Bridges Home Care Limited

Oxford House

Inspection report

Highlands Lane
Rotherfield Greys
Henley On Thames
Oxfordshire
RG9 4PS

Tel: 01491578748
Website: www.bridgeshomecare.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an announced inspection of Oxford House on 2 March 2017.

Oxford House is a domiciliary care agency providing care and support to more than 100 people living in their own homes. On the day of our inspection 169 people were receiving a personal care service.

At our last inspection on 3 February 2016 we found medicines were not always managed safely, medicine records were not always complete. This was a breach of Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014. We also found the provider did not have effective systems in place to ensure the quality of the service was monitored and improved to ensure the regulations were met. This was a breach of Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014.

In addition we recommended the service took action to ensure people's care records identified how they would be supported in line with the principles of the Mental Capacity Act 2005.

At this inspection on 2 March 2017 we found the provider had made improvements and had addressed these concerns.

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.

We were greeted warmly by staff at the service who seemed genuinely pleased to see us. The atmosphere in the office was open and friendly.

People told us they were safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

People were supported by staff who were knowledgeable about people's needs and provided support with compassion and kindness. People received high quality care that was personalised and met their needs.

Where risks to people had been identified, risk assessments were in place and action had been taken to manage these risks. Staff were aware of people's needs and followed guidance to keep them safe. People received their medicines as prescribed.

There were sufficient staff to meet people's needs. Staffing levels and visit schedules were consistently maintained. People told us staff were usually punctual and they had not experienced any missed visits. The

provider followed safe recruitment procedures and conducted background checks to ensure staff were suitable for their role.

Most staff understood the Mental Capacity Act 2005 (MCA) and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected.

People told us they were confident they would be listened to and action would be taken if they raised a concern. The service sought people's opinions through regular surveys and telephone monitoring calls. The service had systems to assess the quality of the service provided. Learning needs were identified and action taken to make improvements which promoted people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

Staff spoke positively about the support they received from the registered manager and senior staff. Staff supervision and meetings were scheduled as were annual appraisals. Staff told us the registered manager was approachable and there was a good level of communication within the service.

People told us the service was friendly, responsive and well managed. People knew the registered manager and staff and spoke positively about them. The service sought people's views and opinions and acted upon them.

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.

There were sufficient staff deployed to meet people's needs.

People told us they felt safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place to reduce the risk and keep people safe. People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff

on how to support people.

People knew how to raise concerns and were confident action would be taken.

People's needs were assessed prior to receiving any care to make sure their needs could be met.

Is the service well-led?

Good

The service was well led.

The service had systems in place to monitor the quality of service.

The service shared learning and looked for continuous improvement.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

Oxford 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 the 2 March 2017. It was an announced inspection. We told the provider two days before our visit that we would be coming. We did this because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be in.

This inspection was carried out by three inspectors.

We spoke with 16 people, three relatives, nine care staff, the data analyst and the registered manager. We looked at 10 people's care records, five staff files and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on their care.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

Good

Is the service safe?

Our findings

At our last inspection on 3 February 2016 we found medicines were not always managed safely, medicine records were not always complete. This was a breach of Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made.

People received their medicine as prescribed. Where people needed support with medicines, we saw that medicine administration records (MAR) were accurately maintained and up to date. Records confirmed staff who assisted people with their medicine had been appropriately trained and their competency had been regularly checked to ensure they were safe to administer medicines. Staff we spoke with told us they had received medicine training and were confident supporting people with their medicines. One member of staff said, "I've had training and I've no problems with medication. There is always some I can ask if there's a problem and lots of our clients are given medicine by their family". One person said, "They give me my pills and we have a chat". Another person said, "Never late with my medicine".

People told us they felt safe. Comments included; "Absolutely safe", "I feel very safe with her (staff)", "I do feel safe, they know what they are doing" and "Everything makes me feel safe".

People were supported by staff who could explain how they would recognise and report potential abuse. Staff told us they would report concerns immediately to their manager or the senior person on duty. Staff were also aware they could report externally if needed. Comments included; "I've had safeguarding training. I would immediately report concerns to the office and the local safeguarding team", "I'd report to my care manager and [registered manager]. I can also call CQC (Care Quality Commission) or social services", "I'd talk to my manager and social services. I could also call a doctor or the police" and "I'd report to the office and I can talk to the police". The service had systems in place to report concerns to the appropriate authorities.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been identified taken to manage the risks. For example, one person was at risk of trips and falls. The person used a walking frame to mobilise independently. Staff were guided to ensure the floor was 'clear of all hazards' and to 'ensure the person used their frame'.

