Oxendon House Care Home Limited

Oxenden House

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

This unannounced inspection took place on 12 March 2015.

Oxendon House provides accommodation for people requiring personal care and can accommodate up to 33 people. At the time of our inspection there 18 were people using the service. The service provides care and many people at the home are living with dementia.

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.

At the last inspection on the 11 September 2014, we asked the provider to make improvements to assessing and monitoring the quality of service provision and the management of records and this has been completed.

There were systems in place to calculate staffing based on people's needs and people received enough support to meet their basic care needs. However, feedback from

Summary of findings

people and staff indicated further improvements were needed. There were medicine management systems in place and people received the support needed to take their medicines as prescribed. Risks to people's care were managed well and staff understood the measures needed to reduce the risk of unsafe care. There were robust recruitment processes in place designed to reduce the risk of unsafe staffing. People were safeguarded from the risk of abuse and there were clear lines of reporting safeguarding concerns to appropriate agencies.

People were supported to choose a nutritious diet; however some feedback indicated to need to improve this area. Staff monitored people at risk of not eating and drinking enough and provided appropriate support. There was a system of staff training and development and this had recently improved to provide more practical training for staff. The manager and staff were aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood how to make best interest decisions when people were unable to make decisions about their care and people were supported to access a range of health services including that of their GP and dentist.

People received care that was respectful of their need for privacy and dignity. There were systems in place to support people to make decisions about their daily lives. People were encouraged to care for themselves and to live an independent life, where this was possible.

The system of care planning was responsive to people's needs and people received a regular review of their care. People were supported to undertake a range of activities to support their social development. The provider had a system of complaints management in place to ensure people's complaints were investigated and fully resolved.

The provider had made improvements to ensure any issues with cleanliness in the kitchen were identified and resolved quickly. The management of people's care records had improved and these were an accurate reflection of people's care needs. However, the arrangements for enabling people to feedback about the service required further improvement. Quality assurance systems were in place and identified potential failings in the service. The provider promoted an open and honest culture and staff raised any concerns about the service.

Summary of findings

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 was not always safe.

There were not enough staff to meet people's need for social interaction and an enhanced level of care.

There were safe systems in place to manage people's medicines.

The provider had appropriate recruitment systems designed to reduce the risk of unsafe staffing.

People received an assessment of any risks relating to their care to minimise the risk of poor care.

Requires Improvement

Is the service effective?
The service was not always effective

People did not always receive food and drinks that were to a consistently good standard.

There were procedures in place to ensure the mental capacity act was fully implemented and where possible people provided consent for their care.

There was a basic system of staff training and development.

People were supported to receive access to health and wellbeing service.

Requires Improvement

Is the service caring?
The service was caring.

People received care which was respectful and mindful of their need for privacy and dignity.

People were supported to express their views and make decisions about their daily lives.

Good

Is the service responsive?
The service was responsive

There was a system of care planning in place and people and their families were involved in providing information about their care.

The provider had appropriate a system in place to ensure people's complaints were fully investigated and resolved.

Good

Is the service well-led?
The service was not always well-led

Requires Improvement

Summary of findings

The provider had made improvements to monitoring areas of cleanliness in the kitchen area. Improvements had been made to the management of people's care records.

People were not always involved in shaping the service.

The provider and registered manager supported an open and honest culture in which staff and people could raise concerns about the service.

Oxenden House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 12 March 2015 and was carried out by an inspector and an Expert-by-Experience (Ex-by-Ex). An Ex-by-Ex is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we also looked at information we held about the service including statutory notifications. A notification is important information about events which the provider is required to send us by law. We also spoke to health and social care professionals and service commissioners. They provided us with information about recent monitoring visits to the service including the outcomes of safeguarding investigations.

During this inspection we spoke to the registered manager and four care workers. We spoke with four people who were using the service and a relative. We undertook general observations in communal areas and during mealtimes. We used the 'Short Observational Framework for Inspection' (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records of three people who used the service and four staff recruitment files. We also reviewed records relating to the management and quality assurance of the service.

