

# Oak House Homecare Limited

## Hill View

### Inspection report

46 St Judith's Lane  
Sawtry  
Huntingdon  
Cambridgeshire  
PE28 5XE  
Tel: 01487 831709  
Website: [www.oakhouseltd.co.uk](http://www.oakhouseltd.co.uk)

Date of inspection visit: 2 January 2015  
Date of publication: 13/03/2015

#### Ratings

#### Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Good 

#### Overall summary

Hill View is a care home which provides accommodation and personal care for up to 16 older people and people living with dementia. At the time of our inspection there were 14 people living in the home.

The home is a bungalow on the edge of Sawtry close to the A1(M) road. There is an enclosed rear garden and car parking and small garden area to the front. The

bedrooms are single occupancy and there are communal bath and shower facilities. There is a communal lounge, dining room and conservatory for people and their visitors to use.

This unannounced inspection took place on 2 January 2015. The previous inspection was on 15 July 2013 and the provider was meeting the regulations that we assessed.

The home had a registered manager in post. A registered manager is a person who has registered with the Care

# Summary of findings

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.

The risk of harm for people was reduced because staff knew how to recognise and report abuse. There was a recruitment process in place and only suitable staff had been employed to work in the home. There were sufficient staff numbers to meet people's care and support needs.

People were protected from unsafe management of medicines because staff had received the necessary training and there were procedures in place for staff to follow.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Staff understood MCA and DoLS and were aware of what they meant for people in the home. People who lacked capacity for decision making had best interest assessments completed but the decisions and actions to be carried out on behalf of the person needed to be better recorded.

Staff received an induction when they first started working in the home and were supported in their roles through regular supervision and annual appraisals.

People's health and care needs were assessed and reviewed. People had access to a wide variety of health professionals who were requested appropriately by staff and who provided staff with guidance to maintain people's health and wellbeing.

People were provided with adequate amounts of food and drink to meet their nutritional and hydration needs.

People were encouraged to take part in their individual social activities and interests, which they enjoyed.

People living in the home and their relatives found the staff and managers to be caring and kind. Relatives were kept up to date about their family member's health and welfare.

People and their relatives were confident that any concerns or complaints raised with the management would be dealt with appropriately. Relatives advocated on behalf of people in the home, but independent advocates could be found for them by the staff or management if required.

The provider had an effective quality assurance system in place which was used to help drive improvements to the quality of people's care provided and the home that they lived in.

# 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 safe.

People felt they were safe. Staff knew how to recognise and report abuse so that people's risk of harm was reduced.

People were looked after by a sufficient number of suitable staff.

Individual risk assessments had been written so that staff could reduce people's risk. The administration and management of medicines was undertaken correctly, which meant people were protected.

Good



### Is the service effective?

The service was effective.

People's rights were protected so that people were not unlawfully restricted or deprived of their liberty, but best interest decisions needed to be formally better recorded.

People were supported to have enough food and drink to make sure their health was maintained.

Staff received supervision and appraisals and had completed training specific to their role.

Good



### Is the service caring?

The service was caring.

People and/or their relatives were involved in agreeing plans for people's care.

Staff knew the care and support needs of people in the home and treated people with kindness.

Good



### Is the service responsive?

The service was responsive.

People had their needs assessed and staff knew how to support people, meet their needs and maintain people's independence.

People who lived in the home and their relatives knew how to make a complaint if they needed to.

People were supported and encouraged to take part in a range of individual interests in the home and in the community.

Good



### Is the service well-led?

The service was well led.

Staff and people who lived in the home were involved in the development of the service.

A robust audit system ensured that any improvements that were required were identified and actioned in a timely manner.

Good



# Hill View

## Detailed findings

### Background to this inspection

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

This inspection took place on 2 January 2015 and was unannounced.

This inspection was completed by an inspector. Before the inspection we asked the provider to complete and return 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 any improvements they plan to make. The provider completed and returned the PIR form to us and we used this information as part of our inspection planning.

We looked at other information that we held about the service including notifications, which are events that happen in the service that the provider is required to inform us about by law.

During the inspection we spoke with four members of care staff and the deputy manager. We also spoke with the cook, domiciliary staff and the person who provides hobbies and interests. We observed the way staff and people in the home interacted. We spoke with six people living in the home and five relatives. We spoke with two district nurses during the inspection and one social worker after the visit.

