Hampshire County Council

Oakridge House Care Home with Nursing

Inspection report

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Date of inspection visit:
22 May 2017
23 May 2017
25 May 2017

Date of publication:
14 July 2017

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

Summary of findings

Overall summary

This inspection was unannounced and took place on the 22, 23 and 25 May 2017.

Oakridge House Care Home with Nursing (Oakridge House) is a home which provides nursing and residential care for up to 91 people who have a range of needs, including those living with dementia, epilepsy and diabetes and those receiving end of life care. The home also offers a discharge to assessment unit for 10 people. This unit is for people who require a period of short term care treatment and support upon their discharge from hospital. This placement is to ensure people are able to meet their own needs safely before moving home or seeking additional support in another social care setting. At the time of our inspection 87 people were living at Oakridge House.

Oakridge House is a large two storey building set in secure grounds on the outskirts of Basingstoke town centre. The home comprises of three distinct units, residential, nursing and discharge to assessment. Each unit includes communal areas such as dining rooms with basic kitchen facilities including a microwave, fridge and food storage and preparation areas with access to a lounge and quiet seating areas. There is a secure garden which sits in the middle of the units with seating and raised planting areas to ensure accessibility by people living at the home. This report will refer to all three units collectively as 'the home' throughout this report where not individually specified.

The home has 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 2008 and associated Regulations about how the service is run.

People using the service told us they felt safe. Staff understood risks to people's health and wellbeing however we did not see this guidance was always documented. Where risks to people's health and wellbeing were known staff did not always take steps to ensure these risks were minimised appropriately.

People told us they sometimes had to wait to receive care however; we could see people were supported by sufficient numbers of staff to meet their needs. The provider was able to adapt their staffing levels appropriately when required in order to meet changes in people's needs.

People were not always supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible however the systems in the service did not support this practice.

Where people lacked the capacity to make specific decisions for themselves that actions taken on their behalf were always in their best interests.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards which apply to care homes. The registered manager showed an understanding of what constituted a deprivation of a

person's liberty and was able to discuss the processes required in order to ensure people were not deprived of their liberty without legal authority.

Documentation relating to the completion of care were not always completed fully to demonstrate people received the care they required to maintain their health and wellbeing.

People were not always provided with the opportunity to participate in activities allowing them to live interesting and fulfilling lives. During the inspection the registered manager launched a new initiative that people would receive a minimum of 10 minutes of staff members time each day however, time was required to see if this practice was effective and embedded in working practices.

People were not always supported to eat and drink safely whilst maintaining their dignity and independence.

Quality assurance processes in place were not always effective in identifying the issues identified during this inspection. Where action had been identified as necessary the provider's action plan had not been regularly updated to show where improvements had been made and where additional action was identified as required.

We saw that people were able to choose their meals and were offered alternative meal choices where required. Most people's food and drink preferences were documented in their care plans and were understood by staff. People were supported to eat and drink enough to maintain a balanced diet.

Recruitment procedures were fully completed to ensure people were protected from the employment of unsuitable staff.

People received their medicines safely, staff had received the appropriate training to enable them to complete their role safely and medicines were stored, administered, disposed of and documented appropriately.

Contingency plans were in place to ensure the safe delivery of people's care in the event of adverse situations such as a fire, flood or utilities loss. These were easily accessible to staff and emergency personnel such as the fire service, if required to ensure people received continuity of care in the event of an on-going adverse situation which meant the home was uninhabitable.

People told us that care was delivered by kind and caring staff who sought to meet their needs and ensure they were happy. We saw that people had friendly and relaxed relationships with staff who would stop and speak with them when moving around the home.

People's health needs were met as the staff and registered manager promptly engaged with other healthcare agencies and professionals to ensure people's identified health care needs were met and to maintain people's safety and welfare.

People received care which was regularly reviewed to ensure it contained the most current guidance for staff on how to effectively meet people's needs. Care plans and risk assessments were reviewed monthly to ensure they remained accurate to enable staff to meet people's needs.

People knew how to complain and told us they would do so if required. Procedures were in place for the registered manager to monitor, investigate and respond to complaints in an effective way. People, relatives

and staff were encouraged to provide feedback on the quality of the service during regular meetings with staff and the registered manager.

People and staff told us registered manager provided positive leadership and fulfilled a number of the requirements associated with their role as a registered manager.

The registered manager had informed the CQC of notifiable incidents which occurred at the service allowing the CQC to monitor that appropriate action was taken to keep people safe.

The provider's values and peoples 'Charter of Rights' were provided to people and known by staff. Staff understood these and relatives told us these standards were evidenced in the way that care was delivered.

The registered manager and staff promoted a culture which focused on being open, honest and delivering care which was highly individualised, respected people's dignity and provided people with the opportunity to fulfil their potential.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we have told the provider to take at the end of the full version of this 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

The service was not always safe.

Risks to people's health and wellbeing had not always been identified and recorded with detailed guidance provided to staff in order to manage these safely for people. Where risks were known staff did not always take the appropriate action to ensure people were kept safe whilst eating.

People were safeguarded from the risk of abuse. Staff were trained and understood how to protect people from abuse and knew how to report any concerns.

There was a robust recruitment process in place. Staff had undergone thorough and relevant pre-employment checks to ensure their suitability.

Medicines were administered safely by nurses and staff whose competence was assessed by appropriately trained senior staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to make their own decisions however, where they lacked the capacity to do so the provider had not always ensured the legal requirements of the Mental Capacity Act (MCA) 2005 were met. Decisions had been made regarding the care people received without following the best interest decision making process.

The registered manager demonstrated an understanding of the Deprivation of Liberty Safeguards.

People were able to eat and drink enough to maintain their nutritional and hydration needs.

People were supported by staff who had the most current knowledge available from detailed care plans to best support their needs and wishes.