We asked registered manager to send us information about complaints and assessing and monitoring the quality of the service. The registered manager sent us the information about complaints within the agreed specified time. However, we did not receive the additional information requested about the results of people's and relatives surveys.

Requires Improvement

Is the service safe?

Our findings

Staffing levels had been calculated based upon people's need for care; however due to a reduction in the number of staff working at the home some people indicated the need to improve staffing. One person said "There are only two [staff] and I think there should be more as there are too many residents for them [staff] to get round." Another person said that contact with the staff was reserved for "very brief periods" when they served meals in their room. They also said "I don't see the care staff; they are in and out and that's it." The staff also reflected the need for more staff to provide an enhanced level of care. One staff said "We can cope with the workload but its more about giving people one to one care; it's more difficult with less staff on duty".

While we saw there were enough staff to meet people's basic care needs; there was little time for staff to spend time interacting with people to provide an improved level of care. The registered manager and the provider had responded to this staffing need and several new members of staff had been recruited. This included a new member of staff to spend time interacting and supporting people to do activities and pastimes and a new cook, care staff and a maintenance staff. We saw that the registered manager regularly monitored people's need for care and this was considered in the planning of staffing at the home. The staff working rota's showed that care was provided by a core team of permanent staff which gave people a continuity of care.

The provider had recruitment systems in place to reduce the risk of un safe staffing and people said staff were of a good character. The provider had undertaken checks such as a Disclosure and Barring Service check (DBS). This check helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

We also saw the provider had obtained employment and personal references to confirm the staff's suitability to work at the service. The staff confirmed that they had received an interview and checks were made to check their suitability to work at the home. One staff said "I had to give an application and have an interview before I got the job; I also had a DBS check and had to give references from a previous employer and someone who knew me".

The provider had systems in place to ensure risks to people's health and safety were identified and managed to reduce the risk of unsafe care. We saw that each person had a series of risk assessments which identified risks in not eating and drinking enough, of having a fall and sustaining a fracture and of developing pressure ulceration. The risk assessments were detailed and considered several factors to accurately identify risks. For example we saw that risk assessments used to assess the risk of fracture considered people's health conditions and any additional factors such as smoking, previous fractures and people's mobility needs. We found that staff were able to talk about risks to people's care in detail and this included how to minimise the risk of people developing pressure ulceration and of not eating and drinking enough.

People told us they felt safe living at the home and there were procedures in place to safeguard people. One staff said "I have had safeguarding training and if I had any concerns about any of the residents I would raise them with the manager". We saw that when safeguarding concerns were identified that appropriate referrals and notifications had been made to agencies such as the Local Authority and the Care Quality Commission (CQC). We saw that safeguarding investigations had been taken seriously by the registered manager who had investigated safeguarding concerns appropriately.

Requires Improvement

Is the service safe?

The provider had systems in place to manage people's medicines in a safe way. For example, a member of staff showed us the systems in place to safely store, obtain, administer and dispose of people's medicines. We also saw that medication administration records (MAR) were in place and these were accurately maintained and medication stock levels were accurate. The staff were knowledgeable about people's medicines and told us how they managed medicine errors. One staff said "There have not been any medicines errors; but if there were I would report to the manager immediately and seek medical advice from the doctor". They also told us that procedures were in place when people refused or were unable to take their medicines and this included accurate recording of why people did not take their medicine and informing the person's G.P to identify alternative solutions. A regular weekly and monthly medicines audit which was in place to identify any errors or discrepancies to people's medicines.

Is the service effective?

Our findings

People were supported to have enough to eat and drink; however some people's feedback indicted the requirement for further improvement. One person said "Well the meals vary and it's a mixture of something's you like and something's you don't like." A relative also said the quality of meals served was variable. They said "They often have lasagne or cottage pie; sometimes it looks appetising and sometimes not". Some more positive comments included ""You do get a choice of two things, it was quite nice today". The registered manager had acknowledged the need for continued improvement to the arrangements for foods and drinks. A new cook had been appointed and they were working with the registered manager to design a new with improved meal choices such as stroganoff, hunter's chicken and a range of homemade puddings and desserts.