Another person could not bear weight and used a wheel chair to mobilise. We saw two staff members were required to support this person and staff were given detailed guidance on how to support this person safely. This included ensuring all equipment was checked and that 'all staff have manual handling training'. Staff rotas confirmed two staff were consistently deployed to support this person. Other risks managed included; pressure care, eating and drinking and the environment. Staff we spoke with and records confirmed this guidance was followed.

Most people and their relatives told us staff were punctual and visits were never missed. People's comments included; "They turn up on time, no really late visits and no missed visits. Some even come a bit early", "Usually on time or just a few minutes late", "Not always on time but they often ring me if they are coming

late" and "Might be a bit late but they are usually on time. Any later than 15 minutes and I get a phone call".

The service used an electronic telephone monitoring system to manage visit times. We spoke with the data analyst who managed this system and asked about late visits. They said, "We have a target of 90%. Because we recently took on at short notice, clients from another service that closed it has taken a little while for things to settle and that has affected our figures. Currently we are in the low to mid 80s but it is getting better. We call if staff are late and I can't remember the last time we actually missed a visit. If a client's visit is time critical, say because of their medicine a member of office staff would make the visit to keep them safe". Records confirmed visit times were slowly improving.

Staff told us there were sufficient staff to support people. Comments included; "We are meeting people's needs but then I work extra shifts. We do not miss visits and I know we are recruiting", "Oh we always need more (staff). However, we have a good bunch of staff and we meet people's needs", "Rotas get changed a lot so I guess we do need more staff but this does not affect our clients. Someone is always there for them" and "I think there's enough staff, we manage". Staff rota's confirmed planned staffing levels were consistently maintained.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

Good

Is the service effective?

Our findings

People told us staff knew their needs and supported them appropriately. Comments included; "They seem well trained", "The three (staff) I have do it very well. They know what I like" and "Very polite and very well qualified. They are very perceptive of my pain levels in the morning". A relative said, "I've no concerns, they know what they are doing. They are also willing to accept suggestions from me. The carers do what has been recommended by the speech therapist".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction and completed training when they started working at the service. This training included safeguarding, moving and handling, dementia and infection control. Induction training was linked to the care certificate which is a nationally recognised program for the care sector. Staff spoke with us about their training. Staff comments included; "Induction was very thorough, it prepared me for the role. I then shadowed an experienced staff member for a week", "The training is good but you also learn out in the field. The training gives you confidence to learn more" and "The training is very good".

Staff told us, and records confirmed they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. For example, one staff member had asked for further training and we saw they were working towards a national qualification in care.
Staff were also supported through spot checks ('service provider quality monitoring assessments') to check their work practice. Senior staff observed staff whilst they were supporting people. Observations were recorded and fedback to staff to allow them to learn and improve their practice. Observations were also discussed at staff supervisions.

Staff told us they felt supported. Comments included; "I get supervision, they are definitely supportive. I've had special training after I asked for it", "I find supervision useful. I get to have my say" and "Supervision, Oh yes all fine".

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. 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. The registered manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected. We saw one person had appointed a relative to have lasting power of attorney allowing them to make decisions relating to the person's 'property and affairs'.

People's care plans included mental capacity assessments which identified the decisions people lacked capacity to make. Care plans detailed how people should be supported in their best interests. For example,

one person's care plan identified they lacked capacity to make decisions relating to their finances but were able to make decisions related to their daily living. People's care plans identified where representatives had legal authority to make decisions on people's behalf and copies of the authority were available. Documents demonstrating how best interest decisions had been made were included in people's care plans.

Most staff demonstrated an understanding of the MCA and how they applied its principles in their work. However, some staff appeared nervous discussing this topic and needed prompting. Staff comments included; "Any doubts over client's capacity and I raise it with the manager. I ask questions and put things in a different way so clients can understand and make their own decisions", "I've had the training, people make their own decisions and sometimes we need to help them. I assume they have capacity and work in their best interests" and "This is about people's capacity to make decisions for themselves. I always assume they have capacity. It is task specific, decision specific and we have to work in their best interests". We spoke with the registered manager about staffs knowledge of the MCA. They said, "We have put on extra training but I clearly need to do more. I will arrange more training and support".

People told us staff offered choices and sought their consent. One person said, "I choose what to wear and I tell them what I want". Another person said, "They are very thoughtful and do what I ask".

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs and district nurses. Details of referrals to healthcare professionals and any advice or guidance they provided was recorded in people's care plans. For example, one person had been referred to a speech and language therapist (SALT) when their condition changed. Their guidance was recorded and being followed.

