Oak House Homecare Ltd

Olivemede

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 22 March 2016. At this inspection we found that there were two breaches of legal requirements. This was because people were not protected against the risks in the event of an emergency and that the provider had failed to notify the Care Quality Commission about important events that had taken place.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Olivemede' on our website at www.cqc.org.uk'

Olivemede provides accommodation and personal care for up to 33 older people including those living with dementia. Accommodation is located over two floors. There were 26 people living in the home when we inspected.

At the time of this inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (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 and associated Regulations about how the service is run.

At our focused inspection on 12 October 2016, we found that the provider had followed their plan which they had told us would be completed by 30 April 2016, and legal requirements had been met.

People's risks were assessed and measures were in place to minimise the risk of harm occurring

Records showed that notifications had been submitted to the CQC in a timely manner.

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

We found that action had been taken to improve the safety of the service.

Risks to people had been identified and staff knew how to minimise the risks

This meant that the provider was now meeting legal requirements.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

We found that action had been taken.

The Care Quality Commission have received notifications of important events in a timely way.

This meant that the provider was now meeting legal requirements.

We could not improve the rating for well led from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Olivemede

Detailed findings

Background to this inspection

We undertook a focused inspection of Olivemede on 12 October 2016. This inspection was undertaken to check that improvements, to meet legal requirements planned by the provider after our comprehensive inspection on 22 March 2016, had been made.

We inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. This is because the service was not meeting legal requirements in relation to these questions.

The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service. Their area of expertise was in caring for older people and those living with dementia.

Before our inspection we reviewed the information we held about the service. This included the provider's action plan, which set out the action they would take to meet legal requirements.

During the inspection we spoke with eight people living at the service, a relative, the registered manager and four members of care staff. We observed staff providing care and support.

We looked at the care records, fire records and records in relation to notifications.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection of Olivemede on 22 March 2016, we found that there were no risk assessments in place to support people in the event of an emergency such as a fire. Not all staff knew where the fire fighting appliances were located. This put people at risk of harm and was a breach of regulation 12 (2) (b) of the HSCA Regulated Activities Regulations 2014 Safe care and treatment.

During this inspection on 12 October 2016 we found that the provider had followed the action plan that they submitted to us following our last inspection and that there was no longer a breach of legal requirements,

We spoke with people who lived at the service and asked if they felt safe. One person said, "I am quite happy here. They are so good and look after me. Anything I need is done for me." Another person told us, "They [staff] come and check on me every hour." A third person said, "I feel safe and secure. I can lock my door and I have every confidence in the staff."

Staff told us they had considered ways of planning for emergencies. They now had an emergency folder, which contained a list of people who lived at the home as well as brief details on the level of their mobility should they need to be evacuated. We spoke with registered manager during this inspection and they agreed that more detail should be included to provide staff with the full action they would need to take in the event of an emergency. For example what they should do a person is being cared for in bed or any additional equipment such as a wheelchair. This would help to ensure that appropriate support would be given in the event of an emergency, such as a fire, at the service. Staff we spoke with were able to explain the action they would take in the event of a fire.

People's risks were assessed and measures were in place to minimise the risk of harm occurring. People had comprehensive individual risk assessments which had been reviewed and updated. Risks identified included, falls, assisting people to move and poor skin integrity. Appropriate measures were in place to support people with these risks. For example there was guidance on safe moving and handling techniques and how people should be repositioned regularly. Staff were aware of people's risk assessments and the actions to be taken to ensure that the risks to people were minimised.

Environmental risk assessments, fire safety records and routine safety checks of services, such as water temperatures were in place to support people's safety.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Olivemede on 22 March 2016 we found that the provider had failed to notify the Care Quality Commission about important events that had taken place. This was a breach of Regulation 18 Registration Regulations 2009 Notifications of other incidents.

During this inspection on 12 October 2016 we found that the provider had followed the action plan that they submitted to us following our last inspection and that there was no longer a breach of legal requirements,

People we spoke with were complimentary about the registered manager. One person said, "I see the [registered] manager most days, she is very nice." Another person told us, "I see the [registered] manager quite regularly." A relative said, "I have met the [registered] manager. I know, they changed recently and they introduced themselves to me." We saw the registered manger spent time talking with people and they had a good knowledge of the people living in the service.

Since our last inspection a manager has been registered with the commission and they understood their role and responsibilities. The registered manager showed us they had maintained logs of any untoward incidents or events within the service. There was evidence that notifications had been sent to CQC when required.. We saw that the registered manager analysed accidents and incidents and action had been taken. For example where a person had had a number of falls, they had arranged a falls review. This enabled them to look at the person to see if any equipment may be required to aid their walking and allow them to remain as independent as possible.