People received sufficient support for a range on nutritional needs. We observed that people who required assistance to eat their meals received this support and people were encouraged and motivated by staff to eat their meals. The staff identified people at risk of not eating and drinking enough and they were regularly monitored by the staff. This included monitoring how much food and drink people consumed each day and making referrals to the dietician where necessary. People were regularly weighed and most people had gained weight over the last few months. The cook had a good understanding of how to fortify people's meals and said "I fortify everyone's diet with cream, butter and full fat milk and cheese; we have also started to buy fresh vegetables as they taste better and people are enjoying them".

There was a basic system of staff training in place which included some practical training to help staff understand dementia care. The training had helped the staff to develop an area of the home to include dressing up costumes and a memory box with objects for people to touch and feel while stimulating their memories. The staff reflected on their training and told us this had given them practical ways of caring for people living with dementia. One member of staff said "I have learnt about different types of dementia and the symptoms and similarities of these conditions. I understand why it is confusing for some people living with dementia to look in mirrors as they might not recognise themselves. We are trying to develop our dementia care and we have a memory box with different things for people to pick up and look". We saw that a system of staff training was in place and this provided a range of mandatory training such as fire safety, health and safety, the mental capacity act and safeguarding adults. We also saw that there was a system of staff supervision to help staff to work to the required standard of care. One member of staff said "I have supervision every month with one of the managers". Another senior member of staff said "We have regular supervisions and talk about any issues and congratulate the staff for good work. It is about enabling staff to do their jobs and to work as a team. We are very well supported".

People gave consent for their care and the registered manager was aware of their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We saw that the registered manager had made appropriate DoLS applications to the local authority where people were unable to give their expressed consent to being continually supervised by the staff. We also saw that where required, mental capacity assessments and best interest decisions had been made which included consultations with people's families and health professionals involved in their care. The staff had an understanding of the need for best interest

Is the service effective?

decisions and when they might be indicated. One member of staff said “I have done training on the mental capacity act and understand our role in assessing someone’s capacity for certain decisions such as medical and financial decisions”. People who were able to give their informed consent for their care signed a consent form which included consenting to assistance to take their medicines.

People were supported with their health needs and accessed a range of health and wellbeing services. One person said “When I had a hospital appointment they arranged the transport and a carer to come with me.” Other people reflected on the support they had to access their G.P when they needed too. A relative said “When [person’s name] had chest pain the staff called their G.P and the emergency services straight away”. The staff told us that health professionals from other services were fully involved in people’s care. One staff said “The physiotherapist has recently been involved in [person’s name] care; they have given us advice on how to help [person’s name] and we have used this to write their care plan. Another staff told us how they were working with the GP and district nurse to provide an improved level of nutritional support and pressure area care. We saw that a visiting optician and podiatrist regularly visited the home and people’s records showed they regularly accessed health services such as the GP, dentist and district nurse.

Is the service caring?

Our findings

People were treated with kindness and respect and people's individuality and identity was maintained. For example people's feedback included; "Oh yes the staff are very caring" and "Here it's very nice, they are all very nice to me" and "They have been marvellous to me here the staff."

We observed that people responded positively to the staff and staff demonstrated a warmth and affection when delivering people's care. The staff used effective interpersonal skills and provided good eye to eye contact and use of touch to engage and empathise with people. For example we observed that one person was nervous about using the hoist to move their position and saw that staff quickly identified this and used their communication skills to re-assure the person and used a step by step approach to enable them to move both safely and sensitively. We saw that people responded in a positive way when staff used people's preferred name when asking them questions about their preferences. The staff approach was kind, considerate and people were spoken to with a genuine warmth and affection.

