. We joined people on both the first and second floor for their lunchtime meal. Tables were neatly laid with napkins, condiments and cutlery. People were offered the choice if they would like to eat in the dining room, in their bedroom or in the lounge. We observed one person who preferred to stay in the lounge. Staff provided people with choices of fruit juices or water and visually showed people the juice cartoons to empower people to make their own decisions. People were offered a choice of two meal options and were visually shown the options to help enable them to make a decision. Where people required one to one support with eating and drinking, staff sat down next to people, providing support in a kind and sensitive manner. Throughout lunchtime, one person was presenting as agitated, calling out for the nurse regularly. Staff responded in a reassuring manner, stroking their arm and chatting away.

On the second floor, some people preferred to remain in the lounge for their lunchtime meal. Although, this meant there was no preparation of the room before lunch to support people's orientation of meal times. This was people's preference and staff provided one to one support in a sensitive manner, talking to person about their meal along with the day ahead. For those who were supported to eat and drink in the dining room, tables were laid, the menu was on display and a pleasant dining experience had been created for people.

Promotion of hydration in older people can assist in the management of diabetes and help prevent pressure ulcers, constipation, incontinence, falls, poor oral health, skin conditions and many other illnesses. People were regularly assessed for nutritional and dehydration risk. Where people were assessed as being at risk, a care plan was put in place to identify how their risk was to be reduced. Staff monitored people's dietary and fluid intake to ensure they received the nutrition they needed and drank enough. The management team told us that previously the completion of food and fluid charts had been poor but they had been working with staff to improve recording. We reviewed a range of records from February 2017 to June 2017 and found significant improvements in the completion of food and fluid charts. Where people required a soft or pureed diet we saw this was provided. Systems were in place to monitor people's weight and where people had lost

weight, documentation confirmed that staff had made referrals to GPs, dieticians and followed advice from the Speech and Language Therapists (SALT). Where people did not engage with a pureed diet, staff worked in partnership with the SALT team to ensure their diet was modified to meet their needs but the risk of choking was mitigated.

The management of diabetes was effective. People living with diabetes can have an increased risk of disability, pressure ulcer development and hospital re-admission. Diabetic care plans were in place which included guidance on the signs of high and low blood sugar and the steps for staff to take. For example, one person's care plan included guidance to take in the event of their blood sugar levels being too low. Documentation confirmed that people's blood sugar (if living with diabetes) was checked daily to ensure their levels were stable.

People's legal and human rights were protected and upheld. Staff adhered to and followed the principles of the Mental Capacity Act 2005 (MCA). 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. Staff were able to confidently describe the main principles of the legislation. One staff member told us, "We support people to make their own decisions, but when they can't make a decision, we will make a decision in their best interest." Decision specific mental capacity assessments had been completed. Capacity assessments covered a wide range of decisions, such as bed rails, consenting to living at Oakhill House, covert medicines and whether remaining in bed was in the best interest of some people.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The management team were aware of their responsibilities and robust procedures were in place to ascertain if a person was deprived of their liberty.

People received effective care that meet their nursing and care needs. Effective management of people's healthcare needs means people can live long healthy, autonomous and fulfilling lives. People's changing health needs were reviewed on a regular basis and referrals were regularly made to healthcare professionals. Each person had a multi-disciplinary care record which included information when dieticians, SALT and other healthcare professionals had visited and provided guidance and support. Staff told us how they appreciated input from the mental health team. One staff member told us, "We are working with people who can be challenging, but it is important that we meet their care needs and understand how best to support them." Staff had identified that one person was presenting with behaviours that challenged and guidance was sourced from the community psychiatric nurse (CPN). Staff were requested to complete a behaviour chart which allowed staff to record any triggers and how well their intervention worked.