People were supported by staff who sought healthcare advice

and support for them as required.

Is the service caring?

Good

The service was caring.

People told us that staff were caring. Staff were motivated and developed positive relationships with people.

People were encouraged to participate in creating their personal care plans.

People received care which was respectful of their right to privacy whilst maintaining their safety.

People's end of life wishes were respected and staff showed compassion when providing care once people had passed away.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were not always sufficient numbers of activities staff to ensure all people received personalised one to one interaction when unable to participate in group activities. The registered manager was taking action to address this.

People's needs had been appropriately assessed. Staff reviewed and updated people's risk assessments on a regular basis and when people's needs changed.

There were processes in place to enable people to raise any issues or concerns they had about the service. Any issues, when raised, had been responded to in an appropriate and timely manner in accordance with the provider's complaint policy.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance processes were not always effective in identifying shortfalls in the quality of the service provided so that continual improvements could be made

The registered manager promoted a culture which placed the emphasis on people receiving quality care from staff in a calm environment which promoted people's independence.

Staff were aware of their role and felt supported by the registered

manager and their immediate managerial staff. They told us they were able to raise concerns and felt the registered manager provided good leadership.

The registered manager informed the Care Quality Commission about important and significant events that occurred at the location.

Oakridge House Care Home with Nursing

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 function. This inspection checked whether the provider was 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 the 22, 23 and 25 May 2017 and was unannounced. The inspection was conducted by three inspectors and two Experts 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, on this occasion both experts had experience of family members who had received nursing care. The Expert by Experiences spoke with people using the service, their relatives, visitors and observed mealtime sittings and interactions between staff and people living at the home.

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We had not requested a Provider Information Return (PIR) before the inspection. A PIR is a form which asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make. We checked this information as part of our inspection.

During the inspection we spoke with twelve people, seven relatives, two visitors, two nurses, the chef and two catering assistants, one activities coordinator, eight care staff, the deputy manager, and the registered manager. We looked at 18 care plans, 10 of these people's associated daily care notes, seven staff recruitment files, staff training records and 30 medication administration records. We also looked at staff rotas for the period 14 April to 15 May 2017, quality assurance audits, the provider's policies and procedures, complaints and compliments and staff and relative meeting minutes. During the inspection we spent time observing staff interactions with people including during activities and lunch time sittings.

The previous inspection took place on the 17, 18 and 19 May 2016 where no concerns were raised.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Oakridge House, one person told us, "Yes, pretty much so (feel safe)". This was a view confirmed by relatives and visitors to the home, one visitor said, "Yes, you can see when you come in she (friend) is safe", a relative told us, "She's (family member) safe here and getting all the care she requires, there's no doubt about that".

Despite people feeling safe not all risks to people's health and wellbeing were identified with guidance provided to staff regarding how to mitigate the risk of harm to them.

People's care plans included their assessed areas of risk, for example: people's moving and handling needs, their identified falls risk and any individualised risks identified such as the risk of acquiring an injury when mobilising due to the types of medicines they were prescribed. These risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people. For example, some people using the service had restricted mobility due to their physical health needs. Information was provided in these people's care plans which provided guidance to staff about how to support them to mobilise safely around the home and when being transferred.

However, these were not always completed when required; placing people at risk of receiving care which did not always meet their needs. For example, we saw one person had been identified as being at risk of choking as a result of eating their food too fast. This risk had been highlighted in this person's care plan and within this information stated staff were to monitor them when eating to encourage them to chew their food slowly. Despite this risk being identified there was no risk management plan completed with guidance to ensure this guidance was made clear for staff regarding the action they were required to take in order to keep this person safe whilst eating. Whilst staff were able to identify this person was supposed to be supported whilst eating to ensure they were closely monitored minimising their risk of choking this was not always the action taken by staff. During the inspection this person was left alone with the inspector whilst they were eating their lunch and during this time proceeded to cough, sneeze and bring up small amounts of food. This was whilst they were displaying their known behaviour of eating too quickly. This was brought to staff's attention and they remained in the lounge whilst this person finished their meal.

Some people living at the home on occasions displayed behaviour which could challenge others and place them; other people and staff at risk of abuse or injury however guidance on how to manage these incidences were not always fully assessed and documented. For example, there were a number of people who could become verbally and physically aggressive during the delivery of their care. There was insufficient information contained within these people's care plans to ensure all staff working with them were able to meet their needs appropriately. This was required to minimise the risk of injury to people, family members, visitors and staff.

Another person was identified during their pre-assessment prior to moving to the home as being allergic to a particular food item. However this information had not been made available to the chef and catering staff. There was no risk assessment in place regarding this person's food allergy. Staff we spoke with were aware

of this person's allergy however if a new member of staff was deployed or staff from another area of the home unfamiliar with this person were deployed to deliver care there was a risk that this person would receive a meal which may not meet their needs placing them at risk of suffering from a physical ill effect.

These issues were raised with the registered manager during the inspection who took immediate action to ensure people's identified risks were documented appropriately. Risk assessments were completed where necessary to ensure risks to people's wellbeing were minimised wherever possible. Time is needed to ensure this additional work is effective and embedded in staff's working practices.

People provided mixed views when asked if there were enough staff deployed in order to meet their needs in a timely fashion. People told us they would often wait to receive care once they had used their call bell to request staff. Staff provided mixed views regarding whether or not there were enough staff available to meet people's needs at the time they required.

One person told us, "I shout out and they (staff) come quickly and they seem to have enough staff." However, other people told us they had experienced delays when using their call bell to request support. One person told us, "There's not enough staff. Sometimes I've had to wait up to an hour". Another person told us, "Not really enough staff". This was a view shared by relatives, one told us, "Think they (the home) are a bit under-staffed at times. Sometimes he (family member) needs the toilet and there's only one person on the whole wing, lunchtime is the worst - he just has to wait". Another relative said, "We've pressed the buzzer and waited 40 minutes…Just not enough staff", another relative told us, "When he (family member) was on the floor above I've literally seen nurses running they were so busy. I've had to go and hunt for carers when he's needed the toilet. And told they will come and then had to follow up again and still wait".

