Healthcare Homes Group Limited

Olive House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Olive House on 2 March 2017. This was an unannounced inspection. Olive House is registered to provide accommodation and personal care for 45 older people, some living with dementia. There were 40 people living in the home when we inspected.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The service was safe; staff understood their responsibilities to protect people from harm or abuse and had received training. People received their medicines as prescribed. Safe recruitment processes were in place which contributed to protecting people from harm.

There were enough staff to keep people safe, and the service had recently recruited more staff so that there would be less use of agency staff and improve consistency for people living in the home.

There were effective processes in place to minimise risks to people. Assessments had taken place regarding people's individual risks and clear guidance was in place for staff to follow in order to reduce them. However, improvements were needed to the consistent recording of supporting people to change position when they were at risk of pressure ulcers.

Staff knew the people they cared for and understood how to meet their needs. People planned their care with staff and relatives, and a variety of activities were carried out in line with people's preferences. There were close links with the local community to encourage people to participate in events which were carried out with the local church or school.

Staff understood the importance of gaining people's consent to the care they were providing to enable people to be cared for in the way they wished. Staff were able to explain how they promoted choice where people had variable capacity. The home complied with the requirements of the Mental Capacity Act 2005 (MCA).

People were supported to access healthcare wherever necessary and in a timely manner, with prompt action taken in response to changes to a person's health needs. People's hydration needs were met by the service. Drinks were available throughout the day.

We inspected Olive House on 7 March 2016, and we found that the quality of the food required improvement. People's nutrition needs were met in line with recommendations such as speech and language therapy, however the food was not always to everybody's taste and adequate choice was not always available. It had not been improved significantly.

Staff were kind and they had meaningful interactions with people. Feedback from people and their relatives about the care they received was complimentary. Staff respected people's privacy and dignity.

The quality assurance systems in place had identified shortfalls and the registered manager was working with the management team and quality monitoring staff from the organisation to improve these areas.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by a sufficient number of competent staff.

Medicines were managed and administered safely.

Risk assessments were in place for individuals and their environment.

The home was working on improving care related to pressure areas.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutritional and hydration needs were met, but improvements were needed regarding quality and choice of food.

Staff received training and were competent in their roles.

Staff sought consent, and people were supported to make their own choices.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, respected their privacy, dignity and independence. They engaged people in meaningful interactions.

People and their families were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People were able to access a wide variety of activities and follow their interests.

Individual preferences were taken into account and people's care needs were planned for.

Complaints were investigated and resolved.

Is the service well-led?

Good

The service was well-led.

There were effective quality assurance processes which helped drive improvement. The improvements required consistent monitoring.

The culture of the staff in the home was positive and staff found the registered manager supportive.

Olive House

Detailed findings

Background to this inspection

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

This inspection took place on 2 March 2017 and was unannounced. It was carried out by two inspectors.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

As part of this inspection, we spoke with seven people who lived at the home, five visiting relatives to the home and six members of staff in the home. These were the registered manager, the head of care, the activities coordinator, one senior carer and two care workers. Additionally, we spoke with two healthcare professionals and an outreach worker who regularly visited the service.

We observed how care was delivered throughout the day. We reviewed care records and risk assessments for six people who lived at the home and checked six medicines administration records with associated audits and records relating to medicines management. We looked at staff training and two recruitment records, as well as policies and risk assessments and reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

All of the people and the relatives we spoke with said that people were safe living in the home. Staff understood how to protect people from harm and what types of abuse there were, and had received training in safeguarding adults. The registered manager of the home had referred concerns to the appropriate safeguarding authorities where necessary. Some staff we spoke were unable to tell us how they would report concerns to outside agencies. We spoke with the registered manager about this, they informed us following the visit that they discussed safeguarding in a team meeting. They also told us they were planning face-to-face training in safeguarding, rather than solely e-learning as they felt this would be more effective. Staff told us they felt comfortable to raise concerns to the registered manager if they felt they needed to. This was supported by appropriate safeguarding policies which contributed to the provider's processes in place to promote people's safety.
Care plans contained detailed assessments of risks for individuals, covering aspects such as manual handling, health conditions, tissue viability, use of bed rails, swallowing and nutrition. For example, there was a clear plan in place for one person who had diabetes. This guided staff on how to recognise if the person had low blood sugars, and how to respond to this. Accidents and incidents were reported and acted upon appropriately and in a timely manner. People who had falls had their falls risk assessments updated and reviewed.