People were encouraged to express their views and received care in line with their preferences. One person said "Yes they do [understand my preferences] because they ask me if I'm satisfied." Another person told us the staff were flexible in their approach and accommodated their care needs by letting them sleep in during the morning. They said "They are good [staff] I over slept, but they got me ready." We also observed staff supported another person who liked getting up later in the morning to do this and we saw they had a freshly cooked breakfast of their choice when they were ready to eat. We saw that people were given a range of choices about their daily care and were supported to make decisions about their personal care, such as their choice of clothing. People had an individual plan of care which contained information about their life history and preferences for care and staff were aware of individual needs and preferences. People were encouraged to attend monthly residents meetings and there were opportunities to voice their opinion about the running of the home.

People told us they received care that met their need for privacy and dignity. One person said "Yes they [staff] knock on doors even when there open." Another person said "They [staff] always tap on the door and say we've come to dress you in the mornings." We observed that staff treated people with respect and asked their permission before care was given. We also saw that staff knocked on people's doors before they entered their bedrooms and told us how they promoted people's dignity by encouraging people to be independent and where possible to care for themselves. We saw that people were supported by staff to receive personal care in a discrete and private way and people had access to their own bedroom and en-suite bath room facilities which were highly personalised with people's belongings, furnishings and photographs.

Is the service responsive?

Our findings

People received a personalised level of care to meet their needs. For example, one person told us that staff had identified their mobility and walking needs and had supported them to make significant improvements so they could return home. We saw that when people started to use the service an assessment was undertaken which looked at people's care needs and also identified the aims and objectives of providing care. A range of care plans were formulated based on people's assessment of need and covered a variety of physical, social and mental health needs. We found that the staff were knowledgeable about people's health and wellbeing needs and spoke with confidence about people's rehabilitation, dementia, nutritional and pressure care needs.

People and their families had been involved in writing a "This is me" care plan which contained information about people's personal history including that of preferred name and language, cultural needs such as diet and religion and an overview of people's lives including that of their family, friends and previous occupation. The staff were responsive to these needs and supported people with appropriate cultural diets and access to religious events and a local vicar was invited to carry out a service at the home.

The provider had arrangements in place to meet people's social needs. One person told us "We have activities and jigsaws and bingo and things like that." Another person told us "Yes we do the bingo; I used to play bowls but am not too bothered now." A relative also told us "[person's name] went to the golf club the other week; they had a good day and enjoyed seeing their old friends".

We observed that a new member of staff had been appointed to work with people and provide social stimulation and support with undertaking activities and pastimes. We observed that they engaged a large group of people by reading the local newspaper out aloud which enabled people to express their views and interact with one another by prompting a discussion about the local area. We observed another person was supported to be independent by taking their dog out for lots of walks and collecting their own laundry.

The staff told us that the service had improved the arrangements for offering social stimulation and support to access the community. One staff said "I've been encouraged to take people out and will do this again. We have also opened up the home and had a Christmas fete and relatives and school children came. We are hoping to do things more often and plan to do a coffee morning for charity". Another member of staff said "We try and take [person's name] out as they like going for walks. There is an activity co-ordinator and they have more time to spend interacting with people". The staff had started to develop an area of the home to provide support for people living with dementia. This included objects to stimulate people's memories such as a tea cosy, old fashioned advertisements, a ration book and picture post cards. One staff said "People have recognised different objects and one person loves to look at the pipe; we are also hoping to get more books in here as another person used to be a teacher".

There were systems in place to respond and deal with people's complaints. People told us they did not have any complaints about the service; however were confident their complaints would be dealt with. One relative said "Yes, I can complain and I know who the manager is; they have resolved a couple of concerns I have had about [person's name] care". The staff were aware of the complaints procedure and how they could resolve people's complaints. One staff said "We can deal with some complaints ourselves; however others are dealt with by the manager. We had several

Is the service responsive?

complaints about the laundry and the manager addressed this at the residents meeting. We appointed a new member of staff to manage the laundry and have labelled people's socks to stop them getting mixed up". We saw that systems were in place to manage people's complaints ensuring that they were logged, investigated and responded to in line with the provider's policy and procedure for managing complaints. We looked at a copy of a recent complaint and found this had been fully investigated and the complainant had been responded and written to with information about how the service had improved based upon the concerns raised in the complaint.