Staff provided mixed opinions regarding whether or not there were sufficient numbers of staff deployed. Most staff told us they felt there were sufficient numbers of staff deployed, however, on the occasions where staff were unable to work due to last minute reported sickness this would result in an increase in the workload of those working. Staff told us people were not missing their care as this was always prioritised, on these occasions additional tasks such as laundry being managed would be delayed until people's care needs were met.

The registered manager identified the staffing levels in the home consisted of three nurses, three deputy managers, one assistant unit manager and 17 care staff during the day with the inclusion of six domestic staff. When people were receiving end of life care or required additional support as a result of their deteriorating health needs additional staff were deployed appropriately to meet these changes. Where shortfalls in the rotas had been identified these had been supported by the existing staff team offering to complete these shifts as overtime and the occasional use of agency staff. Agency staff had been used on two occasions during the time period reviewed to support existing staff numbers. Records and observations during the inspection showed there had been deployment of sufficient numbers of staff to meet people's needs safely. Call bells were not continually ringing throughout the home and when used were responded to promptly by staff. There was a calm atmosphere amongst the units and staff did not appear to be rushing the delivery of care indicating sufficient numbers of staff were deployed to meet people's needs.

The registered manager informed us they did not routinely monitor call bell response times as part of their quality assurance processes to ensure people were having their needs met in a timely way. This auditing would only be undertaken should a complaint be raised by those living at the home, their family members or any visitors. We could see no formal complaints had been made regarding call bell response times therefore this auditing work had not been completed.

People were safe from the risk of suffering abuse as staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns and felt confident to report any concerns to the registered manager, the provider and external agencies such as the local authority social services and the Care Quality Commission if required. People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if they identified these.

When accidents or incidents occurred these were documented fully and audited to enable the registered manager and provider to identify if there were any actions which could be taken to prevent a reoccurrence. The provider had an incident reviewing group which was responsible for auditing incident and accident forms in order to identify trends and patterns of falls. They also provided guidance and advice to the registered manager regarding the steps they could take to minimise future incidents. Through these auditing process the group had identified that one person had experienced a high number of falls in a three month period. A number of suggested actions were made to ensure this person's health and wellbeing needs were met to try and minimise any future falls. We could see positive action had been taken to try and minimise the number of falls this person had been experiencing.

There were robust contingency plans in place in the event of an untoward event such as fire, flood, staff shortages and accommodation loss due to these events. Personal Emergency Evacuation Plans (PEEPs) had been completed for people living at the home. These provided an easy to follow guide for staff and emergency personnel. The PEEPs included information regarding people who required additional assistance due to their complex needs in the event of a fire. If rooms were no longer suitable for habitation then people would be moved to the provider's other homes within the county to ensure continuity of care. These plans allowed for people to continue receiving the care they required at the time it was needed.

Robust recruitment procedures ensured people were assisted by staff with appropriate experience and who were of suitable character. Staff had undergone detailed recruitment checks as part of their application and these were documented and held centrally by the provider. However, the registered manager was able to monitor the application process through the provider's computer system enabling them to see when these checks had been completed. These pre-employment checks included obtaining written previous work and personal character references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff that may be unsuitable to work with people who use care services. Professional registration documents for nurses were not always available and updated to show they remained registered in order to provide nursing care. Immediate action was taken during the inspection to ensure this information was available. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

People living at the home received their medicines safely. Nurses received additional training in medicines management, and records showed medicine administration records (MARs) were correctly completed to identify that people received their medicines as prescribed. Nurses were also subject to competency assessments to ensure medicines were managed and administered safely. Nurses ensured the administration and management of medicines followed guidance provided by the Royal Pharmaceutical Society.

Guidance was provided in people's MARs for nurses regards when the use of additional medicine would be appropriate. This is referred to as 'when required' medicines and can include medicines to manage pain which are not required frequently and medicines associated with relieving constipation. The provider used a documented pain identification guide to enable nurses to measure the level of pain people were suffering

when people were unable to verbally communicate their levels of distress. This allowed nurses to identify the appropriate level of pain relief required to manage people's health and medical needs. We saw information was provided as to when additional medicine would be required and this guidance was followed appropriately.

Some people living at the home required medicines which must be provided at particular times of the day. These can be medicines which are used to manage conditions such as epilepsy, diabetes and Parkinson's disease. These medicines were managed safely and provided at the prescribed appropriate time which was confirmed with a resident we spoke with who told us, "My tablets come on time and they give them to me".

Medicines were stored, administered and disposed of correctly. There was a medicines fridge which was kept at the appropriate temperature. Records confirmed a safe temperature was maintained. The provider used a nationally recognised policy to ensure that controlled drugs were managed effectively. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. The registered manager and nurses undertook weekly monthly audits in all area of medicines management including controlled drugs stocks to ensure people were receiving their medicines as prescribed.

Requires Improvement

Is the service effective?

Our findings

Most people, relatives and visitors we spoke with were positive about the ability of staff to meet people's care needs. One person told us, "No problem at all with staff they're good", another person said, "Oh yes, they know what they are doing, when they come" and another person told us, "Oh yes the staff are very efficient and nice to me". However other people did not always agree with this view, one person told us, "Sometimes they (staff) are pretty good, sometimes pretty awful". A relative told us, "Staff need a bit more training on transferring patients from bed to wheelchair and wheelchair to seat". Other relatives spoke positively about the skills and experience of the staff delivering care. One relative we spoke with said, "Well in my experience the staff do know his (family member's) needs and they are lovely and the level of English is very good".