People's risk of developing pressure ulcers was assessed, regularly reviewed and preventative measures were taken by staff. Pressure relieving equipment was checked regularly by staff to ensure it was in good working order. Staff told us what risks to look for and prompt preventative action was taken when they had concerns about people's skin. A visiting healthcare professional told us they felt staff supported people well with their pressure care. However, we did see that records of staff assisting people to reposition were not always completed as per their care plan. For example, for one person, there were six hour breaks evident between repositioning, when the care plan specified that it should be four hours. We saw that the last provider's audit had identified this issue, and the registered manager had created a home improvement action plan. This specified that the repositioning records were an area requiring improvement in September 2016 following one person developing a pressure ulcer prior to this.

The registered manager told us they were working on this and reminding staff regarding repositioning. The registered manager had introduced 'intentional rounds', which meant that checks were carried out three times daily on documentation within people's rooms. These had not always been effective in identifying when people were not repositioned as per their care plan. The registered manager said they would ensure that staff were allocated to perform these rounds, and address this issue again in supervisions and the next staff meeting. The registered manager also arranged to meet with the training manager for the provider to discuss further training in tissue viability. The registered manager said they would gain daily feedback on this and introduce extra supervisions with staff if they continued to identify concerns. They also assured us that they would source extra training in tissue viability to reinforce the importance of repositioning with all staff. Where recommended, pressure relieving equipment such as airflow mattresses had been provided.

We found that equipment for detecting, preventing and extinguishing fires was tested regularly. People had

individual evacuation plans in place. Lifting equipment was serviced as required and environmental maintenance and risk assessments were in place. Safety checks included portable appliance testing and gas safety.

We had received some concerns about staffing levels at the home prior to our visit. The registered manager told us there had been some periods, between summer 2016 and Christmas 2016, where a high number of agency staff had been used and there had been problems with staff absence and some staff leaving. After reviewing and implementing a new policy on staff sickness, they told us this had improved and they have been using less agency staff. They had also recruited new staff.

The registered manager told us they used a dependency tool and varied staffing levels according to people's need. One person told us that they had to wait longer than they wished for staff support them with their personal care. They explained that they had felt this was when more agency staff were on shift. Another two people told us staff came in a timely fashion when they needed them. Staff told us they felt there was enough staff to meet people's needs, but not always to spend extra time with people. This reflected what we found in relation to staffing when we last inspected in March 2016. Staff felt they could get to people to assist them in a timely way, however one member of staff felt that some people preferred to wait for a particular staff member to be available. Another staff member said, "It would be nice to have a few more staff so you're not rushing about in the mornings." One relative told us, "[Relative] has never been left when they need attention." Another two relatives said that there had been a difficult stage with staffing, however they felt it had been improved significantly this year. This was echoed by another visitor.

There was an audit in place where the registered manager had checked call bell response times, and specified that these needed improving in December 2016, and they found that this had improved when they completed another audit in January 2017. However, one person told us that some staff came and turned off the call bell, and told them they would be back when they had finished doing something, and they had to wait. They therefore felt that staff did not always attend to their needs when they answered the call bell, and found they still had to wait. A relative also told us that the staff member who supported their relative sometimes had to go off and do something else before they were finished, and return to finish later. They felt that this was not ideal. Therefore the call bell audit did not always represent when people received the care, but only when staff turned the bell off.

We concluded that there were enough staff to ensure a safe standard of care was maintained. We found that although at times staff were busy, it did not impact negatively on people's safety at the home and people received care when they needed it.