As part of this inspection we looked at two people's support plans and care records. We reviewed two staff recruitment, induction and training files. We looked at other records such as accidents and incidents, complaints and compliments, medicine administration records, quality monitoring and audit information, policies and procedures, and fire and safety records.

# Is the service safe?

## Our findings

People and their relatives told us they felt safe in the home. One person told us, “I have my own room but I know someone is there if I need help.” A relative said, “[My family member] feels safe and happy and that’s the main thing.”

All staff had undertaken safeguarding training to ensure their knowledge and skills were up to date. During this inspection we found that staff were able to tell us how they would respond to allegations of abuse and the procedures for reporting these concerns to the appropriate agencies so that people could be protected. Staff told us that they were aware of the whistleblowing policy but had never needed to use it. One staff member said, “I would have no qualms about going to the [registered] manager or deputy.”

We looked at the care plans for two people living in the home and found that there was a process in place for assessing and managing risks to their safety. We saw that risks had been assessed using tools such as the Waterlow assessment for risk of developing pressure ulcers and the MUST (Malnutrition Universal Screening Tool) to identify people at nutritional risk. There were also individual risk assessments covering areas such as the safe self-administration of medicines and assistance using equipment such as hoists or wheelchairs. These assessments made sure that all aspects of the risk were identified and used to develop an appropriate and safe plan of care, which staff were able to tell us about.

There was information in the home’s emergency evacuation file that showed plans were in place to keep people safe in the case of an emergency such as a fire. We saw details of how individual people in the home would need to be assisted and staff were aware of where this information was kept.

Where accidents or incidents had occurred in the home, any necessary action had been taken and further measures had been put in place to minimise any similar event happening again. The registered manager checked if there were any patterns of events and, where necessary, referrals were made to other health or social care professionals or other action was taken as a result of learning from these incidents. The district nurses told us that the staff in the

home worked well with them and requested appropriate support when needed. They also said that staff always contacted them for clarification and guidance where necessary.

People told us that there were enough staff to help them when they needed. One person said, “If I need them I have a button [call bell] and they come very quickly. I feel safer here than anywhere else.” On the day of inspection we noted that people’s call bells were answered quickly. We saw that people who were sitting in communal rooms were assisted by staff who were on hand to provide the support they needed. All the staff we spoke with said there were sufficient numbers of staff on duty to meet people’s care and support needs. Staff told us that there were no agency staff used in the home and this was confirmed by the staff rotas we looked at. Staff told us they covered any holiday or sickness so that people in the home received consistent care. One staff member said, “It’s a good team.”

There were recruitment procedures in place and we saw that all appropriate checks had been obtained prior to staff being employed to ensure they were suitable to work with people living in the home. Staff confirmed that they had not been able to start work until a disclosure and barring check, and appropriate references had been received.

We observed staff when they administered medicines for people and checked the medicine administration record (MAR) chart. We saw that MAR charts were completed appropriately and showed that people had been given their prescribed medicines. We heard how they informed people about the medicines they were due to have and heard one person ask the staff member what the tablets they were about to take and what they were for. They received a good clear and understandable explanation and were satisfied with the answer. People who had medicines to take were not rushed when they were taking their tablets. We heard the member of staff listen to one person and discussed with them about the level of pain they were experiencing and reassured them that the district nurse would be informed. The phone call to the district nurse was made as soon as possible and the person was informed.

Specific training had been provided to staff who administered medicines. We saw that people’s prescribed medicines were stored safely and checks were made by staff to ensure that medicines were kept at the correct

## Is the service safe?

temperature. Records of when medicines were received into the home, when they were given to people and when they were disposed of were maintained and checked for accuracy as part of on-going quality checks.

# Is the service effective?

## Our findings

Staff told us they had been provided with an induction, regular supervision and yearly appraisals.

They told us that they had undertaken a range of training including dementia, food hygiene, first aid and infection control and this supported them to do their job effectively. One staff member said, “I’m up to date with all caring, moving & handling and safeguarding training.”

The registered manager and staff had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and had received some training. They knew what steps needed to be made to protect people’s best interests and how to ensure that any restrictions placed on a person’s liberty were lawful. People who lacked capacity had best interest assessments completed. Day to day decisions needed to be better recorded so that staff were made aware of the outcomes for people and could provide consistent care.

We saw that some people who lived in the home were not able to make some decisions about their care due to them living with dementia. Staff were aware that for those people who lacked capacity, their ability to make specific decisions should be assessed each time in line with best interest decisions. Our observations throughout the day confirmed that this was the case.