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager showed a comprehensive understanding of the Safeguards which was evidenced through the appropriately submitted applications and authorisations. Staff were not always able to clearly identify the principles of the MCA, however, people told us and staff demonstrated that they complied effectively with the MCA by offering people choices with their day to day care. Staff spoken with understood why the Deprivation of Liberty Safeguards were required.

However, when people had been assessed as not having the capacity to make key decisions about their care, the provider had not always documented that actions taken were in people's best interests. Best interests decisions are made in conjunction with people close to the person deemed to lack capacity to make that specific decision. These processes are to ensure the decision being made on that person's behalf reflects their needs and that any action taken is for the benefit of the person. For some people applications made to deprive them of their liberty had not always been discussed with relevant persons and documented fully as being in their best interests. This meant people were at risk of having their liberty deprived without the appropriate processes to ensure this action was necessary, proportionate and in the person's best interest.

Other people had been identified as not having the capacity to agree to their personal care however no best interests' decision process had been followed to ensure the care provided was for their benefit. For some people who did not have capacity to agree to their care their next of kin had signed documentation stating they had agreed to the care being provided. However, there was no evidence in these care plans that the

next of kin who signed the documentation had been identified as having a Power of Attorney (POA) for Health and Welfare. A person with a POA for health and welfare has the legal ability to make decisions about a person's care, a relative who is identified as next of kin does not have the legal authority to make decisions or agree to care on a person's behalf. For other people the appropriate MCA and best interest decision making processes had not been followed for people who were receiving medical support and interventions in order meet their wellbeing.

These issues were raised with the registered manager during the inspection who took immediate action to ensure their compliance with the MCA. They reviewed people's care plans and ensured people who did not have capacity to make decisions about their care were appropriately assessed with the best interest decisions processed followed fully. Time is needed to ensure this work is effective and becomes embedded in working practices.

People, relatives and visitors were mainly complimentary about the food provided and some people living at the home were supported by staff during meal times. One person told us about the food, "No, I never get hungry…the food I eat is good", another person said, "Food is good and I get a good choice". Relatives and visitors also spoke positively about the food provided to their loved ones. One relative told us, "Food is good and my wife has a good appetite. She is well fed and kept very hydrated. They still ask her for choice of food" and a visitor told us, "The food is good as far as we know and she (friend) never seems to be hungry". However this was not a view shared by all. One person told us that the food provided was not appropriate to meet their specific needs, 'You get one hot meal a day and sandwiches for the other meal… I have my hot meal for tea…they (staff) keep putting veg on my plate which I can't eat which upsets me". Another person told us, "It could be cooked better and you get the same thing repeatedly mince". A further person said, "Food is 60/40 [60% good]. No one knows how to cook porridge, but I get a choice (of meals)". A relative told us about the food, "It's better than where he was before, the complaint I've made are about the food the veg is over cooked and grey but I have told x the carer I can see why some of the people don't eat it I think they would if it was cooked better".

People were supported at mealtimes by staff who were patient and attentive to their needs. Staff knew the people they were supporting and were able to identify people's preferred choices for meals which were provided. People had drinks readily available to them and these were regularly offered to support people to maintain their health and wellbeing. Snacks such as sandwiches, fruits and yoghurts were available to people day and night in the event they wished to have something additional to eat.

The chef and catering assistants showed a good knowledge of the people they supported, however, were reliant on care staff to inform them of people's preferences and any known food allergies. This process was not always effective. For example it had been identified during one person's pre-assessment prior to moving to the home that they were allergic to a particular food item. The chef and catering staff were unaware of this information and unable to evidence this was documented or noted within the kitchen. Staff we spoke with were aware of this person's allergy however if a new member of staff was deployed or staff from another area of the home unfamiliar with this person were deployed to deliver care there was a risk that this person would receive a meal which may not meet their needs placing them at risk of suffering from a physical ill effect.

People's documented food preferences were not always updated when their diet changed. Whilst people were receiving the correct diet there was a risk if new or agency staff were used they would not be aware and people would receive food which did not meet their needs. For example, a person living at the home had been identified as at risk from choking and their nutrition sheet held in the kitchen identified them as requiring a pureed diet. Staff told us this person had previously required a pureed diet, however, their health

had improved so they were now receiving a normal diet, which we saw was provided. Despite this catering staff were clear about other people who had a range of specific dietary needs such as those who required a diabetic, pureed, fortified or soft diet. We could see that care had been taken when presenting pureed food so that it retained its' visual appeal and foods were separated on the plate to enable people to identify what they were eating.

Documents did not always show people received the care they required in order to maintain their skin integrity. It was not recorded that people at risk of suffering a pressure ulcer were repositioned at the time intervals described as necessary in order to minimise this risk. If people manoeuvre or are placed in one position for a prolonged period of time they can become vulnerable to experiencing pressure ulcers. One person's care plan stated they should be re-positioned every three hours in order to protect their heels; records did not confirm this was happening. Another person's repositioning chart did not identify to staff how frequently they should be supporting this person to change their position in their bed. Another person required their heels to be checked hourly. However, this had not been documented as happening as required. Care staff were aware of the intervals of which people should be repositioned and there had not been a deteriorating of people's pressure ulcers as a result. This indicates correct care was being provided however, this care provided to people was not being documented appropriately. Quality assurance processes in place had not identified these records were not being completed fully.

This concern was raised with the registered manager who took immediate action to discuss the completion of documentation with nursing staff. As a result nurses would now be responsible for ensuring documentation relating to people's care was reviewed on a daily basis. Time is needed to ensure this work is effective and embedded in the nurses working practices.