The provider's recruitment policies and induction processes were robust, and so contributed to promoting people's safety. Appropriate checks were made before staff were recruited, such as disclosure and barring services (DBS) checks and references. This showed that only people deemed suitable, in line with the provider's guidance were working at the service.

We found that medicines were administered by trained staff as they had been prescribed. We checked a sample of medicines and found that these concurred with checks carried out by staff.. There were protocols for medicines that were taken on an 'as required' basis, which guided staff on when to give them. People's allergies were identified and preferences were adhered to when staff administered medicines. We observed that staff stayed with people whilst they took their medicines, and saw that staff discussed people's medicines with them.

Medicines were stored securely and at the correct temperature. Where medicines were kept in people's

rooms they were stored securely. Appropriate risk assessments were in place to guide staff on how to mitigate associated risks. For people preferred to administer their own medicines, we found that this was assessed and carried out safely. Medicines which were associated with higher risk were also managed safely and signed for by two staff members when given. We noted that the provider and the management team completed appropriate audits regarding the management of medicines and when they identified concerns, prompt action was taken to address them.

Requires Improvement

Is the service effective?

Our findings

When we inspected the home in March 2016, we found that the quality and choice of food provided was in need of improvement. During this inspection, we received mixed feedback about the food in the home. There was a choice of two meal options at each meal time. However, people were not always given choices. One person we spoke with at lunch time said, "I was expecting something hot really." They had been given a salad, and they said they did not choose it. Another person said, "The food is dreadful." Another said, "With the food, they don't seem to take care enough." However, two people told us they found the food to be good, and we overheard some people at lunch time say it was nice. One relative told us, "The food's lovely." The registered manager told us they were currently working on making improvements to the food choices available by gaining people's preferences about what they would like to see on the menu. Following the visit, the registered manager informed us that they had recruited a new cook, pending employment checks.

A relative explained that the home had offered more choices at breakfast recently which had benefitted their relative. The registered manager told us they implemented this a few weeks ago to enable people to visually choose what they wanted to have for breakfast. They also placed snack boxes around the home, containing crisps, cakes, chocolate bars which were available to everybody. At the time of our inspection, people were given a menu choice the afternoon on the day before it was given. We noted that there were several people living with dementia in the home and that this was not always effective because they often forgot what they had ordered the day before. Two staff members told us they did not feel that people always received a good choice of things to eat. We discussed choice with the registered manager, who said that they would immediately adapt choices to further accommodate people living with dementia. They said this would include giving the choice of two meals at lunch time, and these would be supported by visual aids so that people may find it easier to choose.

We saw that where people were on thickened fluids and a soft diet due to swallowing difficulties, that care plans were in place for this and staff were able to tell us how to support them. However, staff had not always delivered support with eating according to people's care plans. For example, one person's care plan specified that they required supervision to eat their meal so that they could manage it properly. We found that during our inspection, the person had not received support to eat, and they did not have equipment in place, such as a plate guard, which would have helped them to eat independently. The person had managed to eat their lunch, but told us it would have been easier if the staff had stayed with them. We also found that the person was not given a choice of dessert.

We found that the required improvements regarding the food had not been made and sustained since our last inspection in March 2016. We discussed the concerns with the registered manager, who had identified that the food was in need of improvement. Since the visit, they allocated specific staff to supervise and assist people in their rooms. This included checking that people are in the correct position, have access to the food and are prompted to express their views of the food served. They promptly sent us a development plan which specified they would create personalised nutritional care plans for each person and include all information relevant to their mealtime experience. The registered manager had also organised a nutritional workshop held by the local clinical commissioning group for care and kitchen staff.

We concluded that although people's hydration and nutritional needs were assessed and regularly reviewed, they were not always supported to eat a variety of nutritious, appetising food with adequate choice given.