Most people did not need support with eating and drinking. However, some people needed support with preparing meals and these needs were met. People either bought their own food or families went shopping for them. People had stipulated what nutritional support they needed. For example, one person had stated 'check if I am preparing breakfast' and 'help if needed'. Another care plan noted the person's relative prepared their meals. Where people needed support their likes, dislikes and preferences were listed and staff were provided with guidance on how to support people. For example, one person needed a meal before they took their medicine. Records confirmed this guidance was followed.

Good

Is the service caring?

Our findings

People told us they benefitted from caring relationships with the staff. Comments included; "We talk to each other and they are very nice to me", "My main carer is very good, she is wonderful, like a friend", "We get on very well, like good friends. They listen to me" and "I've a very good team. One of the carers has been coming for years". One relative said, "They are excellent. They are very nice and will do anything you like and they care about my feelings".

Staff spoke with us about positive relationships at the service. Comments included; "Are we caring? Oh very much so, that's why I am here. I do this work because I want to give something back", "I do have caring relationships with the clients, how could you not", "I love it, I love care work and being around to help people" and "I like this job and caring for people".

People's dignity and privacy were respected. When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful.

People told us they were treated with dignity and respect. People's comments included; "They (staff) ask what I'd like and if there is anything else I'd like. They are remarkably polite. It is in their nature" and "They put themselves out to help me a lot. I've had a lot of medical problems but they never make me feel as if I am holding them up".

We asked staff how they promoted, dignity and respect. Comments included; "I keep the curtains shut and cover them (people) up as best I can", "I always explain before I help as this helps reassure them. I also keep family away when I do personal care" and "With personal care I work with what's comfortable for them (people). I don't work in front of family members, I shut doors and close curtains. I respect their private space and property".

People and their relatives told us they were kept informed in relation to their care. For example, staff rotas were available to people informing them of who was visiting and when. One person said, "On my email I have a rota of who is coming". However, some people told us they had different staff on a regular basis. One person said, "I've had different staff this week". Another said, "If there is sickness you might get a different carer". People told us if they did not get on with a particular member of staff the registered manager took action and changed the staff member visiting.

The service ensured people's care plans and other personal information was kept confidential. People's information was stored securely at the office and we were told copies of care plans were held in people's homes in a location of their choice. Where office staff moved away from their desks we saw computer screens were turned off to maintain information security. We saw the confidentiality policy had been signed by staff. The policy gave staff information about keeping people's information confidential and highlighted conditions for sharing people's information.

People's independence was promoted. Care plans guided staff on how to promote people's independence.

For example, one person's care plan highlighted staff were to 'supervise' the person taking their medicine as they liked to do this themselves. We spoke with staff about promoting people's independence. Staff comments included; "I try and encourage them (people) to do as much for themselves as they can", "If someone can do something I let them do it. I don't take skills away from them" and "I'm all about promoting independence. I believe if I take something away they lose it. If they can do it, I make sure they do".

People told us staff promoted their independence. Comments included; "They (staff) help me to shower and encourage me, such as they will do my back and I will do my arms", "She (staff) lets me do what I can for myself. She lowers the chair and leaves me to wash myself but will then wash my hair" and "Sometimes I will wash up and they let me do it".

People's care was recorded in daily notes maintained by staff. Daily notes recorded what support was provided and events noted during the visit. These provided a descriptive picture of the visit. For example, one care plan noted 'made a cup of tea and a cold drink. Chatted and left [person] feeling well'. Another recorded 'washed and dried up, made tea and had a lovely chat. All okay'.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to accessing the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person's care plan stated 'likes jigsaws and puzzles'. Another stated the person 'loves nature' but 'hates tea'. Staff we spoke with were aware of people's preferences.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how to support people. For example, one person had a specific condition where they needed frequent support to manage the condition. The person was able to manage much of their condition themselves and a consultant had assessed the person and found them 'competent'. One staff member had been trained via the 'shared care protocol' to oversee the management of this person's condition and train other staff to support the person.

People received personalised care that responded to their changing needs. For example, following a change in one person's condition the person was referred to a speech and language therapist (SALT) and their care plan was reviewed to reflect new guidance and changes to support needs. We also saw evidence the service responded to people's requests. For example, where people had private or medical appointments they contacted the office and changes were made to the person's visit schedules. These changes were made in consultation with the person to reschedule visits at a convenient time for them. One person spoke with us about changing a staff member when they didn't get on. The person said, "I have a say in who is coming".

People were supported by staff who understood, and were committed to delivering, personalised care. Staff explained to us how they tailored people's care to suit their personal preferences. Staff comments included; "To me this is how they (people) like things done. I offer choices and take instructions from the client" and "This is care for the individual. Everyone is different".