People were assisted by staff who received a thorough and effective induction into their role at Oakridge House. This induction had included a period of shadowing experienced staff to ensure that they were competent and confident before supporting people. Staff told us this was a useful experience and that they felt supported. New staff were required to complete an induction which was based on the Care Certificate and told us they felt this was a valuable experience. The Care Certificate is a structured induction programme which ensures staff are sufficiently supported, skilled and assessed as competent to conduct their role and meet the needs of the people they support.

The provider had identified training which they felt was essential for staff to complete to enable them to provide people's care and ensured training refreshers were completed when required. Staff spoke positively of the training provided, one member of staff told us, "The training is very good here actually", another member of staff said, "There's so much training… Training is good…I've just done my moving and handling refresher it's always done in time, the training in Hampshire is very good". As a mandatory package staff had undergone training in areas including infection control, managing the risk of choking, safeguarding adults and first aid. Staff were also supported to complete training in the following areas, the MCA, epilepsy awareness, dementia care and behaviours which can challenge. Nurses were also supported to undertake training in specific areas which enabled them to maintain their professional registration. This training included specific medical tasks such as, catheterisation (a process for managing people's continence needs), structure of skin and management of wound healing and the management of percutaneous endoscopic gastrostomy (a tube placed directly into a person's stomach through which they can receive, food, water and medication).

People were assisted by care staff who received support in their role. There were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help care staff

develop their skills and abilities. Most staff told us they had regular supervisions and were able to speak to their assistant unit manager or the registered manager at any time if they required additional support. Processes were in place so that care staff received the most relevant and current knowledge and support to enable them to conduct their role effectively.

People were supported to maintain good health and could access health care services when needed. Processes were in place to ensure the early detection of illness. Some people living at the home required regular weighing as they were at risk of losing weight due to poor nutritional input or at risk of becoming overweight which would place an additional strain on their health. Records showed people's weights were being monitored appropriately and identified people were receiving the care required in order to maintain their health and wellbeing.

Professional health care advice was sought and followed by staff when required, for example, when people were identified as living with conditions which made it difficult for them to breathe. We saw staff appropriately sought support and guidance from other professionals to identify whether or not there was any additional action the home could take to meet this person's needs. When action was suggested this was followed by staff.

Good

Is the service caring?

Our findings

People were supported by staff who delivered care in a gentle and caring manner. People and relatives confirmed that support was delivered by caring staff. One person we spoke with told us, "The staff are very nice people here." Another person told us about the staff, "They treat me well. The staff are very good to me. They're lovely people". This view was shared by relatives and visitors we spoke with, one relative told us, "All the staff here have terrific personalities, terrific manner with the residents. I've not heard any bickering between the staff. Not seen any bad attitudes in terms of care. I've not seen anything untoward. A mixture of task and really caring manner." A visitor said, "The staff are very good and very caring towards her (friend)".

Positive and supportive relationships had been developed by staff with people. This was supported by care plans which had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. People's care plans included information about what was important to them such as their hobbies, how people wished to be addressed and what help they required to support them. Staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families and hobbies. Staff in the home took time to engage and listen to people as they moved around the home delivering care and support.

For people who were unable to clearly verbally communicate guidance was provided to staff about how to engage with people documenting the importance of engaging and maintaining eye contact. Guidance was provided on the best way to offer choices in a way which people could respond which included staff using short sentences which required a one word response allowing people to clearly state their preferences. We could see this guidance was being followed by staff during the inspection.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Guidance was provided in people's care plans to help staff identify when people were suffering a low mood as a result of their ongoing health conditions. This included both staff taking the extra time to sit and chat with people about familiar and comforting conversation topics and medical interventions such as the administering of medicines appropriate to the situation. Other people at the home liked to have physical items with them such as dolls and teddy bears as they offered a source of comfort. We could see staff knew this information and how to support people compassionately ensuring people had comforting personal items with them to feel happy and calm.

Where appropriate, physical contact was used as a way of offering reassurance to people. We saw that staff used touch support to interact with people and to engage with them. When communicating staff would often gently place a hand on people's arms to communicate that they were being spoken with. We saw that people were comfortable and actively sought this physical contact with staff and visitors to the home. Friendly conversations were held as staff and people chatted and held hands whilst they moved around the home.

People were supported to express their views and where possible involved in making decisions about their care and support. Staff were able to explain how they supported people to express their views and to make

decisions about their day to day care. This included enabling people to have choices about what they would like to wear or how they would like to spend their day. Care plans and risk assessments were reviewed regularly by staff and signed by people, relatives or their appropriate representatives. Records showed people or their representatives had regular and formal involvement in ongoing care planning and risk assessment. Consequently, there were opportunities to alter the care plans if people and their representatives did not feel they reflected their care needs accurately. Guidance was also provided to staff on how to offer choice in way which would empower the person to be able to respond positively allowing them to make their views clearly known.

People were treated with respect and had their privacy maintained at all times. Care plans and associated risk assessments were kept securely to protect confidentiality. During the inspection staff were responsive and sensitive to people's individuals needs whilst promoting their independence and dignity. Staff were able to provide examples of how they respected people's dignity and treated people with compassion. This included making sure people were suitably clothed and had their dignity upheld when they were assisted with their personal care. We saw this action was taken by staff and the registered manager throughout the inspection. On one occasion a person left their room and walked into the public corridor area whilst they were only partially clothed. The registered manager put her arm around this person and gently supported them back to their room closing the door whilst they assisted them to be appropriately dressed. People were provided with personal care with the doors shut and curtains drawn to protect their privacy. People told us they were treated with respect. One person told us, "They (staff) treat me with dignity", another person said, "Oh yes, they (staff) always knock on my door and if they're doing anything for me they always close the curtains and close the door. Relatives agreed with these views, one relative told us, "They (staff) are so respectful". Staff were seen throughout the inspection to ask people before delivering or supporting with the delivery of care.