People were supported to drink enough, one person who was cared for in bed said, "They supply me with plenty to drink." Some people were assessed as being at risk of not eating or drinking enough, and therefore staff recorded what they ate and drank. Records confirmed that fluid charts were used effectively and there was a daily target that people should drink, which was individual to the person. These were monitored by the registered manager and quality staff from the organisation. We saw that there were drinks available within communal areas to people, however the registered manager had asked staff to ensure everyone had a drink within reach when in the lounge. We saw that after lunch, not everyone had a drink within reach when sitting in the lounge and we fed this back to the registered manager.

People's weight was monitored and recorded in care plans so that action could be taken if needed to refer to a dietician. We saw in one care plan that one person had been supplied with nutritional supplement drinks as they were at risk of not eating enough.

People told us that they had no concerns about the competence of the staff. One relative told us, with respect to staff's competence in dementia care, "We can't speak more highly of it."

We spoke with one member of staff about their induction, which they reported included shadowing more experienced staff. Other members of staff told us that they had received the organisation's mandatory training and we saw that records confirmed this. Mandatory training included first aid, safeguarding, manual handling and infection control. The provider and registered manager told us they had reviewed training methods and had decided to deliver more training face to face to all care staff, such as safeguarding and the Mental Capacity Act 2005 (MCA), to increase staff awareness in these areas. People and visitors told us they felt staff were competent. There was a daily allocation sheet in place which summarised people's basic needs such as if they required manual handling equipment and how many care staff were needed to support them. The registered manager said that if agency staff were on duty, this helped them to know what people needed and they always worked alongside a member of the home's care staff.

Staff told us they had regular supervisions and their competencies had been formally reviewed. Supervisions provided them with the opportunity to discuss their role and any concerns with a senior staff member. They told us that they felt well supported and informally discussed any issues with senior care staff and the registered manager if they needed to. We saw that training was carried out regularly and that any training which was out of date was planned for.

The 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 interest and as least restrictive as possible. Staff were able to tell us about individual's mental capacity, for example when people had variable capacity to make daily decisions and how they supported people with these. They were also able to give example of best interests decisions, and who would be involved in those.

We discussed people's best interests decisions with the registered manager. Although we saw that for some people, best interest decisions had been thoroughly documented, we did find that for one person, a decision had been made by their family and the GP, however it was not recorded properly. The registered manager said they were working through the MCA section of people's care plans to ensure that best interest

decisions were carried out thoroughly and fairly, and took into account the person's wishes. The registered manager had also checked with families that they had the correct power of attorney status for people's health and welfare which enabled them to make decisions on a relative's behalf. We saw that one person had an advocate who visited the service regularly to assist with any best interest decisions that may need to be made.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). 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. Deprivation of Liberty applications were made appropriately in line with the Mental Capacity Act. We found that the service was acting in line with legislation regarding the Mental Capacity Act. We found that staff understood and applied the principles of the MCA. Staff were aware of people's capacity to consent to receiving care. During the inspection we observed consent being sought when staff delivered support to people.

People had access to healthcare, and two healthcare professionals told us they felt that staff communicated well with them to ensure people's needs were met. People had access to other services such as a chiropodist when they required.

Good

Is the service caring?

Our findings

Staff were thoughtful and delivered individualised care. They organised a candlelit meal for one person and their spouse who was invited to this at the home, which made them feel special. One staff member said, "I treat the people like I would treat my own parents." A member of staff told us how staff had stayed with one person whilst they were in hospital, to provide them with reassurance. We observed that staff made conversation with people in communal areas as they went by, and this included housekeeping staff as well as care staff. We also saw that staff reassured people in a kind manner when they were distressed.

Some people and staff told us that when there were a lot of agency staff working at the home, they felt that these staff did not always know them well. However, we received feedback that the home's own staff knew people well and how to meet their needs. A relative told us, "Staff know exactly what [relative] wants." A healthcare professional confirmed to us that they felt staff knew people well.