Care and support was provided to a number of people living dementia. Staff were knowledgeable about the people they supported and specifically how to support people with behaviour which might challenge. One staff member told us, "We support one person who can lash out and throw glasses of water. However, we have identified that a trigger for them is being in a loud environment, so if the lounge gets noisy, that's we when we start to notice their agitation. We will ask if they would like to return to their bedroom and that

calms them down." Some people were prescribed anti-psychotic medicines to help manage their behaviours but documentation confirmed this was not being prescribed. Staff recognised and understood that all steps should be exhausted before administering medication. One staff member told us, "I think we manage people's behaviours well, we work with the dementia crisis team and guidelines are in place for us to follow."

Staff were aware of their roles and responsibilities. Upon commencing employment with the provider, new staff were subject to an induction programme. One staff member told us, "It was probably one of the best inductions I've ever had. It was really good." There was a full and intensive programme of training which included essential training for staff. Training included, moving and handling, infection control and safeguarding. A number of staff's training on behaviours which challenge had expired; however, re-fresher training was due to take place later on in the year. Staff spoke highly of the training provided. One staff member told us, "The training is very good." Another staff member told us, "I have this home the best for training." Registered nurses received on-going clinical training which also maintained their continuing professional development. Training included nutrition; falls prevention, accountability and skin integrity. A member of the management team told us, "The nurse's competency is also assessed and they are then signed off as competent. I have also been providing training on care planning, people handling and MCA." Systems were also in place to support nursing staff to revalidate with the Nursing and Midwifery Council (NMC).

Mechanisms were in place to support staff to develop their skills and improve the way they cared for people. Staff received regular supervision. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. One staff member told us, "Supervision is good, you can tell the management about how you feel." Staff also received a yearly appraisal. A member of the management team told us, "At the beginning of the year, staff set their objectives for the year ahead. For example, what they would like to achieve. We then hold a mid-year review and end of year review where we review the objectives and how they have found the past year."

Good

Is the service caring?

Our findings

There was a friendly, homely atmosphere and people were cared for by staff that were kind and caring. People and relatives praised the caring approach of staff and told us that they were well cared for. One person told us, "They know my name and chat to me. They ask me how I am." A visiting relative told us, "You cannot fault them."

People were cared for by caring, empathetic, kindly staff who cared for the people they were looking after. One staff member told us, "I am here to provide the highest quality of care possible." Another staff member told us, "I love my job, the team supports each other and there is a lot of love given to the home." We heard laughter and informal conversation between people and staff. Staff and people knew each other well and were relaxed in each other's company. One staff member told us, "There is one gentleman here. He is very inquisitive and always getting into mischief. He use to work as a mechanic and enjoyed betting on the horses, so we many conversations about what horses to bet on."

The environment at Oakhill House Care Home was tailored to meet the needs of people living with dementia. Signage was available to orient people and memory boxes were outside people's bedrooms to help them recognise their own bedroom. The hallways of the first floor of Oakhill House Care Home displayed the photographs of many famous actors and actresses from the 1940s and 1950s. This helped to trigger memories and acted as a point of conversation for people and staff. For example, Inspectors spent time with one person who enjoyed walking along the corridors. Whilst walking along, Inspectors and the person spoke about Audrey Hepburn and Marilyn Monroe whose pictures were on display. The second floor of Oakhill House Care Home had recently been re-painted and staff were in the process of re-decorating the walls and adding the signage to help people with their orientation skills.

Care and nursing staff were supportive and people received care which ensured their dignity was maintained and supported at all times. Staff told us how they supported and upheld people's privacy and dignity. One staff member told us, "When assisting with personal care, I make sure the door is closed, curtains are drawn and the person is covered up. For example if helping to wash their bottom half, I'll make sure there top half is covered. It is important that we maintain their dignity." Throughout the inspection, we observed staff knocking on people's bedrooms and gaining permission to enter. For example we observed one staff member, knocking on a person's door, gaining permission to go in and commenting, 'good morning (person), how are you today?' Systems were in place to ensure staff empowered people to remain as independent as possible. For example, plate-guards and adapted cutlery was utilised to enable people to eat and drink independently. Staff encouraged people to retain their independence with personal care. One staff member told us, "When assisting with personal care, I'll hand people the flannel and encourage them to wash their face and body."