People were supported to maintain relationships with friends and family who were important to them. All the people, visitors and relatives we spoke with told us they were able to visit their loved ones without restrictions and were welcomed to the home by staff whenever they were present. One person told us, "My son and my wife come and see me and there are no restrictions when they can come and go". A person's visitor told us, "There are no restrictions when we can come and go were always welcome", which relatives confirmed. One relative told us, "Families can walk in anytime", another relative said, "Yes, I can come and go as I please. I've been here at 8.30 - 9pm before now, no problem." A third relative told us, "I'm here 8-9 hours a day sometimes. They gave me a meal the other day, that was so sweet of them (staff)".

People had been supported to ensure their wishes about their end of life care had been respected and documented accordingly. Care plans provided personalised information for people regarding the support they required and their wishes about the care they wished to receive. Care plans detailed the healthcare professionals who were required to provide assistance during this time. These plans were reviewed monthly to ensure that they were current and reflected people's latest wishes, needs and requests.

We saw that staff took time to treat people who had passed away in accordance with their wishes. Staff offered thoughtful, dignified care respecting people's religious beliefs and followed their religions customs and practice. Staff sought advice and guidance from people's place of worship in order to take the appropriate action to respect and honour people who had passed. People were supported both at the end of their life and once they had passed by staff who showed a dignified respect and appreciation of people's religious needs.

Requires Improvement

Is the service responsive?

Our findings

Where possible most people were engaged in creating their care plan to ensure that the care to be delivered met their needs and preferences. People not able to or unwilling to engage in creating their care plans had relatives who contributed to the assessment and the planning of the care provided. Some people and relatives did not feel there were sufficient activities available to meet their social and interactive needs. One person told us, "I've not seen any activities here" and a relative told us, ""I would like to see more activities for them to do, I don't see anybody doing activities, I've seen it in Nursing but not in Residential they say there is one to one but I've never seen it and I come in quite often".

The provider sought to engage people in meaningful activities however we received mixed views from people we spoke with when asked about the activities made available to them. The home employed one full time and two part time activities coordinators who were to meet the social and interactive needs of 81 full time residents living at the home and six people who were receiving short term re-ablement support at the time of the inspection. The full time activities coordinator had been unable to work for a number of months prior to the inspection which left approximately 40 staff activity hours a week to meet the social interaction needs of all the people living at the home.

Some people spoke positively about the activities provided but this was not a view shared by all. One person told us, "There are lots of activities, we're a bit short at the moment as one lady (activities coordinator) is on sick leave, I've made cakes, very good really, there's quite a crowd and we all mix together", another person told us they were involved in activities, "I do knitting, crochet and embroidery". Other people disagreed and felt there were insufficient meaningful activities available to allow them to live full and interesting lives, one person told us, "No, there's not enough activities", another person told us they had been made aware of a boat trip but had not been asked if they wished to participate. Relatives and visitors also did not feel there were enough activities available to meet people's individual needs for social interaction and mental stimulation. One relative told us, "There was Pat-a-Dog here last Saturday. He (family member) likes that. I wouldn't say they do much though. Christmas was good though", another relative told us, "I've been here and they don't take him (family member) out on trips or garden. Although they took him to a film one time [in the home]".

Staff provided mixed views on the amount and types of activities available in order to meet people's needs. One member of staff told us, "These people need stimulation, they need an activities person every day, we do what we can but it's appalling really, they (people) sleep all day, they need things ticking their mind over, because somebody doesn't speak very well they don't get included (in group activities)". Another staff member said, "No, not really (there are enough activities), nothing bad on the activities staff I know they work really hard but no I don't think there is enough…they (people) get really down, bored, upset and say they want to go back to their home, they get quite bored when there isn't a lot of activities going on, as staff we try and do activities with them as well".

Other staff felt there had been a recent improvement in the types of activities on offer at the home, one member of staff said, "It's a lot better than it used to be, they're (activities staff) are doing more one to ones

for people who are in bed, it's much better now". Another member of staff told us, "I'd have to say no (enough social interaction available) but only because it's a basic mathematical thing, you can't spend as much time as you'd like to with them". When asked if people received daily social stimulation member of staff said, "No, we can't (do it), we can't, they all get one to one time but I would like them to have more".

As a result of the last inspection a one to one tracker was introduced to ensure that people being nursed in their rooms received regular social interaction visits from staff outside of their normal care delivery visits. People's risk of social isolation was measured and recorded, this highlighted where people routinely had no visitors and were therefore at greater risk of social isolation. However, records showed that despite people being identified as having no visitors and requiring social interaction on occasions these people were not receiving or only receiving one or two defined activities a week. This meant these people were not having regular social interaction which meet their ongoing psychological wellbeing. When group activities occurred the number of participants involved only ranged from six people to 20 people who participated in watching a visiting dance group to the home. This showed that not all people living in the home were involved in regular social interaction to keep the simulated and ensure their ongoing wellbeing.

Not everybody living in the home could actively participate in activities. However those identified as being at risk of receiving no social interaction outside of their care delivery their records did not demonstrate that they were being socially engaged and involved.

The registered manager was aware of the need to ensure people received personalised interaction on a daily basis to meet their ongoing mental wellbeing. During the inspection a staff meeting was held where the registered manager introduced the '10 Minute Challenge'. This is where all staff, not just activities coordinators, were to make a conscious effort to interact with people encouraging them to participate in an activity which interested them or they enjoyed such as puzzles, for example, for 10 minutes a day. This also included spending additional time with people when they were completing administrative tasks such as writing care records to ensure people were encouraged to engage in interaction. Time is needed to ensure this work is effective and embedded in staff's working practices.