People's care was regularly reviewed and involved people and their families. We saw reviews were scheduled throughout the year or when people's circumstances or needs changed. People and their relatives told us about reviews of care. One person said, "From time to time the care plan is reviewed, it was done two months ago". Another person said, "They came this week to look at my care plan". "One relative commented, "The plan gets updated from time to time. I think it was six months ago".

People knew how to raise concerns and were confident action would be taken. Everyone we spoke with knew how to make a complaint and felt they were listened to. People's comments included; "If I had a complaint I know they'd do something about it", "I had a complaint about a carer (staff member) and something was done about it", "One staff member was a little heavy hand and I complained. They did resolve it for me" and "I had a problem about a year ago, continuity, and they sorted it".

We looked at the complaints folder and saw there were no recorded complaints recorded for 2017. Historical complaints were dealt with compassionately, in line with the provider's complaints policy. People

were provided with details of how to complain when they joined the service. Compliments to the service were also recorded. We saw numerous compliments from people and their families praising both staff and the service for care and support they had provided.

People's opinions were sought and acted upon. A provider survey was sent to people and asked questions relating to all aspects of care and support. We saw the results of the 2016 survey which were positive. Where issues were identified the provider took action to improve the service. For example, the survey identified 91% of people felt the staff were 'well presented'. The registered manager introduced the 'presentation and staff uniform policy' into the induction programme and increased the frequency of spot checks. One person felt their privacy and dignity was 'not always' respected. This person was offered an immediate review of their care. We noted the 2017 survey had been returned and the results were being analysed.

People told us they received surveys. Comments included; "I have completed one recently and sent it back", "Oh no complaints, I've got the survey" and "I've done an appraisal (survey) for them recently. Things are going very well. I've also seen the manager a couple of times".

People's opinions were also sought through 'quality monitoring telephone assessments'. Office staff called people to ask their opinions about the service provided. Conversations were recorded and those we saw were positive.

Good

Is the service well-led?

Our findings

At our last inspection on 3 February 2016 we found the provider did not have effective systems in place to ensure the quality of the service was monitored and improved to ensure the regulations were met. This was a breach of Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made.

The registered manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audit results were analysed and resulted in identified actions to improve the service. For example, an audit of the electronic telephone monitoring system had identified a staff member had been late for a number of visits. The registered manager interviewed the staff member and offered 'advice and guidance' to support them and prevent further lateness.

Medicine records were audited monthly and the results were analysed to look for patterns and trends. For example, if a person regularly refused to take their medicine. This allowed the registered manager to take action and improve the service. Care plan reviews and staff supervisions were monitored electronically. Work sheets were published informing staff when they were due a supervision or review. The system was also able to highlight if staff were overdue a supervision meeting. This meant staff supervisions and people's care reviews were planned and monitored consistently.

People and their relatives told us they felt the service was well managed. People's comments included; "It's well managed, more favourably than other companies", "This is one of the good ones, I'm convinced of it", "Management is very helpful. I rang them once and they came out immediately", "I know them all, they are excellent" and "They are competent at what they do". One relative said, "Good management, no problems at all".

Staff spoke positively about the registered manager. Staff comments included; "She is brilliant, approachable and very supportive. She's always there", "We deliver very good care. Nice place to work, nice team of colleagues. The managers are approachable and supportive", "She is good and supportive, very professional" and "I've been working here for two years and I'm very happy with the management team. They are very flexible to me as a single mother and they are always accommodating shifts for me".

Staff told us that learning was shared through texts messages, staff meetings and briefings. One member of staff said, "Text messages go to all the carers so we all know. We do have staff meetings but for day to day work we use text". Another staff member said, "We get text updates and we talk to each other about issues. I feel well informed".

Staff meetings were held where staff were able to be briefed and to raise issues or discuss concerns. For example, the last team meeting minutes recorded staff discussed the electronic telephone monitoring system and staff vacancies.

Staff were also provided with a monthly newsletter. This provided information and updates about the

service. This information included pensions, recruitment and other staff related issues.

We spoke with the registered manager about their vision for the service. They said, "I am always looking for continuous improvement, I listen to my staff and clients so I can see how we can improve. We put people first so improvements are vital".

Accidents and incidents were recorded and investigated. The results of investigations were analysed by the registered manager to look for patterns and trends. For example, one staff member had been bitten by a person's dog. The member of staff was not seriously injured. The incident was investigated and a risk assessment created to keep staff safe. Staff were briefed about the risk and measures were put in place to manage this risk.

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.