Guidance produced by the Social Care Institute for Excellence (SCIE) advises that 'contact with a doll or a soft toy fulfils the human needs for comfort and attachment and provides a focus for the person to be able to nurture and protect something else. There are also many reported benefits of enhanced communication between a person with dementia and staff members through the introduction of a doll or soft toy.'

Observations demonstrated that many people spent time sitting in their bedroom or the lounge with a soft toy. One staff member told us, "The cuddly toys can bring people lots of comfort. One person has a soft toy called Billy. However, when agitated they can throw Billy, so we make sure Billy is ok and whether they would like Billy back." We spent time with one person who told us about their soft toy called 'Ted'. They explained, "Ted came over from Ireland with me. He came on the plane, so I wouldn't lose him." Throughout the inspection, we observed a number of people sitting with their soft toys. Staff interacted with people through their soft toys.

People's bedrooms were spacious, in good decorative order and had been personalised, for example with photographs, art and items of memorabilia. This helped to create a familiar, safe space for people. Guidance produced by the Social Care Institute for Excellence (SCIE) advises on the importance of choice and control for older people within care homes and empowering people to retain their identity. Staff recognised the importance of supporting people to dress in accordance with their lifestyle preference and promote their identity. Throughout the inspection, ladies had their handbags to hand which provided them with comfort. A member of the management team told us how it was important to one person to wear tops that matched with their cardigan.

Guidance produced by Skills for Care advises that 'every person with dementia should have the support of people who are confident in adapting their interaction to reduce the stress and anxiety that dementia can bring. It is essential that support is tailored to the person and their personal interests and specific needs, encouraging independence and choice in the decisions they make.' Staff provided support to a number of people who experienced agitation and anxiety. One staff member told us, "We support one person who can be distressed as they have their own reality and will talk to someone who isn't physically there." Another staff member told us, "It can be distressing supporting this person, as they are in their own world and we try and enter their world. Often they talk about cats and babies and we believe they were a nursery worker when they were younger. We have tried doll therapy and soft toys of cats that purr. On occasions they have been successful in reducing their anxiety but we continue to try ideas to minimise their distress." Staff commented that they were committed to adapting their interactions with people to reduce their stress and anxiety.

Nursing homes play an important role in the care of older people at the end of life. Guidance produced by the Department of Health advises that for many, 'a good death would involve being treated as an individual, with dignity and respect, without pain and other symptoms, in familiar surroundings and in the company of close family and friends. Too often, however, people with dementia receive undignified treatment and are ending their lives in pain.' End of life care plans were in place which explored where the person would prefer to pass away and what they would like to achieve in the last year of their life. One staff member told us, "We have end of life care plans, but we haven't received end of life training." Documentation reflected that end of life or palliative care training had been provided. Another staff member told us, "I had end of life training years ago when I worked for a different organisation. I think it is important, especially for people new to care who may not have supported someone at the end of their life." We brought this to the attention of the management team who agreed that end of life training would be beneficial. Subsequent to the inspection, the management team sent confirmation of training dates.

People's care records were stored securely in locked staff areas. Staff told us they were aware of the importance of ensuring personal information was only shared with the appropriate people. Care records were locked away on each floor of the service. Staff were discreet when discussing people's needs on the telephone or between themselves to ensure people's privacy was maintained at all times.

People told us they were able to maintain relationships with those who mattered to them. One visiting

relative told us, "My (relative) was having trouble talking to her sons in Australia and they helped fix up Skype." Visiting was not restricted, apart from lunchtime, when the service encouraged protected meal times. However, relatives were still able to visit. For example, one relative visited at lunchtime as they enjoyed supporting their loved one with eating and drinking at lunch. Throughout the inspection we observed friends and family continually visiting, taking people out and being welcomed by staff.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that staff were responsive to their needs. One person told us, "They are very good, they work hard and always help me when I need help." Staff told us how they treated each person as an individual and it was clear that staff had spent time building rapports with people. Despite, people's praise, we found an area of practice which was not consistently responsive.