The activities rota for the week commencing the day before the start of the inspection was viewed which had activities from Sunday through to Friday. These activities included, a salon morning which was a local hairdresser visit, bingo, Men's Club, cooking, nail care, and one to ones. For people nursed in their rooms a multi-sensory machine was available to provide a sensory experience for those unable to physically participate in activities. The machine was mobile and could be taken directly into people's rooms however staff told us this was only used once every fortnight for those who required this. This played music which reflected the sounds of the rainforest or ocean and projected images directly onto the wall so people with limited mobility could see items in front of them. It also had two large tubes on either side of the machine which contained water and produced bubbles to provide a visual and auditory stimulation and interest.

Other external activities were available which included visiting a local community centre for drinks, coffee mornings and going out for lunch. Immediately following the inspection a boat trip to a local canal had also been planned. The provider also encouraged family and friends to participate in activities to further encourage people to engage, these includes Easter parties and a Mother's Day fundraising cake sale.

People's care needs had been assessed and documented by staff before they started receiving care. These assessments were undertaken to identify people's support needs and care plans developed outlining how these needs were to be met. People's individual needs were reviewed monthly and care plans provided the most current information for staff to follow. People, staff and relatives were encouraged to be involved in reviews to ensure people received personalised care. Where people's preferences or individual needs had

changed during this review process we could see that this change was documented appropriately and known by staff. For example, one person living at the home had been regularly engaging with another person and was supported to maintain this relationship by staff. During a regular review it was identified this person no longer wanted to pursue the same level of friendship as they enjoyed their own company and this change was documented, known and respected by staff.

People were supported to remain independent and to receive care which was responsive to their individual needs. Care plans provided guidance for staff on how to offer care in a way which prompted people's independence. For example, care plans contained information regarding people's preferences when in receipt of personal care such as if they preferred a bath or shower and what personal care tasks people could be encourage to complete for themselves, such as washing and what staff support they required . People were encouraged to shave themselves or brush their own hair whilst supported by staff to ensure they retained an element of control over their personal lives and wellbeing. Staff were able to offer examples where they supported people safely but allowed people to do as much as they could for themselves. This included giving people time, privacy and support in an unobtrusive way so people's independence was promoted.

People, relatives and visitors were encouraged to give their views and raise any concerns or complaints. People and relatives were confident they could speak to staff or the registered manager to address any concerns. One person told us, "No, I've never complained but if I did it would be to the unit manager". A relative told us they had raised a concern but it had been dealt with to their satisfaction, they said, "They (staff) made an effort to get her (relative) up more often then and that was good". The provider's complaints procedure was available in the foyer which was accessible to visitors and relatives. This listed where and how people could complain and included contact information for the provider, registered manager as well as other external support agencies. This included contacting the local social services departments and the Care Quality Commission.

Complaints were documented in a folder held securely in the registered manager's office. A selection of complaints were reviewed. We could see the complaints had been raised, investigated by the registered manager and steps taken to address the cause of the complaint. This had been responded to by both the registered manager and the provider appropriately as per the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

Most people, relatives and visitors we spoke with recognised and knew who the registered manager was and spoke positively of their ability to manage the home. Most people told us they were happy with the quality of the care provided in the home. One person told us, "I like it here, the people are nice", another person told us, "I'm quite happy here the staff are good and the manager is doing their best".

The quality of the service people experienced was monitored through regular care plan reviews, relatives meetings as well as annually completed surveys. The last relatives meeting had been held in December 2016 with the next one planned for June 2017. During this December 2016 meeting the findings of the last Care Quality Commission (CQC) inspection report were discussed as well as the action taken by the registered manager to ensure issues identified were addressed. This included the introduction of the social interaction tracker to highlight those people who did not receive regular visits from friends and families. The last annual residents and relatives annual satisfaction survey had occurred in April 2016 prior to the last CQC inspection and was due to be sent out immediately following this inspection.

The provider also completed a number of quality assurance audits at the home to monitor the service provision which were documented under the title of 'Management Quality Assurance Auditing Framework'. This identified the type and frequency of the audits required as well as details of when completed and where the resulting evidence could be found. The audits included looking at specific areas of care delivery and other supporting functions such as, care plan reviews, food management safety books, supervisions and Malnutrition Universal Screening Tool (MUST). A MUST is a five step screening tool to identify people who are malnourished, at risk of malnutrition or obese. These enable appropriate action to be taken to manage these risks to people's wellbeing and for the effectiveness of these actions to be monitored clearly.

However we could not see these audits were always effective as they had not accurately identified the issues raised during this inspection. For example the Provider's Management Quality Assurance Auditing Framework for April 2017 stated that the home's 'Food Management Safety Books' required auditing monthly. The last audit had been signed as completed the 20 April 2017 however had not identified a number of omissions. Food management safety books are used to record the temperature of food served by each unit in the home when received from the kitchen. However these had not been completed as required. These books stated that the registered manager must review and sign the book every month. These books identified that the temperature of hot food provided should be checked twice a day, twice a week. This was to ensure the temperature at the point of serving was above 63 degrees but ideally not below 70 degrees. Of the five servery books viewed none had been completed as necessary. Food was not being routinely and regularly checked as identified as necessary to ensure it remained safe for meet people. In a provider's audit in September 2016 it was identified that the log books for food temperatures were not always completed. Since January 2017 we could see that these temperatures were not being completely regularly in accordance with the safety guidance provided.

The provider completed an internal audit last produced in March 2017 which was to assess the effectiveness of the measures in place to ensure registered managers were aware of the need for nurses to register and

revalidate with the Nursing Midwifery Council. This also looked at processes in place to ensure nurses registration was completed in a timely manner and that up to date records of training, registration date and revalidation were kept in every home. This audit had taken place across all of the provider's homes and identified that adequate measures were in place to ensure this information was documented appropriately. However, during this inspection the registered manager was unable to evidence that all nurses registration was up-to-date as required. Records held identified that four nurses registration had expired on 30 April 2017. This meant the provider could not assure themselves these nurses were registered to work in their professional nursing capacity. The registered manager acknowledged they needed to implement a system to ensure this registration information was kept current. During the inspection this information was sought by the registered manager and made available to view that the four nurses were still able to practice nursing care.