Is the service well-led?

Our findings

At our last inspection visit we found that there was a lack of formal processes in place to assess and monitor the cleanliness of the kitchen area. We also found that people's records were not always accurate and did not reflect the level of care they needed. At this inspection visit the provider had implemented a new checking system to make sure the environment and kitchen area were cleaned to a good standard. We also found that people's records were accurate and contained appropriate information about the arrangements for their care.

However, we found that some systems in place for making quality improvements at the home required strengthening. For example, people provided a mixed opinion about how well they were involved with feeding back on the service and suggesting quality improvements. One person said "Sometimes, [involving people in making improvements] could be better". Another person said "The provider comes in sometimes, once or twice, I've asked them somethings but it makes no difference." While we found that a people's survey had been completed during 2013; we were unable to ascertain how this information had been analysed and utilised to take account of people's suggestions for improvements at the home. We asked for this information to be forwarded to us; however we did not receive this information within an agreed timeframe. After the agreed timeframe the provider sent us information about satisfaction survey's and this included a people's satisfaction survey completed during 2014. However, during the inspection visit the registered manager had been unaware of this survey or the improvements that were made as a result. We found that other people were more confident about raising their concerns and said residents meetings were held regularly to enable people to voice concerns. One person said "I asked for more staff to be on at night time and this has been taken up with the manager." However, there was a lack of available evidence which showed how people's feedback led to improvements at the service.

The staff told us that they were involved in making changes to the service. One staff said "The staff are more aware that they can take ideas forward to improve things and we can discuss these at our team meetings". They also said "We suggested that people should have 'diaries' in place with information about the care given each day and the manager is going to put them in place". Another senior member of staff said "The staff are much more involved with making improvements to the service. We have got staff more involved in developing people's plans of care and asked staff to interact with people to find out more information about their needs and its working well".

People and staff also told us the registered manager promoted an open and honest culture at the home. One person said "the manager is very obliging". Another person said ""Yes, if I wanted to speak to the manager it would be no bother, I'd go to the office and tap on the door, and they would say what's the problem." The staff also told us they were able to raise any concerns about the service with the registered manager and these concerns were taken seriously. One staff said "The staff can raise concerns and feel supported". Staff were also aware of how they could whistle-blow to external agencies such as the Local Authority or Care Quality Commission (CQC). Whistle-blowing is when a member of staff suspects wrongdoing at work and makes a disclosure in the public interest. One member of staff said "We can raise any concerns with the supervisor and the manager and I can also go to the provider. There is a whistle blowing policy and procedure in place and I know I can go to the Care Quality Commission and the social services if I have any further concerns". The registered manager reported all notifiable events in line with their regulatory duties to the CQC and the local safeguarding authorities.

There was a system of audits and checks to enable staff to maintain the safety of the premises and to improve their practice. For example, we observed that a system checks were in place which included checks to the fire prevention systems such as fire alarms and emergency lighting and checks to the temperature of the water to prevent water borne diseases such as legionella. There was a system of audits in place which checked standards in care planning, medicines and providing dignity in care. Staff received information about the results of audits to help them improve their practice. The registered manager told us "The last medication audit was given to the staff to help them take ownership and to give them an opportunity to comment on how they could change their own practice".

The provider monitored the quality of the service and made quality improvements. For example we saw that several areas of the premises including people's bedrooms had been recently refurbished and plans were in place to

Is the service well-led?

redecorate several other areas. The registered manager submitted a weekly management report to update the provider about people need for care, accidents and incidents and any safeguarding concerns. The provider had appointed a senior manager to review the quality of the service and to provide the registered manager with support to ensure appropriate standards were maintained.