An activity coordinator had recently been employed and on the days of the inspection, they had only been in post two weeks. Visiting relatives and staff highlighted that the service had been without an activity coordinator for some time which unfortunately had a negative impact. One visiting relative told us, "Activities have been very few but I hope things will change now a new co-ordinator has started." A full programme of activities was not yet in place and the activity coordinator told us they were spending time getting to know people and assessing their social, emotional and psychological needs. They told us, "I intend to make a book of residents' interests, likes and dislikes so everyone can have a personalised activity cards. I hope to have a rolling rota of gardening sessions, watering and bird tables. I want to introduce lunch clubs and have storytelling and encourage reading. I shall introduce remembering sessions where we look back. I hope to start lunch clubs and exercise sessions in the morning." On the first day of the inspection, the activity coordinator told us that the planned activities were hairdressing, hand care, jigsaws and colouring. In the afternoon a quiz was planned. During the morning, a number of people were supported to have their hair cut which they enjoyed. Staff commented on people's hair and we heard comments, such as, 'your hair looks lovely with that perm.' However, whilst people were getting their hair cut, a number of people remained in the lounge with little stimulation. Music was playing in the background and staff were in and out of the lounge. However, a number of people spent the morning dozing or sitting passively.

Guidance produced by Social Care Institute for Excellence advises that older people are particularly vulnerable to social isolation and loneliness owing to loss of friends and family, mobility or income. Social isolation and loneliness have a detrimental effect on health and wellbeing. Some people preferred to stay in their bedroom due to preferences or health reasons. People's care plans identified they were at risk of social isolation, however, guidance failed to reflect how that risk would be mitigated. For example, documentation did not reflect how often they would receive one to one activities with the activity coordinator. Care plans included snippets of information about people's hobbies and interests. For example, one person remained in bed all day due to severely contracted legs. Their care plan identified they enjoyed visits from family and watching TV. However, there was no information on their favourite TV channel and what they enjoyed watching on TV. Daily notes also failed to reflect how staff engaged with people to reduce the risk of social isolation. We reviewed a sample of daily notes over a two week period. There was reference to meeting people's care needs. However, there was limited information on how people presented. The daily notes for one person between the period 15 May 2017 and 19 June 2017 had three references to the person's emotional and psychological well-being. The other daily note entries were task centred and failed to reflect how staff interacted with the person to minimise the risk of social isolation.

Arrangements now were in place to provide meaningful activities and reduce the risk of social isolation. However, these were not yet embedded into practice and required strengthening. The management team

were dedicated to making improvements and recognised that care plans could be improved to fully capture and record how the risk of social isolation could be mitigated. We have identified this as an area of practice that needs improvement.

People's needs were assessed prior to them moving into the service and this information was used to develop care plans. Care plans covered a range of areas including; sense and communication, lifestyle, moving around, personal care, going to the toilet and mental health and well-being. Care plans considered what the person could do for themselves and the support they required from staff. For example, one person's care plan (going to the toilet) identified that they needed support from staff due to feeling fearful. Another person's eating and drinking care plan identified that they had experienced recent weight loss and consequently all of their food was being fortified and a food and fluid chart was in place to monitor nutritional intake and they were being offered smoothies twice daily.