The provider also required quarterly audits to be completed by external senior managers. These gathered evidence of compliance with the Health and Safety 2008 (Regulated Activities) 2014 from a range of sources which included auditing of documentation and speaking with staff. When shortfalls were identified during these audits and from other audits undertaken actions were created and were required to be placed on the home's 'Improvement Log'. This was to allow the actions identified to be monitored for their completion and the location of this evidence to be provided. The last completed improvement log was dated May 2016, prior to this it was completed in April 2016. There had been no updates to include shortfalls identified at the provider's quarterly audits since this date. There was no means by which actions identified as necessary to improve the quality of the service could be documented to ensure their completion.

Immediately following the inspection the registered manager collated all the actions from the regulated visits, audits and inspections and updated the existing improvement log. This action log contained the type of audit completed, a summary of the feedback received, actions to be taken, where evidence of this completed action was to be kept and the date of which this action would be met. This included all the areas identified within this report and the action which would be taken immediately to rectify the identified shortfalls. Action had already been undertaken to meet the areas identified as necessary within this report.

Despite this immediate action taken the provider had not ensured effective systems were in place to make sure they assessed and monitored the quality of the service provided. This was a breach of Regulation 17 (Good Governance) HSCA 2014.

The registered manager wanted the home to have a calm and happy atmosphere where staff delivered person centred care which focused on people's individual needs and wishes. This was an atmosphere which was present throughout the inspection at Oakridge House. Despite being busy staff were calm and patient in their approach when supporting people, call bells were not heard to ring continually and when used were answered promptly. Laughter and comfortable humour from genuine individualised interactions were seen between people, relatives, visitors and staff at the home.

The registered manager wanted the staff to demonstrate they were encouraging and demonstrating an open and inclusive culture where people's rights were respected, their dignity maintained and people provided with the opportunity to fulfil their potential. Staff were aware of the registered managers views for how the home was to promote a culture of openness and felt this was integral in their working practices. When staff were asked if they felt there were able to be open and honest with their registered manager and colleagues the responded positively. One member of staff said, "Yes, absolutely, I'm very open", and another member of staff told us, "Yes to the registered manager…her door has always been open since day one".

The provider had a statement of purpose which was included in the residents and relatives information

packs which they received when people began to receive care. This included a 'Charter of Rights' which documented the list of rights people had whilst living at the service and receiving care, these included the right to maintain a high quality of life, to have their privacy respected, to be treated with dignity and to be cared for by adequately and appropriately trained staff. Staff were aware of how the registered manager wanted care to be delivered and the importance of the provider's values to people receiving care. One member of staff told us, "I look upon it as people's dignity and rights and choice should be upheld", another member of staff said, "It's about person centred care…that involves everything, this is their home (people), we're coming into their home even though it's our workplace, we should respect them, their home and wishes and involves everything, care, cleaning and laundry". Another member of staff told us about the values of the home as detailed in the Charter of Rights, "(treat people) With respect…I treat them as if they were my family and I don't act like they're strangers, I treat them as I would like to be treated in a care home". Relatives agreed that staff promoted the providers and registered manager's values during their care delivery and general approach when supporting their loved ones. One relative said, "It's like an extended family here. They (staff) have a great sense of humour. I actually look forward to coming in", another relative told us, "I could eat here but I don't, I get offered cups of tea. In fact, you can help yourself. I'm made to feel very welcome here". The registered manager ensured people's rights were protected by reinforcing these values through staff supervision, appraisal, training and observations conducted around the home.

The registered manager was a visible presence to relatives and staff. Most people and relatives told us they were all able to recognise who the registered manager was and felt they were present and available to them in the home. Staff said that they were able to approach the registered manager and were confident that they would be proactive in dealing with issues raised, all felt supported as a result. Staff told us the registered manager was available to them if they required support or guidance and was actively involved in the day to day running of the service. One member of staff told us, "Yeah I mean if a buzzer is going she'll know we're busy and she'll be in someone's room toileting them, she's quite hands on like that". Another member of staff said "Yes (the registered manager) is quite good, she doesn't think anything about helping out care, doing dinner, (she's) even been in the kitchen washing up she's a pretty decent lady". A further member of staff told us the registered manager was available to them at any time, they told us, "She's the best manager, you know you can tell her anything and she will listen all the time and should I say something she's like 'ok' and you can approach her, she's so easy to approach".

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. We use this information to monitor the service and ensure they responded appropriately to keep people safe. The registered manager had submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance.

Most people, their relatives and visitors spoke positively of the quality of the care provided, one person told us, "I've been here (a number of) years and I'm well looked after". Relatives told us they had a good degree of satisfaction with the home. Written compliments had been received by the home which evidenced staff were motivated to treat people as individuals. One relative had written to the home, 'Dad was at his lowest point both physically and emotionally when he was offered a room at Oakridge…very quickly after moving dad improved visibly in terms of his mood, his independence and his physically ability…his sense of humour has returned, he has told us that he is happy with how he is looked after and he likes the carers'. Another relative had written to the home, 'I and all my family owe an un-repayable debt to you and everyone at Oakridge House, I witnessed virtually on a daily basis the professional care administered with true love and kindness by every member of staff, it was comforting for all of us to know that (family member) was in a place of love and safety. Also the wonderful attitude of all the staff, it never seemed simply 'a job' to tend to any of the residents always respecting their dignity. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed.

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 effective systems were in place to make sure they assessed and monitored the quality of the service provided. Regulation 17 (1)