The CQC monitors the operation of DoLS which applies to care services. The registered manager said that there had been no applications because people did not have restrictions imposed on them. We saw that people were able to move about the home freely and staff said anyone who wanted to leave the home (to go for a walk for example) could be accompanied by a member of staff if necessary and would not be prevented to leave.

People in the home told us the food was varied and the meals were good. One person said, “We tell the cook if we like the food. We also tell him if we don’t.” Another told us, “You can have a cooked breakfast, they’ll do [cook] anything for you.” The district nurse said, “Staff use

different foods to try to get people to eat and encourage them all the time. Food that is fortified or enriched is perfectly done and this shows in the weights [of people in the home].”

The cook told us there was a monthly review of the food provided in the home, which included any changes in people’s likes and dislikes. Most recently sausages had been taken off the menu as people didn’t like them and two people who overheard the conversation agreed that they had not liked the sausages. The cook told us, and people agreed that there were now other alternatives such as pies and lasagne. People told us that if they did not like any particular meal an alternative would be provided, but no one had needed that option. The cook was able to tell us that one person had a gluten free diet and that special food had been provided. People were satisfied with the availability of drinks and there were cold drinks in all areas of the home and hot drinks were available for people when they wanted. We saw that staff asked people if they wanted a drink as they passed by and any request for a drink was supplied straight away. One person said, “You can have a drink when you want. They’re [staff] always making us a drink.” There was fresh fruit available in the lounge for people to take and eat at any time.

People and their relatives were satisfied with how their health needs were met and had access to a range of health professionals. Relatives said they were contacted whenever their family member had any health issue. One person said that they had seen their GP and medicines had been provided. A relative said, “[My family member] sees the GP and chiropodist whenever they need them.” Another relative said, “[My family member] has seen the district nurse today.”

Care records showed that the GP, district nurses, dietician and chiropodists had provided care to people where necessary. One district nurse said, “We come every morning. Everything we need is handed over. All the staff are approachable and have a great rapport with the people in the home.” They also told us that whenever they provided instructions for staff, in relation to people’s health and welfare, their instructions were always followed. For example inflated seat cushions were always in the seat for the person and always properly inflated.

# Is the service caring?

## Our findings

People told us the staff were caring and kind. One person said, “I’m being well looked after.” One relative said, “We [the family] are very happy and content with [family member’s] care. The family know she is well cared for.” Another relative told us, “I know all the carers [care staff] and I wouldn’t have put [family member] in the home if I hadn’t known the people who work here.” One District nurse said, “Staff treat them [people living in the home] like their own family.” We saw that there was a consistent approach from staff that was very supportive with people and their relatives. We saw that people were assisted appropriately and involved individually or with others in the home to join in conversations and enjoy a sense of fun and banter.

We heard how people asked staff questions and these were always answered by staff in a way that meant they had been understood and listened to. For example one person had lost their walking stick and staff immediately talked with the person about where they had been. Staff checked with them in their bedroom then other communal areas, told other staff to be aware and ensured the person was assisted to walk because they were slightly unsteady without the stick.

People received individualised care that was caring and supportive. We saw that staff engaged with people and explained to them what was going on, for example, if there was a task being completed such as assisting to walk to the lunch table or to the bathroom.

We saw that people’s privacy and dignity were respected. People had their own bedroom with a wash basin. There were communal bathing and toilet facilities, all of which were lockable. People had a number of communal rooms such as the lounge, dining room and conservatory they

could use. We saw that people were able to chat with visitors in the lounge or went into their bedroom for privacy. One person said, “I like to watch TV or read in my room [bedroom]. I choose not to go out.” People in the home told us they were able to spend time in their own rooms or in communal areas and those people in their bedrooms confirmed to us that they had chosen to be there.

People’s privacy and dignity were maintained because staff knocked on people’s bedroom doors and waited until the person had responded before they entered, even where the bedroom door was already open.

The deputy manager told us that people in the home had relatives who acted on their behalf, but information would be found for an independent advocate if anyone in the home wanted one. Advocacy information on the internet was available but not displayed within the home. Relatives confirmed that they advocated informally on behalf of their family member, some had legal powers in place to do so through the Power of Attorney.