Care planning and documentation included an overview of the person's care needs titled 'my day, my life, my portrait'. This included a brief overview of the following areas of care; 'what's important at this time, what does a normal day look like, sense and communication' along with other areas of care. Although consideration had been given to what a normal day looked like for each person. This failed to reflect the times people preferred to get up and go to bed. On the first day of the inspection, we arrived at 08.45am. A number of people were still in bed, whilst a number of people were having their breakfast or enjoying their morning cup of tea. We spent time with one person and commented on their glamorous night dress. Staff told us how they enjoyed having their morning cup of tea in the lounge before getting ready for the day. It was clear that staff had a firm awareness of people's preferences regarding getting up and going to bed. One staff member told us, "Some people are early risers as they use to get up early for their jobs, so they are supported by night staff to get ready for the day. Whereas other people like their lie in's or prefer to get up just before lunch." However, this information was not reflected in people's care plans. We brought these concerns to the attention of the management team who agreed this information should be reflected in people's care plans and agreed to take action.

On the days of the inspection, England was subject to a heat wave and the weather was extremely hot. The management team told us that they had shared the heat wave guidance with care staff and actions had been implemented to provide responsive care. One staff member told us, "We have been encouraging people to drink plenty of fluids, we have fans around the home and those who prefer to stay in their bedroom, we have their windows open and the curtains drawn to keep their bedroom cool." We observed this in practice throughout the inspection.

There was a complaints policy in place, this was clearly displayed on the notice board and people were informed of their right to make a comment or complaint, in the guide that was provided to them when they first moved into the home. Complaints that had been made had been dealt with promptly and in line with the provider's policy. The provider had received eight complaints since the last inspection. Clear action had been taken following each complaint and people and their relatives told us they would approach the management team or registered nurses if they had any concerns or wished to make a complaint.

Requires Improvement

Is the service well-led?

Our findings

Oakhill House Care Home had been subject to a period of instability. The registered manager was away and the service was being supported by a regional management team. This had resulted in a period of unsettlement. One staff member told us, "It is a really caring home, however, morale has been low and previously things weren't so calm. The registered manager is very good and I look forward to them returning. We are currently being supported by a regional management team who have lifted morale and things are improving."

On the days of the inspection, the registered manager was away and the service was being supported by a lifestyle manager and regional support manager. The regional support manager told us, "Between myself and the lifestyle manager, we have been supporting the service. A quality manager is also working here and their role is to work alongside the clinical team to promote best practice and improve the quality of care. We have identified areas of care which we can improve on and we have also identified the key strengths of the service which we want to add to and strengthen." Staff spoke highly of the regional management team. One staff member told us, "A couple of weeks ago, I felt rather down. The impact of working with agency staff meant I felt like I needed eyes in the back of my head. The regional support manager was very supportive. We had a chat and they are working hard to sort things out."

Systems were in place to assess and monitor the quality of the service. This Included weekly, monthly, quarterly and annual audits and reviews for safety, security and health care. The service was also supported by various professionals who worked for BUPA (the provider). In May 2017, a nurse visited the service to complete an antipsychotic medication audit. A first impression audit also took place in May 2017 which considered the home environment and 'resident's experience. Following each individual audit, any actions or recommendations were added to Oakhill House Care Home 'home improvement plan' (HIP). For example, the HIP included various action points to help improve the provision of activities. A member of the management team told us, "A key focus for us is to improve the documentation and make care plans more person centred." Throughout the inspection, we reviewed a range of documentation and identified that improvements were being made. However, we identified some shortfalls within care documentation. For example, care plans identified that people were unable to use their call bell to summon assistance and therefore should be checked on regularly. However, there was no reference to what 'regularly' meant and where staff evidenced that people were checked on regularly. People's ability to access the toilet was assessed and robust continence assessments were in place. These considered and explored the symptoms of urinary incontinence and the symptoms of urge, stress and overflow incontinence. Based on this assessment, a plan of care was then devised and a number of people required the support of incontinence pads to meet their continence needs. Staff members told us they always had access to continence aids and supplies were never short. However, documentation failed to consistently reflect when people received support to their continence needs. For example, one person's care documentation reflected that they only received support once a day to meet their continence needs. Staff were able to consistently advise how often they supported people, yet this was not reflected in people's documentation. Choking care plans were not consistently in place. For example, one person had a choking episode in September 2016. However, their nutritional care plan failed to address the risk of choking.