All of the visitors we spoke with said they felt staff were very caring. One relative explained how they supported their family member, who lived with dementia, when they became distressed, and would help them to phone home if they wished. Another relative was highly complementary about the way staff supported their relative with their dementia.

Staff understood how to support people living with dementia in a compassionate way. One staff member explained how they adapted their communication in showing people choices of what to wear, for example. They said, "It's the way you approach things, your attitude, the way you phrase things and your tone of voice."

People's relatives were involved in their care where appropriate. We saw that for one person, their daughter supported them to have a bath. One relative explained that they liked to get their relative's clothes ready and choose outfits for them to wear, and staff supported this. This meant that the home gave people the opportunity to be actively involved in caring for their family member if they wished.

We saw in people's care plans that they had been actively involved in planning their care, including being asked about their lives and deciding their preferences. We saw that people were supported to make their own informed decisions about their care, and that this was documented.

Staff told us how they promoted privacy and dignity for people. They explained that they always shut doors and curtains when carrying out any personal care. We saw that they knocked on people's doors and people told us they respected their privacy. People were also empowered to be as independent as possible; one person took the bus into the local village by themselves. People were supported to maintain their lifestyles as they preferred. A couple living in the home had their own cat which they had brought with them.

Visitors told us they were welcomed at any time of day or evening to visit their loved ones, and staff involved them in the home as much as possible. One person living in the home told us that relatives sometimes attended the activities such as the quiz in the home. The registered manager told us that the kitchen staff

made a birthday cake for a relative who visited regularly. We saw that people had personalised bedrooms with pictures and other items of comfort from home.

Good

Is the service responsive?

Our findings

Individual care needs had been assessed prior to people's admission to the home, which included specific requirements and preferences in order for the home to effectively meet their needs. People were actively involved in developing their care plans, which included their personal preferences and likes and dislikes. For example, they contained information about what times people liked to have a hot drink, whether they like a bath, and what they preferred to eat or wear. A relative told us that staff were flexible and responded accordingly to their relative's condition. They told us that they knew that their relative found a bath to be very calming if they were distressed, and they said that staff always provided this when needed.

Care plans were reviewed monthly and any changes such as weight loss were responded to appropriately. We saw that the team had good internal communication to ensure changes in people's care were communicated to all staff.

Staff were able to give examples of people's individual preferences which correlated with information in people's care plans. People told us that they got up and went to bed when they wanted. People also had access to a hairdresser regularly. This showed that the service was responsive to people's wishes and preferences with regards to their care.

We saw in the care records that reviews of people's care included people's families where appropriate. The home provided families and staff with additional knowledge and understanding around living with dementia by hosting a workshop. The head of care explained to us that this was a day where they tried different techniques to show to people's families examples of visual changes and memory loss. They said the visitors engaged well in the day and felt that it helped them understand what their loved ones were going through.

There was a range of activities in the home and a daily activities programme developed by a full time activities co-ordinator. Regular activities included a drama group, quizzes, word games and knitting groups. The activities coordinator told us that she got ideas from people's personal histories and met with people when they first moved into the home to discuss their preferences. We found that everyone living at the home was offered time for activities wherever possible, including one to one time. We were concerned that for people who were cared for in bed, they may not receive enough one to one time to interact and stimulate them. One person told us, "No-one comes to see me." We discussed this with the registered manager and the regional manager, who put into place an action plan, which stated that people cared for in bed would have daily dedicated one to one time with staff, to enhance their wellbeing. They also said they would organise a workshop where staff and activities personal could discuss ideas about this. They also said they would improve the key worker role to oversee that each individual has dedicated time.

During the afternoon of the inspection some people had gathered in the lounge and were taking part in a crafts session with the activities coordinator. They were enjoying the session with smiles, conversations and helping each other. One person said, "We've made some lovely things today." One person told us about the drama group and various activities they enjoyed. There was a timetable displayed on the wall were a variety

of activities to meet different tastes. A relative said, "[Activities coordinator] is absolutely marvellous", and this was echoed by another relative, who said, "Activities are really good." Another relative we spoke with said that the activities had impacted their relative's life positively, and that they had noticed the difference as their relative wished to be involved in all the activities.