End of life care was supported in the home by the district nursing service because the home does not provide nursing care. Staff told us that they tried, as far as possible, to allow people to remain in the home at the end of their lives and not go to hospital. The district nurse said, “End of life care is excellent. It is so smooth, nothing is a problem.” Both district nurses felt people would have access to the specialist services they required in the home at the end of their lives. We saw that there was some information in people’s files about the arrangements and supports they wanted for their end of life care. There was no-one in the home who needed end of life care at the moment. More information would be necessary to ensure staff knew how to manage and follow people’s choices and wishes to meet their end of life care needs.

# Is the service responsive?

## Our findings

Pre admission assessments had been completed so that people were living in the appropriate home where staff could meet their care and support needs. Staff told us that care plans had been written by the manager or deputy manager and there was evidence that people or their relatives had been involved in their completion. The care plans provided individual information about each person that showed how their care needs should be met. Staff we spoke with were aware of each person's care needs, how to meet them and how to ensure their independence and individual identity. There was a process in place where monthly reviews were completed. Where changes had occurred in a person's health or welfare, care plans had been updated.

We spoke with one relative who told us, "If I make a suggestion or constructive comment [about family member] they [staff] act on it." The relative felt staff listened to them and then responded to support their family member's individual care needs.

Two people told us they had a bath or shower on a specific day but were quite happy with that arrangement. One person told us, "I go to bed when I want to or go to my room whenever I like. I can have a shower or bath but I missed my day this week with not being so well." The person told us they could have had a bath or shower at any time in the week but chose not to.

People were supported to pursue their own interests. One person said, "I don't go out – I choose not to. I watch television and do crosswords and word searches with the activities person." Another person said, "I read, do skittles, and staff do our nails and play dominoes." Evidence showed that staff supported people with their individual interests, which included nail painting, card games, word searches and musical afternoons. Relatives we spoke with gave us examples of visits out of the home their family members had made to garden centres and shopping trips. Relatives confirmed, and we saw during the inspection, that people were involved and encouraged to join in different games such as dominoes, cards, skittles and individual time to chat. Many relatives visited during the day and they spent time talking with not just their family member but other people they knew in the home, which gave the home a very family like atmosphere.

People and their relatives said that they knew who to speak with if they were unhappy about something. One person said, "I've got no grumbles. I would go to the manageress [registered manager]." Another person told us, "I had trouble with [a piece of equipment]. It was done immediately." One relative said, "No complaints about the care; if there were any problems we would get right onto it." There was a record of the complaints which showed they had been dealt with appropriately and action taken where necessary.

# Is the service well-led?

## Our findings

There was a registered manager in post and they were supported by the registered provider and deputy manager. Most people we spoke with knew who was in charge of the home and their name and said they had seen them recently. The registered manager was not in the home at the time of the inspection. When the deputy manager walked around the home people recognised them and knew their name but not their title. We saw that the deputy manager was familiar with people and their needs and that people were comfortable talking with her.

Staff had a clear vision of the aims of the home. The cook said, "I love working here. I know people's likes and dislikes, I check their tablets to make sure the food is right for them and I make special cakes for people who need gluten free foods." One member of staff said, "Anything to do with the residents and they're [registered manager and deputy] straight on it. The residents come first." One district nurse said, "Marvellous. I'm moving in here. This is like people's own home." A member of staff said, "I like it here. It's small and you get to know the residents [people living in the home] and they get to know you. It's the personal touch. They see the same faces."

We had received notifications which demonstrated that the provider was meeting their legal requirements and responsibilities.

People in the home and staff said they felt involved in the running of the home through the regular meetings that

were held. Staff said the meetings had open discussions. One person told us that, "The meetings talk about what we like and don't like, [for example meals], and what we want to do [for example interests or hobbies]." Minutes of both meetings showed the actions to be taken and the outcomes. Where staff felt the action had not progressed they brought the issue back to discuss at the next meeting. Staff said that this did not occur often. We saw that changes had been made as a result of the comments such as menus changes and different trips and social activities being made available.

There were regular visits from the provider to check quality monitoring of areas such as care plans and audits and to improve standards. We saw that an issue in relation to the laundry had been addressed and information and guidance given to ensure the issue did not arise again.

Accidents and incidents were reported appropriately and we saw that action was taken when this was needed. For example if a person fell a body map, showing any injuries, was completed and information on any health professionals who had been requested and involved was recorded.

We saw that a number of audits, checks and quality monitoring from the provider had been completed regularly in the home. There were fire procedures in place and fire drills were undertaken (including some at night) so that all staff knew what to do in the event of a fire.