Mechanisms were in place to ensure the provider and management team had oversight of the management of medicines. This included regular medicines audits and spot checks. Despite, a range of systems in place, we found action had not yet been taken to address ongoing concerns with the administration of topical creams. At the last inspection in February 2016, the provider had implemented a new procedure for the administration of topical creams. The administration of topical creams was undertaken by care staff. However, staff dispensing the medicines signed to state the creams had been administered on the MAR charts. We found this system remained in place. For example, there were gaps of signatures on MAR charts and where the prescription was to apply creams, 'as needed' it was difficult to understand whether the gaps in the MAR chart indicated that creams had not been administered or if they were not administered because they were not required. One staff member told us, "They changed the system for recording topical creams last year. We use to record in people's daily notes then on the MAR charts but it's not always done." One person's care plan stated, 'Person relies on staff to ensure their skin is kept moisturised by the prescribed cream zerobase.' Gaps in documentation meant, we could not be assured that people were receiving their prescribed topical creams as needed. We brought these concerns to the attention of the management team who identified this was an on-going issue.

The above examples, demonstrate that the provider's quality assurance framework was not consistently robust. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

A quality manager was now based at Oakhill House Care Home and had implemented a number of positive improvements. These included the implementation of a handover sheet. The management team told us, "Due to the use of agency staff, it is important that they have access to a handover sheet which provides them with an overview of each person's needs." The handover sheet provided information on the person's medical history, skin, diet, allergies, if a DoLS was authorised, monitoring charts, moving and handling and any additional comments.' Alongside the implementation of the handover sheet, the quality manager had been holding weekly clinical risk meetings with the nursing staff to ensure there was strategic oversight of clinical risk within the service. Minutes from the last clinical risk meeting on the 16 June 2017 reflected that tissue viability, nutrition, incidents involving challenging behaviour and safety.

People, staff and relatives were actively involved in developing the service. Satisfaction surveys were sent out on a regular basis. Staff and 'resident' meetings were held on a regular basis and these acted as a forum for people and staff to raise any concerns or queries. Minutes from the last staff meeting in June 2017 reflected that time management, personal care, housekeeping and handover was discussed. Minutes from the 'resident and relative meeting' in May 2017 reflected that staffing, meal service, housekeeping and activities were discussed. A visiting relative told us, "I have attended residents and relatives meetings. The agenda always includes lacks of activities and standards of agency staff." We reviewed a sample of 'resident and relative meetings' and identified this was a standing agenda. The management team recognised that activities and use of agency staff had been an ongoing issue at Oakhill House Care Home and was committed to driving improvement and addressing these ongoing areas of concern.

Feedback from staff, people and relatives identified that Oakhill House Care Home had experienced a period of challenge and low staff morale. One staff member told us, "We have had an unstable management team. The manager has been off for a while and we are currently being supported by a management team who are very good and we can now see improvement. Although we still use agency staff, I know recruitment is a challenge." The management team were aware of the challenges faced by Oakhill House Care Home and were working on the necessary improvements required. These improvements focused on activities, staffing and care documentation. Although the provider and management team had recognised and identified the required improvements. These improvements were not yet embedded into practice. We have identified this as an area of practice that needs improvement.

The management team was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

Staff members described their passion for the job and told us why they enjoyed working at Oakhill House Care Home. One staff member told us, "I love my job, I really enjoy supporting people." Another staff member told us, "I really enjoy making sure people are ok and I've done the best I can." Systems were in place to recognise staff achievements and the provider offered 'employee of the month.' On a monthly basis, people and staff nominated a staff member or a staff team who they felt had gone above and beyond. For example, in May 2017, a staff member was awarded 'employee of the month' because they ensured all the residents had a hot meal on the 27 May 2017 when the chef failed to arrive to work.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service. Regulation (17) (1) (2) (a).