There was also visiting entertainment to the home such as singers as well as events such as a BBQ. People told us that they were supported to access church services. The service worked closely with a local outreach worker, who we also spoke with. They told us that they worked closely with the activities coordinator. For example, they had organised weekly lunches at the local church, where people from the home went and met with other friends from the local community. They also took people out in their wheelchairs for a walk and went around in the home to talk with people. They had arranged for the local school to come and visit people as part of a project, and they had built a relationship with the home. One person said, "The children came and asked us all about our wartime experiences. They're going to make a tea for us. That's absolutely lovely." The staff confirmed that the school had organised to host a tea for the people at Olive House in March. The outreach worker also told us they were in the process of recruiting two volunteers who would also visit people at Olive house as part of their role. The registered manager also explained that the outreach worker had organised for the home to have an electric wheelchair, and this meant that more people could go outside and into the village.

The registered manager told us they had themed days which entertained people. This included a 'wedding' themed day where staff dressed up and spoke with people about their own experiences. They said that some people enjoyed reflecting on their wedding days and people engaged in the day. They were organising a special day for Mother's Day in March.

Complaints were responded to and acted upon appropriately by the registered manager and staff. There was a monthly meeting for people living in the home to discuss any issues and ideas. Feedback was sought from people and the registered manager had held a relative's meeting recently. As they felt it was not well-attended, they said they were considering ways to maximise attendance, and had begun to gather relative's email addresses as they felt this would be a better way of inviting some people to a meeting. All of the relatives we spoke with said they felt that the registered manager was approachable and they would go to them if they had any concerns.

Good

Is the service well-led?

Our findings

One person said, "[Registered manager] is always there to help you." Another person told us they would prefer to see more of the registered manager. A visiting healthcare professional said they felt the service was organised and well-led. A relative also said, "I would recommend this home." There were regular staff meetings where staff were encouraged to bring forward ideas.

We observed, and some staff told us that, there was good team work amongst the staff. However, three staff members did say that there were times when the team did not work as well together. The registered manager and the head of care felt this may be due to recent changes in management and some changes in the way the home was run, as well as changes in staffing. They said they would continue to address any concerns within supervisions and team meetings.

The registered manager kept close links with other professionals to share ideas. They said they received training and had regular contact with the other managers within the organisation in the region. The home had also employed an external organisation to inspect the home and we looked at the report. The registered manager had implemented ideas following this, such as extra face-to-face training. They had also implemented weekly time with people to complete life histories more thoroughly. The home kept a strong link with others in the local community, facilitated by the outreach worker who told us, "It's lovely to work with the home and make them a big part of the community."

The home has had a manager in post since June 2016, who was registered with the commission in October 2016. Other people, staff and visitors told us that the registered manager was approachable and they would go to them should they have any concerns.

The registered manager was well-supported by the regional manager who visited regularly, as well as another member of staff from the organisation who was responsible for overseeing quality monitoring and improvement. They also visited regularly and carried out audits which had identified concerns and actions needed. These audits included checking details about staff competency as well as records. We saw that the audits had led to some improvements, for example in the management of medicines. Audits had also checked staff files to ensure they were complete and included supervision records. However there were other areas which improvements still needed to be made, such as the recording of people's repositioning, which had been identified in the provider's audit on 13 January 2017. The daily monitoring of repositioning and recording needed additional attention, which the registered manager assured us they would give.

The registered manager also oversaw recording of accidents and incidents and reviewed these. They also investigated complaints, and the regional manager and quality staff also reviewed these areas.

The registered manager had an open and honest approach, and was aware of the issues which we also identified within the home. The regional manager and quality officer were in attendance supporting the registered manager with the necessary improvements. The registered manager was aware of what they needed to notify the Care Quality Commission CQC and other organisations of. There was a whistleblowing

policy in place, which staff were aware of.